Generations
GERIATRIC MENTAL HEALTH
PO Box 3300, Manchester, NH 03105
(603) 645-5977 Fax (603) 645-5980

Patient Name: _____
Patient Date of Birth: _____
Patient MRN: _____

LIFETIME GENERAL CONSENT FOR OUTPATIENT TREATMENT AND DISCLOSURE OF INFORMATION

INFORMED CONSENT FOR PSYCHIATRIC SERVICES

Patient Name:_____ DOB: _____

I request, consent and authorize Generations Geriatric Mental Health (GGMH) to provide care and treatment and to administer diagnostic, and/or therapeutic procedures and treatments as determined necessary or advisable.

I understand and agree, or will discuss any questions I have with GGMH staff, the various aspects of this treatment contract. GGMH staff will review with me a treatment plan, which includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment will be described including the extent, possible side effects and possible alternative forms of treatment. I understand that I may withdraw from treatment at any time; but if I decide to do this, I will discuss my plan with GGMH staff.

I understand that my protected health information will be a means by which a third party payor can confirm that services were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to request restrictions as to how my health information may be disclosed. However GGMH staff is not required to agree to the restrictions requested. Examples of restrictions GGMH staff would not honor would be restrictions on divulging information to my insurance carrier. I understand that if GGMH staff agrees to a requested restriction, GGMH staff will honor that restriction.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I will be subject to a missed appointment fee if I do not keep a scheduled appointment or cancel the appointment with less than 24 hours of notice.

I understand that health care professionals in training may be involved in my case. All trainees are supervised by professional staff.

I give permission for myself/my ward to receive services from GGMH.

Patient or Legal Guardian Signature: DATE:_____

I request the following restrictions to the use or disclosure of my health information:

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

GGMH receive payment from insurance companies and health programs. I agree to have my insurance company, Medicare, Medicaid, or other program make payments directly to GGMH. I authorize GGMH to submit claims and required information to my insurance company or program. I understand that I am financially responsible for any services that are non-referred, not medically necessary, or experimental/investigative. I understand that I must pay all charges, co-payments, or deductibles not covered by health insurance or other programs for which I am eligible.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION:

GGMH creates and maintains health records in electronic and other forms. The records describe my health, symptoms, examination and test results, diagnoses, treatment, any plans for care or treatment, and billing and other demographic information ("Health Information"). I understand and agree that GGMH is a multi-provider health care system, and that GGMH may release my Health Information within the system. I also understand and agree that GGMH may communicate or release my Health Information to my referring health care provider and other providers involved in my care.

I acknowledge receipt of the GGMH Notice of Privacy Practices that describes uses and disclosures of my Health Information. I understand that my Health Information is confidential to the extent required by law. I understand that I have the right to elect not to receive communications about fundraising for the benefit of GGMH.

MY QUESTIONS HAVE BEEN ANSWERED. I AGREE TO THE INFORMATION IN THIS FORM. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL REVOKED BY ME IN WRITING.

SIGNED:

(Patient or Authorized Representative)

Relationship of authorized representative:

DATE: TIME: