LifeSkills Admission Consent Forms

Client Name: _____ Client DOB: _____

I am the: ☐ Client ☐ Legal Guardian ☐ Parent

Permission to Treat

Permission is hereby granted to the staff of LifeSkills to render treatment and/or services to the above-named client. Furthermore, I certify that I have full legal right to grant such permission and I am not being coerced to receive these services.

I have received an explanation of my rights regarding confidentiality, the grievance policy, information disclosure, voluntary participation in research studies/data collections, late/missed appointment policy, and program orientation via the Outpatient Treatment Handbook. I have also received a copy of the "Notice of Privacy Practices".

I have had the opportunity to discuss this information with a center staff member and understand my rights.

I also agree to release Lifeskills and its employees from any liability for injuries which I might suffer while riding as a passenger in an automobile operated by a LifeSkills employee.

**Minors with substance use issues are required to sign as well as the parent/guardian.

☐ I agree and consent ☐ I do not agree and do not consent

Fee Eligibility

LifeSkills offers services to its clients at fees based on the cost of services. When available, the Center accepts third-party fund sources. Center staff will ask for detailed income information to determine if any discount may be available to help defer the full cost of services not covered by a third-party fund source. The responsible party requests a discount for this account where applicable.

Responsible party authorizes release of any medical or other information necessary to process claims and requests payment of all government benefits, third party fund sources, and EAPs to LifeSkills. This authorization entails all third-party fund sources and is not limited to those specifically listed in this document.

By signing, the responsible party accepts responsibility for the fee for all services not covered by a third-party fund source. I also understand that it is my responsibility to notify LifeSkills staff if changes with my insurance or other third-party fund sources, including discontinuations or additions.

☐ I consent ☐ I do not consent

Telehealth Informed Consent

I hereby consent to engage in telehealth with clinical/medical staff of LifeSkills or contracted provider, as part of my treatment. It is of my own free will that I consent to engage in treatment through the use of telehealth. I understand that telehealth includes the practice of mental/physical health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold, limit or withdraw consent at any time without affecting my right to future care or treatment.
(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential unless the information falls within the limits of confidentiality requiring mandatory reporting to the proper authorities.
(3) I understand that there are risk and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of LifeSkills that: the transmission of my medical information could be disrupted or distorted by technical failures, or the transmission of my medical information could be interrupted by unauthorized persons. I also understand that if the professional staff providing the services believes I would be better served by another form of therapeutic services, then referrals for the appropriate service, location and/or provider will be made.
(4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured as with any type of treatment provided.

I have read and understand the information provided above. I have discussed it with LifeSkills staff, and all of my questions have been answered to my satisfaction. This informed consent will remain in effect for all future telehealth services provided by LifeSkills unless I provide written notice to withdraw this consent.

DISCLAIMER: I understand that a computer monitor, camera, and keyboard will be used in this process. I understand that I will be held responsible for any damage(s) I, my child, or whomever I allow in the room during the appointment, to the equipment provided by LifeSkills. I agree to pay for any/all damage(s) I or my child may cause to the provided equipment while being seen via telehealth. I understand I will not be able to participate via telehealth at any LifeSkills location until I have paid, in full, for any/all equipment damaged by myself or my child.

☐ I consent ☐ I do not consent

Email/Text Messaging Authorization

We are committed to communicating with you about your care while protecting your privacy and personal information. Email and text communication, however, come with risks and limitations that you should be aware of. Although we have employed every commercially reasonable safeguard possible, we cannot guarantee protection of the communication that occurs between you and your provider via text.

LifeSkills maintains reasonable administrative, technical and physical safeguards in an effort to protect against unauthorized access, use, modification, and disclosure of Personal Information in our control and custody. However, no data transmission over the Internet or wireless network can be guaranteed.

By consenting, I acknowledge its terms and provisions, and offer my voluntary and informed consent for LifeSkills staff and providers to communicate with me through texting and email services. I further understand that I may revoke this consent at any time by doing so in writing.

☐ I consent ☐ I do not consent

Consent for Telephone Contact

As a courtesy to clients, we make appointment reminder calls alerting you to an upcoming appointment, as well as inform you when it is necessary to change an existing appointment. You also have the right to refuse this service. Please mark your choice below.

☐ I consent ☐ I do not consent

_____ _____

Signature of Client or Representative Date

_____

Relation of Representative to Client

_____ _____

Signature of Witness Date

***Minors with substance use issues that have been identified for treatment or are being screened for substance use issues will need to agree and consent to treatment and sign this form in addition to parent/guardian.*

_____ _____

Signature of Minor Date