The COUNSELING CENTER of Wayne & Holmes Counties

Treatment, Payment and Operations Consent Form

Client First & Last Name: _____

DOB: _____Client ID #: _____

Treatment consent authorization is being given by:

☐ Self

☐ Name of Parent(s) of Minor listed above: _____

☐ Legal Guardian / Name of Legal Guardian: _____

I consent to The Counseling Center of Wayne and Holmes Countie's (TCC) to use/and or disclose my Protected Health Information (PHI) and, alcohol/drug use and/or abuse (Title 42 CFR Part 2), which identifies me or which can reasonably be used to identify me, for purposes of treatment, payment and health care operations. I understand that if HIPAA covered entities and business associated receive these records for treatment, payment and health care purposes, the records may be redisclosed in accordance with HIPAA.

Treatment includes but is not limited to the administration and performance of all treatments such as diagnostic assessments, clinical documentation, outcome summaries and discharge notes.

Payment includes but is not limited to the authorization of payments directly to TCC. I hereby acknowledge the release of my health care records to third party insurers or authorized persons whose disclosure is necessary to establish or collect a fee, such as insurance payors, The Mental Health and Recovery Board of Wayne and Holmes Counties, and billing and collection services.

Health Care Operations include but are not limited to my health care information for anyone involved in my treatment of my quality of my care including but not limited to quality assessments and outcome evaluations, reviewing qualifications of health care professionals, and health insurance contacts or benefits (42 CFR 164.501)

I understand that records or information disclosed under this consent may be redisclosed by the recipient and that the information redisclosed may no longer be protected by 42 CFR Part 2. 42 CRF prohibits unauthorized use or disclosure of the records.

I understand that information shared for treatment, payment, or health care operations, to covered entities and business associates, cannot be redisclosed for civil, criminal, administrative, and legislative proceedings against me unless I have given separate, written consent.

This consent will remain until revoked or expire one year from the end of your treatment date.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I certify that I have received TCC's Privacy Notice.

_____ _____

Client signature/Guardian Signature Date

_____

Client printed name/ Guardian printed name

If I do not consent to the disclosure of my records or information, it may not be readily available to those who need the information to give you appropriate care, coordinate care, or provide reimbursement for services rendered.

If I choose not to consent to the use or disclosure of my information for payment purposes, I understand that TCC may be unable to bill my insurance or other third-party payors on my behalf. Regardless of my consent for the use or disclosure of my information, I accept financial responsibility for services rendered at the applicable self-pay or adjusted fee rate

If you have additional questions, please contact the Manager of Health Information or Compliance Officer.

I certify that I have read and fully understand the above statements and consent fully and **do not** consent to the above.

_____ _____

Client signature/Guardian Signature Date

_____

Client printed name/ Guardian printed name