Grand Island Mental Health
& Medical Clinic, LLC

# Informed Consent

(Please print)

***Patient Information***

**Patient's Name**: (First)_____(Middle)_____(Last)_____

**Street Address**: _____ **P.O. Box**: _____ **City** _____

**State**: _____ **Zip Code**: _____ **Phone Number**: (_____) _____ - _____

**Patient's Email Address:** _____ **Patient's Age**: _____

**Social Security Number**: _____ - _____ - _____ **Patient's Date of Birth**: _____ /_____ /_____

**How would you like your appointment reminder** (circle one): Text / Phone Call **Race** (optional): _____

**How did you hear about us** (circle one): Online Search (ex: Google) / Social Media (ex: Facebook) Friend

Doctor or Medical Group / Other: _____

***Insurance & Primary Care Provider Information***

**Is the patient covered by insurance?** Yes / No ***If yes, please provide your insurance card to the receptionist in order to be scanned.***

**Insurance Policy Holder's Date of Birth:** (mm-dd-yyyy) _____

**Who is responsible for the bill**: (First name) _____ (Last name) _____

**Street Address**: _____ **P.O. Box**: _____ **City** _____

**State**: _____ **Zip Code**: _____ **Phone Number**: (_____) _____ - _____

**Who is the primary care provider (pcp)?** _____

***Emergency Contact Information***

**Emergency Contact** (not living at same address): (First)_____ (Last)_____

**Relationship to Patient**: _____ **Phone Number**: _____) _____ - _____

***Release of Schedule Information***

**Would you like Grand Island Mental Health to release schedule information to someone other than the patient/guardian? This could include past appointment dates, future appointment dates, creating an appointment, and/or canceling an appointment.** Yes / No

**Name of authorized person:** _____ **Authorized person's phone number:** (_____) _____ - _____

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Phone: 308-398-0350 Fax: 308-398-0351 Text: 308-225-6464
www.grandislandmentalhealth.com - grandislandmentalhealth@gmail.com

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***Financial Agreement***

All fees have been explained to me and any questions have been answered. I authorize my insurance benefits be paid directly to the physician who has treated me. I understand that I am financially responsible for any balance unpaid by insurance. I also authorize the release of any information to my insurance company required to process my claims. I understand that it is my responsibility to inform of any insurance coverage and/or eligibility changes and that failing to do so may result in a charge of the full billed amount. I understand that payment is required at the time of service unless other arrangements have been made. Prompt payment is required and past due accounts will be sent to collections. Returned check fee is $25.00.

- ❑ Insurance will be billed the full amount for service
- ❑ No insurance coverage; I agree to amount for service of:
- ❑ Sliding Scale option; I agree to the amount determined by income qualifications $ _____.00 _____ (←Initial Here)
- ❑ Probation Voucher option; a voucher will be provided by my probation officer
- ❑ NDRA Voucher; a voucher will be provided by Legal Aid of Nebraska when available

***Informed Consent of Treatment and Release***

I agree and consent to participate in the services offered by providers employed by or associated with Grand Island Mental Health & Medical Clinic, LLC. This could include any or all of the following services from the time of intake to discharge: community support, behavioral health, and/or medical health care. I agree to release information regarding my treatment to all providers associated with Grand Island Mental Health & Medical Clinic to use as a benefit and resource to my overall treatment goals. I understand that I am consenting and agreeing only to those services that the provider(s) is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the health care providers directly supervising the services received by the patient. If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

***Current Fees***

Initial Session with Diagnostic Assessment - $160.00
45 Minute Individual Session - $130.00
Family Session - $120.00
Initial Medication Visit - $231.00
30 Minute Follow-up Visit - $95.00
60 Minute Individual Session - $160.00
30 Minute Individual Session - $90.00
Substance Abuse Evaluation - $225.00
60 Minute Follow-up Visit - $226.00
Community Support Visit Per 15 Min - $30.00

***Insurance Billing***

We are happy to bill your insurance company or payor source on your behalf. Check with the front desk staff to be sure the provider who is treating you is in-network with your insurance company. If you have a secondary insurance company, we will send claims for payment to your secondary insurance upon receipt of Explanation of Benefits from your primary insurance company. Any remaining balance will be your responsibility to pay in full in a timely matter. We ask that you inform our office as soon as possible of any insurance coverage and/or eligibility changes. Failing to do so may result in a charge of the full billed amount. Copay amounts will be collected at the time of service. Any Medicaid charges will be considered payment in full.

