CRUZ CLINIC

CONSENT TO SERVICES

Patient:_____ Date of Birth:_____

I acknowledge that I have received the Cruz Clinic's pamphlet, "Important Information for Patients," in which is described the policies and procedures of Cruz Clinic regarding confidentiality of patient records, emergencies, fee payment requirements, canceled and missed appointments, termination and discharge from treatment, and my rights and responsibilities as a recipient of services.

I understand that the services I, or my dependent, will receive at Cruz Clinic is based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent. I have been provided with the name and credentials of the clinician who will provide services to me, or my dependent.

Also, I understand that in order for Cruz Clinic to provide care to me or my dependent, I may be asked to consult with a psychiatrist at Cruz Clinic when this is considered necessary by a clinical staff member. I too may ask to consult with a psychiatrist on staff at Cruz Clinic, if I consider this necessary. Further, I may request that I be referred to another organization for services.

I understand that all providers are under the regular and continued supervision of Victor M. Cruz, MD. And, that some providers may also receive additional supervision from practitioners within their specific field of practice.

I understand that my records, or the records of my dependent, at Cruz Clinic are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and Federal guidelines, or as allowed by my signature on a release form, with the exceptions written below and in other patient information I have received.

If services are paid either in part or in full for by a third-party payor such as an insurance company, I understand that the funding source or its agent has the right to examine my records at any time. I hereby authorize the examination of my or my dependent's patient records sources as required for reimbursement and/or clarification of services.

I also understand that it may be necessary to release information regarding me, or my dependent, to a Case Manager or insurance verifier from my third-party payor in order for Cruz Clinic to obtain authorization to provide services. I give permission for this release. I also give my permission for Cruz Clinic to release information acquired to process billing claims for services provided to me, or my dependent by the third-party payor reimbursing for these services.

I understand that fees for services are to be paid at the time of the appointment, unless other arrangements have been made. If my third-party payor does not cover any fees or any portion of fees for the services I, or my dependent have received, I accept responsibility for them. If maximum third-party benefits have been reached, I understand that I am responsible for any fees for services subsequently rendered.

I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic has contacted my insurance company to receive my benefit information, yet sometimes the

(Please continue on reverse side)

insurance companies do not give clinics accurate information. Therefore, I realize it is in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic was quoted incorrect information, resulting in lesser benefit coverage, I understand that I am responsible for the difference. I agree to provide information for the development of the treatment plan to be used, and that I will keep scheduled appointments. I accept that I am financially responsible for all scheduled appointments. **I understand that I will be charged for missed appointments and late cancellations with less than 24 hours notice.** I am aware that because third-party payors, such as insurance companies, will not pay for missed appointments or late cancellations, any appointment that is missed or canceled without my giving 24 hours notice will be billed directly to me. I understand that I may be billed for these appointments at Cruz Clinic's usual and customary fee. Payment for a missed or late canceled appointment is due within two weeks of the appointment. If treatment or diagnostic evaluation is terminated by my choice or because of violation of program rules, I agree to pay all outstanding fees existing at the time of termination.

I agree to inform Cruz Clinic of any changes in my health insurance benefits and to assign insurance benefits to Cruz Clinic. I understand and hereby agree that accounts more than 90 days delinquent, excluding those where payment is made directly to Cruz Clinic by a third-payor (e.g., and insurance company), may be subject to collection action.

If I have been referred to Cruz Clinic by a court, agency, Employee Assistance Program, physician, attorney, hospital, or another mental health or substance abuse treatment practitioner or program, Cruz Clinic may want to acknowledge the referral by another professional. In order for this to occur, my consent is necessary. I hereby give consent to this limited release of information. Further, unless specified herein or by statute, the release of any further information to anyone required my written permission.

I recognize that if I, or my dependent, have been ordered by a court to seek services at Cruz Clinic, the court will require one or more reports. My separate, written consent is required for this to occur. I understand that Cruz Clinic shall not be obligated to send or release a copy or original of any report or any clinical records concerning me or my dependent to anyone until the balance on my or my dependent's account is paid in full.

I understand and accept that it may be necessary for Cruz Clinic to reach me by mail or by telephone during, or after, my or my dependent's treatment with Cruz Clinic for confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys and any necessary follow-up.

Patient Name _____
ID _____

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Cruz Clinic for myself, or my dependent. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services by Cruz Clinic. If termination of services

by Cruz Clinic does occur, I understand that I have the right of appeal. Further, I have read, understand and accept what is written in this "Consent To Services" and the "Important Information for Patients" pamphlet. I also understand that I may request a copy of this "Consent To Services" form.

_____		_____
Signature of Patient	Date	Witness
_____		_____
Signature of Parent/Guardian	Date	Witness

Revised 1-5-2017

Saved: N/forms/patient forms/Consent to services

Patient Name _____
ID _____

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