ART OF RECOVERY SERVICES NFP
1512 ARTAIUS PARKWAY, STE 200, LIBERTYVILLE, IL 60048

Client Name: _____

DOB: _____

Client ID: _____

INFORMED CONSENT FOR TREATMENT AND PAYMENT

I, _____, consent to treatment by Art of Recovery Services NFP (AOR).

_____Myself; Name: _____ DOB: _____
_____Minor/Person for Whom I am Guardian; Name: _____ DOB: _____

All individuals under the age of 18 are eligible for services if they have obtained written parental consent or if they are otherwise permitted under Illinois law to consent on their own behalf to such care. In addition, a parent, legal guardian, or minor child who is permitted under Illinois law to consent on their own behalf has a right to refuse any health care services. Illinois State Law requires a parent's or legal guardian's consent to provide treatment to a minor child except for family planning, sexually transmitted infection services, and certain mental health services when the minor is 12 years of age or older. (325 ILCS 10/0.01 et seq.; 410 ILCS 210/0.01, 4, 5 et seq.; 740 ILCS 110/1, et seq.)

_____ (Initial) I agree to adhere to all facility policies for which I am responsible. The nature, purpose, risks and benefits of the treatment and possible alternatives have been or will be explained to me.

_____ (Initial) I hereby grant AOR permission to call for an ambulance in the event of emergency, injury, or accident requiring such action. I also specifically grant AOR permission to authorize medical services needed if I am unable to do so.

_____ (Initial) **I UNDERSTAND THAT I HAVE A RESPONSIBILITY TO ACTIVELY PARTICIPATE IN MY TREATMENT, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF MY INDIVIDUALIZED RECOVERY PLAN. I HEREBY AUTHORIZE AOR TO PROVIDE MENTAL HEALTH SERVICES TO ME.**

AUTHORIZATION FOR RELEASE OF INFORMATION FOR PAYMENT

Services will be billed to Medicaid, Medicare or other third-party payers based on the information I provide. AOR reserves the right to bill me if the information I have provided is not valid. It is my responsibility to notify AOR of any changes in my healthcare coverage within 30 days of change and/or affected service dates. Failure to notify of changes may cause the charge for visits to become my responsibility. We do charge a usual and customary fee for services. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Your insurance policy is a contract between you and your insurance company. No one will be refused services because of an inability to pay.

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_____ (Initial) I authorize the AOR to release and/or send any medical information necessary for the processing and payment of my medical bills to any insurance company or third-party payer who may be responsible for paying any part of my medical treatment. This includes release to my employer for employment related injuries under worker's compensation claim. We will make every effort to ensure confidentiality in all transactions.

_____ (Initial) I, the undersigned, also give my consent to AOR to release all information necessary, including my name, date of birth and Social Security Number (SSN), family income and number of dependents, to the Illinois Department of Human Services (IDHS) and the Illinois Department of Healthcare and Family Services, in order to establish my eligibility for funding for my treatment. I understand that the release of my SSN is voluntary. Failure to provide my SSN may jeopardize funding for my treatment from state agencies and may make me responsible for payment for treatment. If I am required to provide toxicology testing as part of my care, I understand that my SSN may be used to report the results to IDHS.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

As a patient of AOR, I have been provided with its Notice of Privacy Practices, which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights. I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of AOR and my rights to privacy protection and access to my medical information. AOR will use and disclose my personal health information to treat me, to receive payment for the care they provide and for other health care operations. Health care operations generally include those activities they perform to improve the quality of care, including sharing information with health information exchanges and/or Record Locator Services. I understand that the Privacy Officer is available to answer any questions that I may have regarding issues of privacy. I also acknowledge that this Notice of Privacy Practices is not a contract between the AOR and the undersigned, but merely a notice of my privacy rights under state and federal law. The terms of the notice may change with time and the current notice will always be available online, posted at each of the facilities, and copies made available for distribution upon request.

_____ (Initial) I consent to participate and to work with staff to develop treatment goals and needs. I understand that students (nursing, medical assistant, medical, physician assistant, counseling, nurse practitioner, pharmacy), interns, residents and fellows may be involved in my care and I have the right to let my care team know if I do not want these individuals involved in my care.

_____ (Initial) I have been informed of my rights and responsibilities. I have received a copy of the Client Handbook and Client Rights. The terms of the Client Handbook and Client Rights may change with time. AOR will have copies of the Client Handbook and Client Rights available for distribution upon request. I understand that questions regarding rights,

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responsibilities, the Client Handbook and the Client Rights may be directed to the Privacy Officer.

A copy of this signed form may be available upon request.

I understand that Family involvement may be helpful in my treatment. Please check one of the following:

____ I agree to involve my family/significant other in my treatment. (Authorization for Release of Protected Healthcare Information is required)

____ I do not want my family/significant other involved in my treatment.

I have read and had the opportunity to ask questions and agree to the conditions stated above signature:

_____ _____

Patient Signature Date Parent/Guardian Signature Date

NOTICE FOR WITNESS: In witnessing this consent, I verify that I have explained the patient's rights and believe that the patient understands these rights. In order to ensure that the client is providing informed consent, I have explained the mental health services to be provided, the nature of treatment, possible alternatives treatments/services, and the potential risks and benefits of treatment to the client and the client's guardian, if applicable.

_____

Witness/AOR Employee Date