eXclusive Services
11134 Luschek Drive
Cincinnati, OH 45241
Office: (513) 827-9273
Fax: (513) 818-9960
treatment@xservices.org

Consent for Outpatient Treatment Mental Health Treatment & Financial Responsibility Agreement

CONSENT TO TREATMENT

The undersigned, patient/patient's legal guardian, voluntarily consent to outpatient treatment for mental health and authorizes the eXclusive Services to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, pharmacological management services, mental health assessment and community psychiatric supportive treatment. Services at eXclusive Services will be provided by a multidisciplinary team that may include one or more of the following: psychiatrists, psychologists, independent licensed social workers, licensed professional clinical counselors, licensed social workers and professional counselors, certified chemical dependency counselors, advanced practice nurses, qualified mental health specialists, case managers, and experiential therapists.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby permits eXclusive Services, and/or their authorized personnel, to access and/or release all or any part of the patient information (including information regarding drug/alcohol treatment, HIV testing, AIDS and mental health treatment) to, including but not limited to, the appropriate healthcare insurer(s), third party payer(s), and/or the eXclusive Services agent(s), attorney(s) and/or consultant(s) for purposes including improving patient care, performance improvement initiatives, discharge planning, risk management, collection agencies, regulatory and licensing agencies and/or as required by law.

RESEARCH FACILITY

I understand that eXclusive Services may participate in research. As such, I grant the eXclusive Service's research treatment team access to my or the patient's records to determine if I or the patient may be eligible for a current or potential study. This consent involves only the review of records, and additional information and consents would be provided in the event that I or the patient would be considered for the study.

MEDICAID AND MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicaid/Medicare Beneficiary, I have the right to receive Medicaid/Medicare covered services. This includes medically necessary services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON_APPROVED SERVICES

Ohio law requires eXclusive Services to inform the undersigned that if your insurance company did not give prior approval for medical services and you choose to have the services provided, you would be required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicaid and Medicare, if the patient is a Medicaid/Medicare beneficiary, be made on the patient's behalf to eXclusive Services for any services provided to the patient. It is my responsibility to notify eXclusive Services of any changes in my health care coverage. I acknowledge that I am financially responsible for all charges associated with health care services provided by the center to me (or the patient named below). (Insurance) I do have insurance that provides coverage for mental health and/or alcohol/drug treatment services. I am requesting the center bill my insurance provider. I agree to pay all deductibles, co-payments and any fees that my insurance company does not cover, that are associated to the services I receive at eXclusive Services. I can request whether or not to (or the patient named below) have my insurance to provide coverage for mental health services, the center not bill my insurance company for privacy reasons. I acknowledge that my request that the center not bill my insurer creates a personal financial obligation on my part. *this should be in written by the patient or patient's guardian.

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OTHER INFORMATION

I, the undersigned, agree to abide by eXclusive Service's policies and procedures and recognize that my compliance will minimize the danger of accidents or injury to myself, other Patients, and employees of eXclusive Services. I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my acts/omissions while I am being treated at eXclusive Services. I, the undersigned, acknowledge that eXclusive Services is not responsible to me or my property for the acts/omissions or any liability arising from the acts/omissions of any other patients at eXclusive Services.

I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal. I have received a copy of the Client Handbook which includes the patient rights and grievance policy, notice of privacy practice, an explanation of the risks & benefits of treatment, alternative treatments, and of no treatment.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE

Patient's Name: _____

Signature: _____

Date: ____/____/_____

Guardian's Name: _____

Signature: _____

Date: ____/____/_____

eXS Staff's Name: _____

Signature: _____

Date: ____/____/_____