Western Mental Health Center

Treatment Agreement

I am applying for and consenting to evaluation and/or treatment and/or other services at the Western Mental Health Center (WMHC). This may include the use of standard medical, psychiatric, psychological procedures deemed necessary and with consent of client and/or parent or legal guardian.

Since Western Mental Health Center has a multi-disciplinary staff, I understand and agree that a free exchange between pertinent staff members regarding my evaluation and treatment may take place if deemed necessary. I further understand that this application and anything else I tell you, orally or in writing, will be kept private with these exceptions.

1. In emergencies when it appears there may be danger to myself or others;
2. Upon a proper court order;
3. Upon failure to make agreed payments (only name, address, and financial information may be released);
4. In the gathering of statistics and the making of reports to improve clinical services, but that in the latter uses, neither I nor my family will be identified by name;
5. If I sign a release of information authorizing specific disclosure; an individual may revoke such authorization;
6. When abuse of a child or vulnerable adult is involved;
7. When a pregnancy may be a risk because of chemical abuse;
8. When federal or state law requires it.

As a client (or parent/guardian of client) of Western Mental Health Center, I shall have the right to:

1. Considerate and respectful care.
2. Services in the least-restrictive setting that is necessary under the circumstances.
3. Have an individualized treatment plan.
4. Participate in the planning of my treatment.
5. Full explanation of the risks associated with the use of any therapeutic procedure.
6. Refuse treatment except in emergency situations or where a conrt order exists.
7. Privacy and individuality as it relates to my social, religious, and psychological well being.
8. Privacy and humane treatment environment.
9. Privacy of treatment/records except that my name and address may be turned over for collection purposes if I fail to make payments as I have agreed upon.
10. Request an examination of my treatment record.
11. Assert grievances and have them considered through an impartial grievance procedure.

12. Exercise my rights without reprisal.

13. Referral as appropriate to other providers of mental health or chemical dependency services upon discharge.

14. Minors have the right to deny parents ability to see records (under certain conditions).

15. Request reminder calls not be made. (WMHC routinely makes reminder calls for upcoming appointments)

As a client of Western Mental Health Center, I agree to be responsible to:

1. Be honest and direct about all that relates to me as a client.

2. Understand my health problem. Should I wish assistance in understanding my problem, it will be my responsibility to ask my provider for assistance.

3. Advise those involved in my care if I cannot or do not want to follow a treatment plan.

4. Inform my provider of any changes in my health status.

5. Respect the rights of other clients to privacy.

6. Complete my individual financial agreement I have made with Western Mental Health Center or take responsibility to discuss my financial needs with the Billing Department for appropriate resolution.

7. Review notice of Privacy Practices and Patient Bill of Rights posted.

8. NOTIFY WMHC 24 HOURS IN ADVANCE OF APPOINTMENT TO CANCEL OR CHANGE AN APPOINTMENT.

9. Fulfill my financial obligation for services at WMHC. I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for those services.

PRE-CERTIFICATION/PRIOR AUTHORIZATION AGREEMENT:

I understand that it is my responsibility to contact my insurance company and comply with the rules and regulations regarding pre-certification and prior authorization requirements. Failure to do so will result in being charged the standard fee for services I receive. I authorize this facility to release to my insurance company and/or designated managed care organization medical records/treatment information as required for payment of claims and treatment review/authorizations. (Realize these claims may take 3 - 6 months to process.) This information may include Intake Summary, Progress Notes, Diagnosis and past medical and physical information, Evaluation/Testing Results, and Treatment Plan. I request that payment for services be made directly to Western Mental Health Center. I understand that I may revoke this consent at any time by notifying this facility in writing, but such revocation will not apply to information already released. I understand that if I refuse or revoke authorization for release of information for the above stated purposes I will be fully responsible for all charges not paid by my insurance company.

If I am past due in making a payment under this agreement, I consent to allow the Center to release my name, address and account balance to a third party for collection purposes and accept having a late fee added. All balances sent to collections will be charged a collection fee and will also be reported to the Credit Bureau. I understand that I may request and the Center may mutually agree to adjust my weekly/monthly payment to reflect changes in my income or family status or for other unusual circumstances. I acknowledge that I have received a copy of WMHC fee schedule.

To qualify and receive a fee adjustment, I will release information to Western Mental Health Center regarding my family income. I also agree that if I do not provide income information on the form as requested by the Center, that I will be charged the Standard Fee for the particular type of service I am receiving.

It is my responsibility to keep Western Mental Health Center informed of any changes of insurance, family income, family size or any information, which will affect my billing. Failure to do so will result in being charged the Standard Fee for the services I receive.

