Adult Consent to Treatment

Patient Name: ____

You are agreeing to treatment at our clinic, Advanced Behavioral Medicine PC ('ABM') according to the following agreement and guidelines.

Patients Rights:

- You have the right to receive necessary care regardless of your race, sex, national origin, marital status, sexual orientation, beliefs, values, language, functional, age, disability or source of payment.
- You have the right to receive considerate and respectful care in a smoke-free environment.
- You have the right to privacy, to receive information about rules involving your care or conduct, and to be free from mental or physical abuse or harassment.
- You have the right to information about your condition, treatment, including safe use of medications, and prognosis, including unanticipated outcomes of care.
- You have the right to know who is taking care of you and his/her professional titles.
- You have the right to be involved in the planning, completion and review of your plan of care.
- You may refuse treatment to the extent permitted by law. It is our responsibility to discuss with you the possible results of your refusal.
- You have the right to participate in health care decisions and we will try to understand and respect your requests so long as they are medically appropriate and within our reasonable capability.
- No experimental procedure can be a part of your care without your approval.
- Your right to make decisions about health care does not mean that you can demand treatment and services that are medically inappropriate or unnecessary.
- You have the right to have health information provided in a manner and form that you can understand.
- You have the right to details about all items on your bill. Notice of non-coverage by an insurance policy will be given to you as we receive it. Upon request, information on financial help will be given to you.
- You have the right to express any concerns you may have regarding your care. We encourage you to communicate concerns or compliments to the individual involved, or to Recipient Rights Officer, Evelyn Dionise or the Clinic Director, Dr. Matossian, both at (517)548-1537.
- Please file a written or verbal grievance with the clinic office if we don't promptly resolve your concerns.
- You also have the right to lodge a grievance with the State of Michigan Department of Consumer & Industry Services, Bureau of Health Services, PO Box 30670, Lansing, MI 48909-8170, (517) 373-9196.

You are responsible for:

- Following the rules involving patient care and conduct.
- Identifying the problems you want help with and to work with the clinicians on a treatment plan.
- Providing a complete and accurate medical history, including all prescribed and over-the-counter medications that you are taking, all recreational drugs or alcohol use and all treatments and interventions that you are involved in.
- Following the suggestions and advice prescribed in a course of treatment by your health care providers, or accepting responsibility for the consequences of failing to do so. If your refusal of treatment prevents us from providing care according to ethical and professional standards, we may need to end our relationship with you after giving you reasonable notice.

- Being considerate of the rights of other patients and ABM personnel.
- Providing information about unexpected difficulties you have involving your health care, and making it known whether you clearly understand your plan of care and the things you are asked to do.
- Making appointments, arriving on time, and paying for appointments missed, rescheduled or cancelled less than one business day in advance of the appointment time.
- Knowing your insurance benefits and co-pays, getting pre-approval when necessary, and paying for any balance remaining after insurance adjustment, regardless of our prior estimates of your co-pay amount.
- Providing us with correct information about your sources of payments and ability to pay your bill, and paying for charges not covered by insurance.

Patient Consent:

By signing below, I agree to accept services from Advanced Behavioral Medicine, PC. I received a copy of the HIPAA Privacy Notice. I agree that my confidential information may be released to my insurance carrier, my doctor, and to others, as described in the HIPAA Privacy notice.

I agree to keep all scheduled appointments or provide advance notice of cancellations, whenever possible. I agree to pay a $50.00 fee for appointments missed, rescheduled or cancelled without 24 hour notice the first time and the full clinic rate following, regardless of reason. I agree to pay an interest charge of 1.4% per month on any unpaid balance after 30 days.

I have been given and read the information rate sheet and you understand that fees are subject to change.
I understand that ABM policies described above may change over time and if so, the changes will be posted in the clinic lobby or distributed to me directly.

I agree _______ or **do not agree** _______ to allow my ABM to share, for the purpose of coordinating care, my evaluation and treatment information with my current physician or other medical professional involved in my care, listed below. This permission to share information will expire 6 months from today.

Current physician or other medical/mental health provider:

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I agree ________ or **do not agree** _______ to allow ABM to survey me during or after treatment about the quality of the care I received. I understand that I may ignore the survey or choose not to participate.

I have understood and agreed to all the rights and responsibilities described above. I am voluntarily seeking services, including medical assessment and treatment, at Advanced Behavioral Medicine, PC. If I am found to have a medical illness I will be offered usual and customary treatment or be advised to the contrary. I understand that this process begins with an initial assessment and may include recommendations for psychological testing, psychiatric evaluation, prescription medication, individual psychotherapy, family or group psychotherapy, and other prescribed treatments

Patient Name: ____

Patient Signature: ____

Date: ____________________

Optional
Email: ____
For communication use between you, the doctor, clinician staff and office staff of Advanced Behavioral Medicine.