MRN:_____

Linn County **Alcohol and Drug Treatment Program**
Consent for Treatment/ Individual Rights & Responsibilities

_____ _____
Individual's Name Date of Birth

## General Consent for Treatment/Services

I hereby authorize Linn County Department of Health Services (the Department) to provide evaluation, treatment and/ or additional services including general health care as indicated by the physicians, nurse practitioners and other providers of the Department. With this authorization:

- I understand that I am receiving these services voluntarily.
- I understand that I may refuse services at any time.
- I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.
- I understand that all services will be explained, and I can ask questions.
- I have received the program orientation materials for services that I am seeking.
- I understand that I won't be refused care for an inability to pay; and I will work with staff to set an affordable payment arrangement.
- I understand that my protected health information that is created, maintained and/or received during the provision of services may be used for treatment, payment and operations of the Department in compliance with state and federal regulations.
- I agree to protect the confidentiality of other people receiving services that I may have contact with in the Department.

I hereby authorize the Department to bill my insurance, including Medicare/Medicaid, for services received by me, if applicable. I authorize my insurance carrier to pay directly to the Department. I understand that if any insurance information I have provided to the Department is found to be false, I become financially responsible for the full amount of my bill. I understand I am financially responsible for co-pays if applicable.

## Individual Rights & Responsibilities and Complaint Procedure

Information regarding my rights and responsibilities is included in the Individual Rights and Responsibilities handout. If I have questions about the services I am receiving, or if I am displeased, I understand I can discuss these concerns with any staff.

## Acknowledgement of Notice of Privacy Practices

I understand that the services I receive and my health records are confidential, except but not limited to, the following circumstances:

- When required by law or court order;
- To protect my safety or that of others in the cases of threat of harm to myself or others;
- Communicable disease reporting when required by law;
- To report or investigate a crime or threat of a crime against Department employees or a crime committed on the Department premises;
- When required by law in cases of suspected abuse or neglect. All employees of the Department are mandatory reporters.

Voter Registration

If I am an eligible individual, I have been provided the opportunity to register to vote and provided assistance in completing the form.

Initial Here: _____

By signing below, I agree that I have received copies of the Notice of Privacy Practices, Individual Rights and Responsibilities handouts and any program orientation materials. I have reviewed the information above and was provided the opportunity to ask questions.

_____ _____

Individual's Signature Date

_____ _____

Signature of Guardian/Legal Representative Date

_____

Relationship of Representative