Patient Name:_____ Date of Birth:_____

Account Number:_____

FHN FAMILY COUNSELING CENTER
CONSENT TO TREAT

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I acknowledge that I have received or been offered the Notice of Privacy Practices of the FHN Organized Health Care Arrangement bearing the Effective Date of September 23, 2013. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute the FHN Organized Health Care Arrangement and informs me of my rights with respect to my protected health information. _____ (initials)

I hereby consent to the use and disclosure of my protected health information by FHN for treatment, payment and health care operations.

Consent to Treatment and Procedures Provided at all FHN Subsidiaries

I authorize my health care provider(s) and his/her designee(s) to provide medical services to me, including diagnostic tests and therapeutic procedures necessary for the diagnosis and treatment of my illness or condition. I further authorize the medical care, testing, and treatment as necessary in emergency situations to preserve my life and health and to protect the health of persons involved in my care without first obtaining consent from me or my family. I understand that FHN may be a teaching institution, providing clinical training opportunities for medical, nursing, and allied health students and residents. I consent to such students and residents being involved in my care and treatment and understand that they are not employees of my health care provider or FHN. I understand that students may be present and/or participate in my care at FHN. _____ (initials)

Advance Consent for Treatment of Minors

In those circumstances when the legal guardian or parent can not accompany the minor for treatment; I understand the initialing of this paragraph permits FHN to provide treatment/procedure(s) as described in the preceding paragraph to the unemancipated minor when accompanied by the following persons named or self if so indicated. _____ (initials)

The minor may come for treatment alone _____ (initials)

Name _____ Relationship to minor _____

Name _____ Relationship to minor _____

Release of Information and Assignment of Insurance/ Medicare Benefits

I authorize FHN to submit all medical charges to insurance companies or their administering entities, governmental agencies or their intermediaries, third party payers providing benefits to me, and to third party collectors. I further understand that FHN may release to such entities and to physicians participating in my care, and to their agents, copies of all medical records or other information necessary to determine available benefits and to obtain payment for services rendered. I understand that I have the right to instruct FHN not to release information for billing purposes, and understand that I will be billed directly for these services if I provide such instructions. I understand that my medical records may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/AIDS test results, and genetic information, and I authorized release of such medical records for purposes of billing and collection. I assign to FHN all claims and rights to payment under any insurance policy or health plan of which I am a beneficiary, and consent to whatever legal action FHN and its agents determine appropriate to obtain payment.

Financial Agreement

I agree, whether signing as a legal representative or as a patient, that in consideration of the service to be rendered to the patient, he/she is ultimately financially responsible for the bill. I may request, and will be provided a copy of the "Important Patient Financial Information" brochure. Should the account be referred to an attorney or collection agency for collection, the undersigned may also pay reasonable attorney's fees and collection expenses.

I certify that I am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature:_____ Relationship:_____
(patient/parent/guardian/other) (if signed by other than patient

Date:_____ Witness:_____