***High Deductibles:***

If you have a high deductible plan or have not met your deductible yet, we ask that you pay $50 at the time of your visit to ensure that your account balance does not get too large. Once you have met your deductible, you will no longer be asked to pay $50 for each session at the time of service and the amount due at time of service will reflect your copay and/or co-insurance amounts set by your insurance company. If insurance happens to pay the entire amount for your session or you have a credit on your account, this amount will be reimbursed to you.

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***Financial Hardship Sliding Scale for Therapy***

We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. Household adjusted gross income x .001 = Rate of session with no amount being less than $45 or higher than regular session rate. (Ex: $45,000 per year = $45/session, $95,000 per year = $95/session)

***Financial Hardship Sliding Scale for Medication Management***

We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. Household adjusted gross income x .001 + 70% = Rate of session with no amount being less than $75 or higher than regular session rate. (Ex: $45,000 per year = $75/session, $95,000 per year = $161.50/session)

***Service Definitions***

Community Support provides a wide array of services to recipients based on their individual needs and disabilities. Services are designed to assist children, adolescents, and adults challenged with mental health, substance abuse, and/or intellectual/ developmental disabilities. These services help service recipients achieve, regain, and maintain their highest level of functioning, thereby allowing them to live more independently and participate in the community.

Outpatient Therapy services are provided to persons of all ages with mental health, substance abuse, or co-occurring disorders. Treatment services are provided by qualified clinical personnel, utilizing an array of treatment modalities (e.g., individual, family, and/or group therapy) to assist service recipients in addressing a variety of behavioral health challenges.

Medication management is the level of outpatient treatment where the sole service rendered by a qualified prescriber is the evaluation of the individual's need for psychotropic medications, provision of a prescription, and ongoing medical monitoring of those medications. Complete with an initial assessment that identifies the need for medication management and medication monitoring routinely and as needed.

***Office Infectious Control/Sickness Information***

If you are currently sick or have been exposed to a communicable disease and are not seeking medical services for that illness from our office, we do ask that you kindly notify our staff prior to your appointment and reschedule to a later date. If you have any communicable diseases we ask that you indicate them on intake paperwork in order for us to accommodate any needs you may have and better protect and reduce risk to all other individuals in our office. We ask that all individuals in our office practice safe hand hygiene by washing hands with antibacterial soap and/or use hand sanitizer to decontaminate hands. Hand hygiene guides are posted in all bathrooms. All staff in this office are trained in standard precautions and will provide care to the best of their ability according to CDC regulations. A copy of the office Infectious Control Policy can be obtained by request at any time.

***Complaints and Grievances***

Your care and treatment in our office are our top priorities. If any of our services do not exceed your expectations please report to administration as soon as possible. (308-398-0350 Debra: ex 1 and Jordan: ex 2) Report billing discrepancies to the billing department at 308-398-0350 ex 3. If necessary, report complaints to the DHHS hotline at (402) 471-0316 Hours: M-F 8 a.m.- 5 p.m. CST or ACHC at (919) 785-1214. More detailed information regarding this process can be obtained by request at any time.

***Power of Attorney/Advanced Directives and Release of Medical Information***

In the state of Nebraska, it is your right to appoint an individual to make health care decisions on your behalf, would you like to be given information to appoint a medical or psychiatric power of attorney?

❑ No ❑ Yes

Would you like us to release information regarding this treatment to any person or clinic on your behalf?

❑ No ❑ Yes**: (**If yes, to whom:) _____

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***Telehealth Treatment***

Telehealth consultation means any contact between a client and a health care practitioner relating to the health care diagnosis or treatment of such client through telehealth. For the purposes of telehealth, a consultation includes any service delivered through telehealth.

Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring.

