INFORMED CONSENT FOR TREATMENT

GENERAL INFORMATION

I, ____ , voluntarily give my permission and consent to The Affiliated Sante Group (ASG) for providing behavioral health services including evaluation, treatment and/or services provided by ASG. I have been informed and understand that the services rendered by ASG may include an intake, diagnostic process, evaluation of treatment and/or rehabilitation needs and any additional evaluations, therapies, and/or medication that may be recommended or provided by the ASG and its programs. I understand that the information gathered through the above interventions will be used to help me develop a crisis plan when necessary. I have had these services explained to me and have had the opportunity to ask questions. Any questions I asked were answered fully to my satisfaction.

I understand and acknowledge the results of evaluations will be made available to me as appropriate according to law. I understand all evaluation, treatment, and services are voluntary and I may request, refuse, and/or terminate any or all of them at any time which request ASG will honor. I understand the consequences, if any, will be explained to me if I refuse or terminate evaluation, treatment, or services.

CONFIDENTIALITY

I understand and acknowledge that strict confidentiality of my information is practiced and ensured by ASG with the following exceptions:

1. If I have signed a consent form to release designated information to named parties.
2. If there is a court order signed by a judge directing the release of designated information to named parties.
3. If ASG finds that there is a perceived threat of injury to myself or others, ASG is legally bound to disclose certain information to designated parties.
4. If ASG believes that there is a suspicion of abuse involving children or other vulnerable individuals (e.g.., intellectually disabled or elderly adults) ASG is legally bound to disclose certain information to designated parties.
5. If ASG is required to defend against a claim or investigation it may use certain designated information in its defense.
6. If ASG is part of a legitimate audit certain information may be disclosed.
7. If ASG is required to disclose certain information in order to obtain payment from a third party payer.

I understand and acknowledge that demographic and utilization information regarding my treatment and/or services may be reported in statistical form to the State of Maryland and/or the contracted managed care organization. This information will be kept confidential and may not be released to any other agency or person without my consent except as identified previously. I understand that information obtained by law enforcement during my involvement with ASG may not be covered by ASG's confidentiality policy. All substance abuse information will be confidential according to 42 CFR Part 2.

I understand that although email and text message correspondence may not be considered as a preferred form of communication between consumer and staff, there may be times when these forms of communication may be useful and necessary. I understand any information relayed in email or text message will be limited and will not be used to provide any form of treatment. You are advised that ASG cannot guarantee complete privacy with regards to text messages and emails that you send. I also understand that ASG will apply reasonable safeguards to protect confidentiality with regards to these forms of communication.

FEES

I acknowledge that any fees for evaluations, treatment, and/or services provided by ASG are charged to the contracted managed care organization or to my insurance plan. I understand services provided by agencies, programs, or companies working with ASG are billed and paid for in accordance with that agency's programs, or company's procedures. I also understand ASG is not responsible for explaining the provisions contained in another agency's programs or company's billing structure or procedures.

NOTIFICATIONS

I acknowledge I have been provided a copy of ASG' Human Rights Notification, HIPAA Privacy Practices, Grievance Procedures and general orientation information. I acknowledge this information was explained satisfactorily to me and I was given the opportunity to ask questions and am satisfied with the responses given to me.

STATEMENT OF UNDERSTANDING

By my signature, I indicate that I have reviewed and understand the above information. I acknowledge that my rights as a consumer have been satisfactorily explained to me and I had the opportunity to ask questions and am satisfied with the responses given to me. I understand that I may withdrawal this consent at any time. I voluntarily give my informed consent for evaluation, treatment, and/or services.

Consumer or Consumer Representation Signature	Date
Print Name of Consumer Representative	Relationship of Representative to Consumer
Staff Signature	Date