VALLEY HOSPITAL
MEDICAL HEALTH AND CHEMICAL DEPENDENCY CARE

Patient Label

CONSENT FOR OUTPATIENT SERVICES

CONSENT FOR TREATMENT

The undersigned authorizes Valley Hospital Outpatient Services, its staff, and attending physician to render to the patient all customary care, therapy, treatment, test and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is also given for any diagnostic procedures, medical treatment, recreational activities and therapy, and other treatment ordered by Valley Hospital Outpatient Services and/or attending physicians including but not limited to services provided by other Healthcare Professionals to the patient.

The undersigned acknowledges understanding that certain healthcare professionals furnishing services to the patient, including, but not limited to, psychiatrist, social workers, nurses, and/or counselors may be independent contractors and may not be employees or agents of Valley Hospital Outpatient Services. **The undersigned further recognizes that the patient may be billed separately by their attending physicians and/or other healthcare professionals for their services provided.**

CONSENT FOR OUTPATIENT SERVICES

The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provided to the patient, including but not limited to therapy, treatment, tests or procedures, while an outpatient of Valley Hospital Outpatient Services. The undersigned further understands that, unless otherwise disclosed, Valley Hospital Outpatient Services may use physicians, or a physician to whom the patient may be referred and any other physician who may consult or provide services or other healthcare professionals that are not employed by and are not agents of Valley Hospital Outpatient Services, but are independent physicians who exercise their judgment in the services they render to patients.

I acknowledge that Valley Hospital is a teaching facility and that professional students may have patient contact and access to the patient's medical record information. Students providing direct patient care are subject to the Hospital's orientation and training requirements. These students are supervised by a licensed professional and are required to meet the hospital confidentially standards. Therapists providing psychotherapy and psychoeducation may be supervised by a licensed professional who will review therapist documentation and supervision of therapeutic services. Questions about therapist clinical supervision may be directed to the Director of Outpatient Services at 602-952-3914.

The undersigned consents to the taking of photograph(s) for the purpose of identification. This photograph(s) may be permanently retained in patient's medical record.

CONSENT FOR RELEASE OF INFORMATION

The undersigned authorizes Valley Hospital Outpatient Services to release all patient information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Valley, to any insurance company, and/or third party payors, or representative providing coverage for this admission and services, or to any Valley Hospital Outpatient Services representative, including, but not limited to Valley Hospital Outpatient Services employees, attending physicians, other healthcare professionals or organizations. This information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned acknowledges that disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person (s) or entities to which the information is released.
The undersigned further authorizes Valley Hospital Outpatient Services to release information for the purpose of obtaining pre-authorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payors providing coverage or having responsibility for this outpatient admission.

The confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations. Generally Valley Hospital Outpatient Services may not disclose information to anyone outside of Valley Hospital Outpatient Services which would IDENTIFY any patient as an alcohol or drug abuser unless the patient has consented in writing; the disclosure is allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or local authorities.

The undersigned may request to receive a copy of this Consent to Release Protected Health Information (PHI) and may revoke this Consent at any time, except to the extent that action has been taken in reliance thereon. The undersigned acknowledges that this consent shall be valid until all third-party payors liability is resolved for this outpatient admission.

CONSENT FOR OUTPATIENT SERVICES

RESPONSIBILITY FOR DESTRUCTION OF PROPERTY

The undersigned understand(s) that patients are responsible for any damage to or destruction of Valley Hospital Outpatient Services property, or property belonging to others which may be located at Valley Hospital Outpatient Services. The undersigned agrees to accept liability for, and reimburse Valley Hospital Outpatient Services or other owners of, property which the patient may damage or destroy.

GUARANTEE OF PAYMENT

The undersigned, hereby agree(s) to guarantee the payment of the bill *for* services rendered by Valley Hospital Outpatient Services. The undersigned agree(s) whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of Valley Hospital Outpatient Services in accordance with the regular rates and terms of Valley Hospital Outpatient Services. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due. I give permission to run a credit report on the guarantor or insured party if payment arrangements are requested on any accounts with Valley Hospital Outpatient Services.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all treatment services rendered by Valley Hospital Outpatient Services, to the extent permitted by law, I hereby (I) irrevocably assign, transfer and set to Valley Hospital Outpatient Services (II) all of my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, and dependent eligibility and (IV) to have an individual policy continued or issue in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Valley Hospital Outpatient Services during pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the *recovery* on said policy (ies) or insurance but shall not be construed to be an obligation of Valley Hospital Outpatient Services to pursue any such right of recovery. I hereby authorize the insurance company (ies) or third party payor(s) to pay directly to Valley Hospital Outpatient Services all benefits due for services rendered.