Please be advised that alternative options to telehealth are available, including in-person services as long as the office is open for business. If telehealth is being offered due to office closures, other options such as in-person services may not be available. In this case, be advised that telehealth services are offered as an alternative out of convenience and are not required to continue with treatment.

All existing laws and protections for services received in-person also apply to telehealth, including: confidentiality of information; access to medical records; and dissemination of client identifiable information. Telehealth consultations with our office will not be recorded unless a separate informed consent is signed in advance. Only the provider and the client will be allowed to be present during the telehealth session.

Should there be an emergency or urgent situation at any time during or after the provision of telehealth, the client and/or provider will contact local emergency services as necessary. This could include but is not limited to, calling 911 or the Midplains Crisis Stabilization Unit at 308-385-5250. Should there be a disconnection of services at any time, the provider will work to contact the client to discuss options for continuing or rescheduling services as needed.

For a client who is a child receiving telehealth behavioral services, an appropriately trained staff member or employee familiar with the child's treatment plan or familiar with the child will be immediately available in person to the child receiving a telehealth behavioral consultation in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child's parent or legal guardian with proper documentation. In cases in which there is a threat that the child may harm himself or herself or others, the provider will contact the parent or guardian to notify as well as emergency personnel services as necessary. These contacts could include but are not limited to, contacting the legal parent or guardian, calling 911, or the Midplains Crisis Stabilization Unit at 308-385-5250.

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***Rights and Responsibilities***

You have the right as a Patient to:

- Be fully informed in advance about service to be provided, including the disciplines that furnish service and the frequency of visits, as well as any modifications to the plan of care
- Participate in the development and periodic revision of the plan of care and receive a clear explanation of your condition and treatment options
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed, in advance, both orally and in writing, of services being provided; of the charges, including payment expected from third parties and any charges for which you will be responsible
- Have your property and person treated with respect, consideration, and recognition of your dignity and individuality
- Be able to identify personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of service recipient property
- Voice complaints/grievances regarding services, lack of respect of property or recommend changes in policy, personnel, or service without interference, coercion, discrimination, or reprisal
- Have complaints/grievances regarding services that are (or fail to be) furnished, or lack of respect of property investigated
- Have confidentiality and privacy of all information contained in the service recipient record and of Protected Health Information (PHI)
- Be advised on agency's policies and procedures regarding the disclosure of clinical records
- Receive appropriate services without discrimination while being treated fairly and with respect, regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Be informed of any financial benefits the treating organization may have when it refers the service recipient to another organization
- Be fully informed of one's responsibilities
- Receive information about the scope of services that the organization will provide
- Be informed of your rights under state law to formulate an Advanced Directive
- Receive proper and timely medical care.
- Be protected in this office by staff who are trained and follow emergency, safety, and infectious control protocols
- Have voiced concerns or complaints to proper sources investigated and without experiencing reprisals.
- Have interpreters available, if necessary, during appointments and in all discussions with your health care providers.

As a patient you are responsible to:

- Keep scheduled appointments or call your healthcare provider in advance if you cannot keep an appointment.
- Inform your healthcare provider of your medical and mental health diagnosis, symptoms, and concerns.
- Ask questions if you do not understand.
- Follow your health care provider’s orders and treatment plan
- Treat those giving you care with dignity and respect.
- Give providers accurate information needed in order to deliver quality care
- Tell your provider about medication changes, including medications given to you by others.
- Put your own health and the health of others at a high priority which may include rescheduling an appointment if you contract a communicable disease and/or comply with appropriate treatment to cure communicable diseases
- Let your provider know if the treatment plan is not working for you

I have been made aware of and understand all Member Rights and Responsibilities. I have been offered a copy of the office Notice of Privacy Practices. Any questions I have regarding these have been answered and I understand the risks and benefits related to treatment. If participating in the Community Support Program, I understand that my participation is voluntary and my progress will be evaluated every 90 days to continue participation. I attest the above information is true to the best of my knowledge. My signature authorizes my provider to provide treatment to the person listed as the client.

**Patient/Guardian Name (Please print): _____**

**Signature: _____ Date: _____ / _____ / _____**

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