Consent for Treatment

I Consent to Treatment and Authorization to Release Information to Third Party Payer for the purpose of billing and/or reimbursement and for pharmacy benefits.

I, the undersigned, acknowledge that I am currently experiencing or previously experienced mental health symptoms and/or addiction disease, conditions that may require diagnosis and treatment.

I hereby voluntary consent to such diagnostic and treatment procedures and care provided as is necessary in the judgment of the Licensed Provider at Worthington Consultation and Behavioral Medicine.

I understand that I have the right to refuse treatment according to Rule 5122:2-1-2 of the Administrative Code of the Ohio Department of Mental Health. I also understand the consequences of refusing or withdrawing consent of treatment.

I hereby acknowledge that no guarantees have been made to me as to the result of treatment or examination provided by Worthington Consultation and Behavioral Medicine.

I agree to provide copies of insurance cards and / or claim forms so that my insurance company can reimburse me for services that I have received.

This consent, unless otherwise revoked by the patient or responsible party, expires upon formal discharge, with the exception, of permission to bill (when applicable). Permission to bill and follow-up with the payer of services rendered will expire within two years from the date of discharge.

I, the undersigned, do hereby authorize Worthington Consultation and Behavioral Medicine to release to my insurance carrier or other category of third party payer, that is responsible for payment of my medical charges, the following information (as requested by payer): medical information including diagnosis, Initial evaluations, progress notes and lab reports, for the purpose of securing direct or indirect payment of my treatment beginning on the date listed below.

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance thereon, and by giving written notice. If no prior written notice of revocation is received, this consent will automatically expire two years after the date indicated below.

X **PATIENT'S SIGNATURE** (or Legal Guardian):	**Date:**

NOTICE TO RECEIVING AGENCY/PERSON: PROHIBITION ON REDISCLOSURE.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of the information without the specific written and informed release of the individual to whom it pertains, or as otherwise permitted by state law.