Insufficient Insurance Coverage: I understand if my insurance or other third party coverage rejects the claim or pays only part of the claim, then I will be responsible for payment of the balance due, as determined by the Hospital or other Healthcare Professional.

Primary/Secondary Insurance Coverage: I understand it is my responsibility to furnish the Valley Hospital Outpatient Services with all of my insurance policies in order to authorize my care. I understand if I did not provide all insurance information at the time of admission, I will be responsible for any amounts not paid by either carrier, including but not limited to denied days due to no pre-authorizations.

Insured Employer: On the **Valley Hospital Consent To Release Information** form, I authorize Valley Hospital Outpatient Services to release and to obtain information from the Insured and/or Insured's Employer of the policy, regarding employment, verification of insurance coverage, benefits or any other information necessary to process the insurance claim.

I acknowledge that the above information has been read and understood.

Patient Name: _____

Signature: _____ Date: _____ Time: _____

Signature of Insured/Guarantor: _____ Date: _____

Staff Name, Signature, Credentials: _____

Date: _____ Time: _____

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

PATIENT LABEL

FACE SHEET

PLEASE COMPLETE ALL INFORMATION

DATE_____ **TIME** _____

1. Patient Demographics

Patient Last Name:			**First:**		**Middle:**
Sex: ☐M ☐F	DOB:	Age:	Marital Status:☐ S ☐ W ☐ M ☐ Divorced ☐ Separated	Ethnic Origin: ☐Caucasian ☐African-American ☐American Indian ☐Hispanic ☐Asian ☐Other	Religion:
Address:			Apt#:	City:	State/Zip:
Home Phone:	**Cell Phone:**		Social Security #:		Driver's License and State:
Vehicle Make/Model:			Year:	Color:	License Plate#:
Employer Name:	Occupation:		Length of Employment:		Employer Phone:
Employer Address:		Suite#:	City:		State/Zip:
Have you had recent change in coverage? ☐ Yes ☐ No			Term date:		Do you have Cobra? ☐ Yes ☐ No Date:
Was premium Paid? ☐ Yes ☐ No			Amount of Premium?		Date of premium payment
Have you been incarcerated in the last 30 days? ☐ Yes ☐ No					

2. Guarantor/Legal Guardian of Minor:

Last Name:	First:	Sex: ☐ M ☐ F	DOB:	Relation:
Cell Phone:	Social Security#:	M. Initial:	Occupation:	
Address:	Apt #:	City:	State/Zip:	
Employer Name:	Length of Employment:		Employer Phone:	

3. Primary Insurance Information:

Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:	Middle Initial:	Sex: ☐ M ☐F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

4. Secondary Insurance: ☐ None-Go to Section 5 ☐ Yes - Complete Section 4

Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:	Middle Initial:	Sex: ☐ M ☐F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

PATIENT LABEL

ADVANCE DIRECTIVE/HEALTHCARE PROXY ACKNOWLEDGEMENT

Yes	No	Answer the questions below
		I have executed an Advance Direct for Medical Care
		I have executed an Advance Directive for Mental Health Treatment
		I have identified a Health Care Proxy/surrogate decision maker to make decision on my behalf. **If yes, name of healthcare proxy/surrogate decision maker:** Name: Phone #:
		Patient has a legal Guardian: Name: Phone #:
		If you have answered yes to any of the above, are you able to provide the facility with a copy of these Advance Directive documents?
		If you do not have an Advance Directive or Healthcare Proxy, do you wish to execute an Advance Directive or Healthcare Proxy or name a surrogate decision maker?

I acknowledge the following:

- I understand that I am not required to have an Advance Directive in order to receive treatment at this facility.
- I understand the terms of any Advance Directive I have executed will be followed by the facility and my care givers to the extent permitted by law.
- Under NO circumstances will a DO NOT RESUSCITATE order be honored at Valley Hospital. All patients who are or become non-responsive will be resuscitated within the facilities capabilities and transferred to the closest medical facility.

For more information and forms on advance directives, you can contact the office of the Arizona Attorney General at the address below:

Office of Arizona Attorney General
Life Care Planning Information and Documents
Direct Line: 602.542.2123
Toll Free: 800.352.8431
Fax: 602.364.1970
http://www.azag.gov/life_care/

_____
Patient Name

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Staff Name, Signature Date Time

FOR STAFF COMPLETION ONLY:

☐ Patient has received information regarding Advanced Directives and HealthCare Proxy but refuses to sign form.
☐ Patient is incapacitated. Advance Directives and HealthCare Proxy information has been provided to patient's family/guardian.
☐ Patient culture/spiritual beliefs preclude discussion regarding Advance Directives.