Grievance Policy

Clients shall be adequately informed upon intake, of their rights to express concern about the services received. A grievance shall be defined as a claim based upon an event or situation, which is felt to be unjust or is felt to adversely affect the conditions or circumstances of treatment. A client filing a grievance shall have the right to follow all the steps of the grievance procedure with complete freedom from reprisal. This does not confer the right upon anyone to make slanderous or libelous statements or to violate Board policies. A client filing a grievance may request and receive a copy of Western

Mental Health Center's complete grievance procedure, which is summarized below:

PROCEDURE

STEP 1: Client shall discuss grievance with primary provider/clinical director within five (5) working days of occurrence. Provider/clinical director shall respond verbally to client within five (5) working days of discussion, shall make a written record of this response and shall provide the client with a copy.

STEP 2: If grievance is not resolved in Step 1, client may appeal the decision by forwarding written grievance to Executive Director within five (5) working days of the therapist's response. The Executive Director will meet with the client and must reply to the client in writing within five (5) working days of receipt of the client's written grievance.

STEP 3: If the grievance is not resolved in Step 2, the Executive Director may take the grievance to the Executive Committee of the board within five (5) working days of the Executive Director's written response to the client. The Executive Committee may advise the Executive Director regarding further action required by Western Mental Health Center.

STEP 4: If clients are not satisfied with the response to their grievance or complaint from Western Mental Health Center, Inc.,

A complaint may be filed with the Minnesota Department of Human Services by contacting:

Department of Human Services, Division of Licensing, Human Services Building, 444 Lafayette Road, St. Paul, MN 55155

651-431-6500

I understand that I may also contact the Executive Director of Western Mental Health Center, Inc., at 507-532-3236 between 8 am. and 5 p.m. or the Ombudsman, at 800-657-3506 and you will be transferred to the Ombudsman for your county.

I, the undersigned, have read and understand my TREATMENT AGREEMENT, release for pre-certification and/or prior authorization to my insurance company, grievance procedures, my rights as a client of the center, and agree to pay the per

hour/day rate and make payments under the terms contained in this agreement. If not previously revoked, this consent will terminate within one year of dated signature. I have been told and understand the purpose of this agreement.

Authorization and Consent to Communicate Electronically

I authorize Western Mental Health Center staff to communicate and send appointment reminders by electronic methods including but not limited to fax, email and text messages. I understand my wireless carrier may charge me for such messages.

I understand that communicating electronically is not secure and there is potential for personal health information to be accessed by unauthorized persons. I understand Western Mental Health Center cannot insure the confidentiality of information contained in an electronic communication.

I understand this authorization will expire when treatment ends. I understand I may with draw this authorization at any time by notifying Western Mental Health Center staff in writing.

I understand I will need to withdraw this authorization in writing and sign a new authorization if I would like to be contacted at a different email address/number.

Health Information Exchange Consent (CareTrac)

Southern Prairie Community Care's Integrated Community Care Program (the "Program") is a member of CareTrac, an electronic health information exchange that enables the secure exchange of medical records among hospitals, doctors and other health care entities for specific purposes relating to a patient's treatment, including payment for treatment. Where there are many benefits to participation in CareTrac, you may elect to opt out of CareTrac by selecting the opt-out option below. By opting-out of CareTrac, you recognize that information sent to SPCLink will be stored in CareTrac and not available to view by any CareTrac participants, including in the event of a medical emergency. You may change your decision at any time by informing your provider.

If I select to Opt In, I am specifically requesting that my information from the CareTrac service be viewable by any CareTrac participant. (Circle one)

Opt In Opt Out

Consent to share medical information

Yes No

Consent Period:

Exclusions Yes or No

If Yes select:

Check the box of the section(s) you wish to exclude

- ☐ Allergies
- ☐ Clinical Instructions
- ☐ Encounters
- ☐ Medications
- ☐ Medications Administered
- ☐ Patient Decision Aids
- ☐ Pending Diagnostic Tests
- ☐ Referrals to Other Providers
- ☐ Care Plan
- ☐ Cognitive & Functional Status
- ☐ Immunizations
- ☐ Procedures
- ☐ Smoking Status
- ☐ Care Team
- ☐ Encounter Diagnosis & Problems
- ☐ Lab Tests & Results
- ☐ Reason for Visit/Chief Complaint.
- ☐ Vitals
- ☐ Future Appointments
- ☐ Future Tests
- ☐ Referrals to Other Providers
- ☐ Assessment
- ☐ Goals
- ☐ Health Concerns
- ☐ Medical Equipment
- ☐ Problems
- ☐ Results
- ☐ Social History