Patient Consent for Treatment and Payment Responsibility

I, _____ or _____, _____
(Client's Name) (Guardian's Name) Client #

hereby consent to receive evaluation and/or treatment by Aspire Indiana.

I understand that such evaluation and treatment may consist of psychiatric, psychological, psychosocial, medical and primary health evaluations, medication, psychotherapy, and other modes of treatment available and tailored to my needs including hospitalization, if required. I understand in order to be seen for addiction services I must provide breath samples or urine specimens for analysis at the time requested, I am responsible for the cost of the testing, and urine specimens sent to a laboratory for analysis will be identified only by client number and first name. I also understand that this consent does not waive my civil rights and I reserve the right to decline treatment against medical advice.

I understand that mental health services will be provided by a behavioral health professional directly supervised by a qualified provider within the scope of licensure, certification and training.

I understand that integrated health services will be provided by a primary care health professional directly supervised by a qualified provider within the scope of licensure, certification and training. I am aware that the practice of medicine and other health care professions is not an exact science and I acknowledge that no guarantees have been made to me as to the results of any treatment, examinations, procedures or other services provided by Aspire.

I understand that **The Aspire Notice of Privacy Practices**, a **copy of my rights as a client,** a document on **Confidentiality of Alcohol and Drug Abuse Client Records, Tuberculosis Information** and **DMHA registration** and submission information are available to me in paper form in Aspire offices, via Aspire's website, or I may request copies to be mailed to me. All have been explained to me and I understand that I may voice my dissatisfaction at any time. I have the right to request to complete an Advance Directive or Psychiatric Advance Directive.

In order to provide the most convenient and accessible service to our customers and to help us meet the regulatory requirements of our services, Aspire utilizes a variety of internet based products to supplement and enhance our services including Tele-Health. Each product or service is reviewed for compliance with HIPAA requirements for safety and security of Protected Health Information. There are certain risks associated with using internet based services which will be explained to you should you choose to register for any particular service.

I understand and agree that failure to provide accurate/up to date insurance information at the time of my appointment may result in me being responsible for payment.The Sliding Fee Scale Discount that Aspire offers will be applied to my account as long as I provide income verification within **30 days**, whether I have insurance coverage or not. **Income verification will take place if I have changes in my income status or every 12 months.**

I authorize my insurance company to make payments directly to Aspire Indiana for the cost of services. I authorize Aspire Indiana to bill my insurance company on file and release all information necessary to process claims for any and all the services that I may receive including substance abuse counseling, drug and alcohol related information, HIV/AIDS and other infectious disease information.

I understand that in the event that I do not pay for services rendered to me by Aspire Indiana and any amounts due become delinquent, that I shall be obligated to Aspire Indiana not only for the value of those services, but also for payment of all reasonable attorney fees incurred by and cost associated with Aspire Indiana's collection of such delinquent amounts.

This release may be revoked by me in writing and further disclosure will not occur, except to the extent that Aspire Indiana has already acted in reliance on it. At that point I will be responsible for any costs for services that I incur. This release will expire when all related billing issues, including payment audits, have been resolved to the satisfaction of Aspire Indiana.

Patient Acknowledge and Confirmation

- I understand that I am giving consent for treatment
- I understand/agree to the above financial and payment obligation
- I understand that if I do not bring proof of income, it will prevent my eligibility for sliding fee discount.

_____or _____ _____
Signature of Patient Parent/Legal Guardian Date