Staff Name/Signature (if appropriate): _____ Date: _____
☐ Patient has provided a copy of Advance Directives: ☐ Yes ☐ No ☐ N/A
☐ Patient has provided a copy of Healthcare Directives: ☐ Yes ☐ No ☐ N/A

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

GROUP THERAPY CONFIDENTIALITY STATEMENT

Participation in group therapy is private and confidential. In group therapy, everyone shares the responsibility for maintaining confidentiality, including both members and facilitators. All Valley Outpatient Services staff members are bound by the therapeutic ethical and legal rules of confidentiality. However, the information that is revealed within a group setting is usually available to all the individuals who were present. Clients are asked not to share what goes on in therapy sessions with anyone outside of the group. This is done out of mutual respect for every individual in the group.

Exceptions to the rule of confidentiality:

- When there is reason to believe you present an imminent danger to yourself or others.
- When the life or safety of a readily identifiable third person is endangered.
- When there is reason to believe that a child or vulnerable adult is being subjected to abuse, neglect, or exploitation.
- When disclosure is made necessary by legal proceedings.

Under any of the above circumstances, laws and ethics mandate mental health professionals to report these situations to the appropriate persons and/or agencies without your consent or authorization.

I understand the meaning and importance of confidentiality and agree to not disclose the identity of any group member or personal information shared in group.

I understand that responsibility is essential to success in recovery from addiction/alcoholism. The signing of these expectations and confidentiality statement is the first step in the process of becoming a healthier adult.

Patient Name	Patient Signature	Date	Time

Witness Name	Witness Signature	Date	Time

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

CONSENT FOR TRANSPORTATION
Outpatient Services

I understand and give permission for myself to receive transportation services provided by Valley Hospital Outpatient Services in accordance with the information provided below.

Valley Hospital Outpatient Services staff members will transport outpatient clients to and from their outpatient appointments at the Valley Hospital Outpatient Facility. Transportation has been deemed necessary by the treatment team, and as required by specified contracts with referral sources. To ensure clients receive transportation as needed this service will be identified in the client's treatment plan or by their assessment. If a client is deemed unstable for transportation services the treatment team is made aware of this decision and coordination with outside community referrals is completed and documented in the client medical record.

Transportation/ Vehicle Safety

1. Clients will be transported in a vehicle owned or leased by Valley Hospital Outpatient Services
2. The vehicles will be safe and in good repair.
3. The seats in the vehicle are securely fastened to the vehicle and provide sufficient space for the client's body.
4. The vehicles will contain the following:
    a. First aid kit
    b. Drinking water sufficient to meet the needs of each client present
    c. A working heating and air conditioning system
    d. Insurance information

Transportation/ Vehicle Driver:

1. The driver of the vehicle will:
    a. Be 21 years of age or older
    b. Have a valid Arizona driver's license
    c. Shall not wear headphones or operate a cellular phone while operating the vehicle
    d. Shall remove the keys from the vehicle and shall engage the emergency brake before exiting the vehicle
    e. Shall not leave any clients unattended in the vehicle
    f. Shall operate the vehicle safely
    g. Ensures the safe and hazard-free loading and unloading of clients
    h. Ensure that each person in the vehicle sits in a seat and wears a seat-belt while the vehicle is in motion

Transportation/ Staff Members:

A sufficient number of staff members will be present to ensure each client's health, safety, and welfare.

Transportation/ Emergency Information:

1. The following emergency information for each client transported shall be maintained in the vehicle used to transport the client:
    a. The client's name
    b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the client during the anticipated duration of the transportation
    c. The client's allergies
    d. The name and telephone number of the individual to notify at the facility in case of medical emergency or other emergency
    e. Emergency contact information for the client

_____ _____

Patient Name/Signature Date

_____ _____

Staff Name/Signature, Credentials Date

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

EMERGENCY CONTACT INFORMATION

Last:	First:	Initial:

Phone Number:

The following person(s) should be notified in case of an accident or emergency:

Name:	Relationship:	Phone Number:

VALLEY HOSPITAL

HEALTH INFORMATION EXCHANGE
OPT IN/OUT FORM

This is the "Opt In/Opt Out Form". If you opt in, your healthcare providers will be able to access your health information through the Health Information Exchange, even in an emergency if you opt out, your healthcare providers will not be ab le to access your health information through the Health Information Exchange, even in an emergency. If you are the legally authorized representative and are filling out this form for that person, the reference to "you", "I" and "my" in this form refer to the person for whom you are authorized to consent.

☐ **Option 1 – Participate in the Health Information Exchange.** I wish to share my information with the Health Information Exchange.

☐ **Option 2 – I do not wish to participate in the Health Information Exchange:** I do not want any Valley Hospital information visible in the Health Information Exchange effective with today's visit and forward (Unless I elect option 1 at a later date.)

