

PATIENT AUTHORIZATION FORM

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

If patient is a minor:

Parent/Legal Guardian Name: _____

CONSENT FOR TREATMENT

I consent to participate in behavioral health care services offered and provided by Integral Health Associates (“IHA”). I have read IHA's “Policies, Terms, and Conditions” document and understand and accept the contents therein. This document is included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I have read, been shown, or given a copy of the Notice of Privacy Practices of IHA and understand that my protected health information may be used and disclosed for treatment, payment, healthcare operations, and as otherwise permitted by law. This notice is posted in our waiting rooms, included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

RELEASE OF INFORMATION

I authorize IHA to obtain, use, and disclose medical, behavioral health, billing, and related healthcare information as necessary for treatment, payment, healthcare operations, insurance processing, referrals, care coordination, and prescription management, as permitted by applicable law. I understand that I may revoke this authorization in writing except to the extent action has already been taken in reliance upon it.

E-PRESCRIBING CONSENT

I authorize providers at IHA to use electronic prescribing systems and access medication history from pharmacies and related healthcare entities for treatment purposes.

HEALTH INFORMATION EXCHANGE

I understand that IHA may participate in Connie, the statewide health information exchange, as permitted by law for treatment, payment, healthcare operations, referrals, and care coordination. I understand that I may opt-out and disable access to my health information available through Connie by calling or completing and submitting an Opt-Out form to Connie by mail, fax, or through their website (www.conniect.org). Public health reporting and controlled dangerous substance information, as part of the Connecticut Prescription Monitoring and Reporting System (PMP), will still be available to providers.

ASSIGNMENT OF INSURANCE BENEFITS & FINANCIAL RESPONSIBILITY

I authorize IHA to release any and all necessary medical information to my insurance carrier for the purpose of processing claims. When applicable, I authorize IHA to act as my agent in dealing with my insurance carrier to obtain payment and authorize payment of insurance benefits directly to IHA. I accept full responsibility for all charges not paid by insurance, including co-payments, deductibles, coinsurance, missed appointment and late cancellation fees, and other patient-responsible balances. This includes full balances if insurance coverage is denied or terminated. Insurance verification is not a guarantee of payment. If I receive payment from my insurance company for services provided to me by IHA, I agree to submit the payment to IHA. If my account is not paid, I will pay all costs incurred as a result of IHA's collection efforts, including, without limitation, attorney's fees and court costs.

As a courtesy, IHA may assist me in processing insurance claims; however, I understand IHA accepts no responsibility for any processing procedures, acts, omissions, or neglect. I understand IHA does not guarantee coverage, eligibility, or reimbursement by the insurance company. I understand I am responsible for understanding my insurance benefits and keeping IHA informed of current insurance information. I understand IHA does not submit insurance claims directly for all out of network or self pay services. If I elect to self-pay for services, I understand that IHA will not bill insurance directly, and that I may request a detailed receipt (superbill) to submit directly to my insurance carrier for possible out of network reimbursement, if applicable. I understand that reimbursement is determined solely by the insurance company and is not guaranteed.

If my bill is not paid in full in a timely manner, I understand IHA reserves the right not to provide future services to me.

SMS (TEXT) MESSAGING AUTHORIZATION

I authorize IHA to employ a third party outreach or messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of sending SMS (text) messages for appointment reminders, scheduling changes, account notifications, missed appointments, overdue visits, and other reasonable healthcare related communication. I understand that texting may carry privacy risks, that standard messaging or data rates may apply, and that IHA may opt to not communicate by text. I further understand that this consent in no way indicates that IHA will utilize SMS texting as an appropriate or reliable means for me to communicate with them other than by responding to a text I receive with one of the provided response options.

TELEHEALTH CONSENT

I consent to telehealth services which includes communication forms such as telephone, cellular phone, and audio-video that occur over information networks. I understand and consent to the following:

1. Engagement in telehealth is completely voluntary. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. IHA has the right to offer or cease the offering of telehealth for any reason not specifically excluded by law.
2. Medical documentation of telehealth sessions by IHA will occur based on generally accepted standards, but IHA will not voluntarily record or allow recordings of any part of any telehealth session. Likewise, I agree not to make or allow recordings of any part of any telehealth session.
3. Despite reasonable efforts by IHA, there are risks and possible consequences from telehealth including, but not limited to, possible disruption of the transmission of my health information

by technical failures, possible access and misuse of my health information by unauthorized persons, and the possibility that telehealth services may not be as complete or effective as face-to-face services.

4. Services provided by IHA through telehealth services are professional services that may or may not be covered by insurance companies. IHA may be able to assist me in filing insurance claims, but ultimately, I am responsible for full payment just as I would be for face-to-face office visits.

5. I agree to be physically within the state of Connecticut and available for telehealth sessions at the time of my telehealth appointments. This includes having the ringer on for telephone appointments, logging in for video appointments, and being in a quiet, private location with reliable telephone, cellular, wifi, or ethernet connectivity as needed.

6. Missed appointments will be charged the same as missed face-to-face sessions according to office policy. If I am available and my provider does not contact me within 15 minutes of a scheduled telehealth session, I am free to move on to other activity without being charged for a missed appointment.

7. If a telehealth session is interrupted due to a technical problem, I agree to immediately make reasonable attempts to reconnect or contact my provider through some other means if available.

AUTHORIZATION AND SIGNATURE

By signing below, I acknowledge that I have read and understand this form, have had the opportunity to ask questions, and consent to the policies, authorizations, releases, financial terms, communications, and healthcare services described above.

Signature of Patient, Parent, or Legal Guardian: _____

Date: _____