For Office Use: Client Name: Last, First Middle (Maiden, if applicable)	Client ID #

Consents/Acknowledgements

Treatment

I voluntarily consent for services/treatment at NorthCare under the guidelines of the Oklahoma Health Law.

I have received a copy of my rights and responsibilities, have read (or had it read to me) and understand its intent.

I acknowledge that I was informed of NorthCare's Notice of Privacy Practice and was offered a paper copy.

I understand that in entering treatment I must conduct myself in such a way to protect myself and others from exposure to, or transmission of, infectious diseases such as hepatitis, AIDS, venereal disease, and any other communicable disease.

I understand that services NorthCare provides are holistic, meaning that behavioral health is dependent upon overall health. I understand that I will receive coordinated care, integrated services and my health care providers must talk to one another and share information about me in order to effectively and efficiently provide the care I need for a healthy life. By signing this form, I agree to allow my various health providers to see, read, copy and share my health information with each other, primarily, through a health information exchange. I also understand that this information may contain data about my health history, illnesses, injuries, test results, x-ray reports, blood test results and medication.
Furthermore, I have been advised that if at any time I want to do so, I may choose another qualified provider to coordinate my care and deliver my needed services.

Consent for Follow-up
I understand the agency periodically conducts follow-up surveys with patients in order to determine outcomes of and satisfaction with services and provides statistical information. I ☐ **agree** ☐ **do not agree** to be contacted by NorthCare for this purpose. If I do not agree to follow-up, I understand it will in no way restrict my treatment at this agency. I would prefer to be contacted: ☐Text Message ☐Traditional Mail ☐E-mail

I consent to NorthCare providing my email address to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) for their purposes.

Consent to Photograph
I authorize being photographed for the purpose of identification during treatment at NorthCare. I understand that this photograph becomes part of the permanent confidential record. These digital pictures will not be used for any other purpose.

Financial Responsibility
I agree I have received, read and understand the Employee Court Appearance Fee Agreement and I further agree to pay the fee if and when indicated.

I understand if I become eligible or am certified for Medical Assistance through the State Medicaid program, I agree to apply for coverage or continued coverage. Claim for payment of fees will be submitted to the OK Health Care Authority. I understand I will not be charged for services provided by NorthCare that are covered by Medicaid.

I hereby authorize payment directly to NorthCare for the benefits otherwise payable to me, which may include, but are not limited to, major medical benefits. I understand that I am financially responsible for charges not covered by this authorization.

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Transportation and Medical Care

In the event that a medical emergency occurs while I and/or my family members are with a NorthCare representative receiving services and/or on NorthCare property and I am unable to consent to medical treatment, I hereby authorize any NorthCare representative to seek appropriate medical treatment for me and/or my family members.

I, the undersigned, hereby authorize NorthCare staff to transport me and/or my family as necessary in the course of services (i.e., outings, therapeutic activities, etc.) and acknowledge that my family and/or I may engage in activities which may involve risk of personal injury and/or property damage. I also understand if riding in a NorthCare vehicle, the vehicle may be marked with NorthCare identification, including NorthCare's name and/or logo.

Notice regarding Pharmacy Services

NorthCare offers an onsite pharmacy for consumer convenience. NorthCare has an ownership interest in this pharmacy. Consumers may fill prescriptions at NorthCare's pharmacy, but are not required to do so. It is each consumer's decision where to fill his/her prescriptions.

Consent for Release

I understand that my records are confidential, and will not be released without my expressed written consent unless (1) A court so orders; (2) An emergency exists in which holding information would likely result in harm to you or another; (3) Cases of suspected child abuse or neglect must be reported as required by law.

I authorize release of information as required and/or requested by my insurance company(s) for the purpose of admission certification, benefit determination, extensions of stay, payments, or other insurance matters as necessary. I furthermore release NorthCare from liability under Title 76, Oklahoma statutes, Section 19, and 42 USC 290 (DD) (EE) 3 for releasing information for these purposes.
I understand that if part of the cost of my treatment is paid by Federal or State funding sources, and that these sources have the right to review my file on a periodic basis to verify and evaluate the services that have been delivered to me. This review is done for accounting or evaluative purposes only, with no files or clinical information removed from this agency.

I understand that my records may be protected under 42CFR, Part 2, governing alcohol and drug abuse patient records; the Health Insurance Portability and Accounting Act of 1996 (HIPAA), 45CFR pts. 160 & 164; State confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law prohibits any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

HIV/AIDS/STD EDUCATION, TESTING AND COUNSELING:

***I ☐ accept/☐ reject HIV/AIDS/STD education / testing and / or counseling for myself.**
***I ☐ accept/☐ reject HIV/AIDS/STD education / testing / and / or counseling for my spouse/significant other.**
If yes, client/spouse/significant other will be referred to the Health Department for requested services.

Client/Parent/Guardian Signature:

_____
Date

Staff Signature and Credentials:

_____
Date

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Outpatient Client Rights

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

(A) Allow other individuals of the consumer's choice to participate in the consumer's treatment and with the consumer's consent;
(B) To be free from unnecessary, inappropriate, or excessive treatment;
(C) To participate in the consumer's own treatment planning;
(D) To receive treatment for co-occurring disorders if present;
(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment, and
(F) To not be discharged for displaying symptoms of the consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.

(6) No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(8) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

(9) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

These rights have been explained to me upon admittance and I have been offered a copy of them.

Client/Parent/Guardian Signature:

_____
Date

Staff Signature and Credentials:

_____
Date