_____ _____

Patient/Authorized Representative Relationship

Date: _____ Time: _____

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Legally Authorized Representative

Provider Office Only: Please complete before sending via secure fax or secure mail to the Health Current Information Exchange.

Organization/Provider: _____

Print Name: _____ Date/Time: _____

Signature: _____ Phone: _____

Rev: 8/2020

IHOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

CONSENT FOR TELEHEALTH SERVICES

What are Telehealth Services?
Telehealth services are used when our patients and their respective physicians, psychiatrists or other clinical personnel (hereafter "Clincians") cannot be physically together for mental health evaluation needs, medication prescribing or the provision of individualized or group-level services. Telehealth services use video and audio technology to send both voice and visual images between you and the Clinicans.

How do Telehealth Services work?
All patients participating in Telehealth delivery should use their reasonable best efforts to interface with Clinicians in a private setting using a two-way, interactive device with video capability (e.g. personal computers, tablets, smartphones or other personal devices with video capability). Treating Clinicians interfacing with patients will also utilize similar equipment in private settings when delivering care. Patients participating in group-level services should use their reasonable best efforts to maintain patient privacy for all participating patients and should ensure third parties are not able overhear or view participating patient information.

Are Telehealth Services private and secure?
The interactive electronic systems used comply with federal privacy and security law and/or as otherwise directed by Health and Human Services, Office of Civil Rights and other Federal oversight agencies. However, when it comes to privacy and security with group-level services, it is the responsibility of each participating patient to ensure that while participating in the telepscyhiatric services they ensure that no third parties are present or listening to the group-level session.

What happens if I choose not to consent to Telehealth Services?
If you choose not to consent to Telehealth services, you will be provided with an onsite Clincian to provide you face-to face psychiatric services, subject to the Facility's capability to provide onsite psychiatric services.

My Rights and Responsibilities

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth services.
- I understand that the technology used is encrypted to prevent the unauthorized access to my private medical information or is otherwise consistent with guidance from Health and Human Services, Office of Civil Rights and other Federal oversight agencies.
- I understand that in some circumstances I may only be able to provide my verbal consent to the terms of this Consent and that verbal consent shall be documented by the Clinicians and/or the facility and shall be of the same force and effect as my written consent.
- I have the right to withhold or withdraw my consent to the use of telehealth services during the course of my care at any time. I understand that my withdrawal of consent will not affect my eligibility to receive future care or treatment. I further understand that declining telehealth services may result in delays or restrictions in accessing on-site care subject to facility capabilities.
- I understand that the Clinicians and/or facility have the right to withhold or withdraw this consent for the use of telehealth services during the course of my care at any time if it is determined I am not able to reasonably particapite in telehealth delivery.
- I understand that in the event I do not make my reasonable best efforts to ensure the privacy of other participating patients in group-level services, the Clinicians and/or facility have the right to withhold or withdraw the availability of Telehealth services to me.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Arizona also apply to telehealth services.
- I understand I may not have any face to face contact with my Clincians, except for my telehealth services visits.
- Telehealth services will not be recorded.
- The Clinicians will inform me if any other person can hear or see any part of our telehealth services session before the session begins.

Patient Consent To The Use of Telehealth Services
☐ I consent to telehealth services and I have read and understand the information provided above regarding telehealth services. I have had the opportunity to ask questions about this information and questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth services in my psychiatric care and authorize use of telemedicine in the course of my diagnosis and treatment.

Patient Signature:_____ Date: _____

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

PATIENT LABEL

CONSENT FOR TELE-PSYCHIATRY SERVICES

I,_____, agree to participate in Tele-Psychiatry services via interactive video conferencing with the psychiatrist who is providing my treatment.

I understand that during the Tele-Medicine session the following may occur:

1. Discussion of my medical history examinations and tests;
2. Discussion and assessment of psychiatric symptoms and behaviors;
3. Discussion of treatment plan goals and discharge planning.

I understand my participation is voluntary and I may withhold or withdraw consent to the use of Tele-medicine at any time without affecting my care. My privacy and confidentiality will be protected at all times. All reasonable and appropriate measures will be made to eliminate all confidentiality risks.

I understand that interactive video equipment is the method of health care delivery with the psychiatrist. I will be shown the equipment and a demonstration of the equipment will be provided prior to the receipt of this service.

I understand that, at this time, there are no known risks involved in receiving my care in this manner.

My psychiatrist and/or his/her designee, has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read this consent form.

I give my consent to receive services through interactive video conferencing. I understand the services I receive are part of my medical record. I understand the psychiatrist and unit staff at both sites will have access to my relevant medical information, including psychiatric and/or psychological information, alcohol and or drug use, and mental health records. I understand this consent form will become part of my medical record.

_____ _____

Patient Signature Date

_____ _____

Staff Name, Signature, Credentials Date