NEWPORT INTEGRATED BEHAVIORAL HEALTHCARE, INC.
1810 MOSERI RD, DECATUR GA 30032
404-289-8223 FAX: 404-286-7009
WWW.NIBHINC.COM

Patient Name:

CONSENT FOR TREATMENT – Outpatient, Residential

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Newport Integrated Behavioral Healthcare, Inc (NIBH), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following:

1.**CONSENT FOR TREATMENT**: I request and voluntarily give consent to my physician and other clinicians, including nurses, counselors, nurse techs, medical residents, who may attend me during this present period of treatment, their associates and assistants, Newport Integrated Behavioral Healthcare, Inc and its agents and employees and students under the direction thereof, to provide and perform evaluation, treatment, consultation and/or other care, services and supplies as are considered advisable by my physician for my health and well being. I recognize that certain clinical staff furnishing services may be independent contractors and not employees or agents of Newport Integrated Behavioral Healthcare, Inc. I understand that services will be provided or supervised by appropriately staff within the scope of their license, certification and training. I acknowledge that no representations, warranties or guarantees as to results or cures have been made to me.

2. **RELEASE OF INFORMATION FOR PAYMENT OF SERVICES AND CONTINUITY OF CARE:** I understand that Newport Integrated Behavioral Healthcare, Inc and my physician(s) will release any and all information regarding diagnosis, treatment and prognosis with respect to any physical or psychiatric condition-including treatment for alcohol or drug abuse-for which I am being treated at Newport, to any insurance company, employer, school, sponsored payer and/or third party payers, or representative providing coverage for this admission. Information will also be released to healthcare providers for continuity of care.

I understand that federal law and regulations do not protect any information about a crime committed by a patient at Newport Integrated Behavioral Healthcare, Inc or against any person who works for Newport Integrated Behavioral Healthcare, Inc or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected abuse or neglect from being reported under state law to appropriate state or local authorities.

3. **ASSIGNMENT OF BENEFITS:** In consideration for services rendered or to be rendered to me by or through Newport Integrated Behavioral Healthcare, Inc, I hereby assign to Newport Integrated Behavioral Healthcare, Inc all insurance benefits, including Medicare, covering this present period of treatment. I understand that regardless of this assignment, I remain primarily responsible to Newport Integrated Behavioral Healthcare, Inc for all actual charges related to this present period of treatment. It is further agreed that any self pay credit balance resulting from payment of the insurance benefits may be applied to any other account owed to Newport Integrated Behavioral Healthcare, Inc by me or my family.

4. **FINANCIAL AGREEMENT**: I will make every effort to actively assist Newport Integrated Behavioral Healthcare, Inc with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third-party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Newport Integrated Behavioral Healthcare, Inc submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made.

I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Newport Integrated Behavioral Healthcare, Inc to process insurance claims, I will be responsible to pay Newport Integrated Behavioral Healthcare, Inc and standard fees. I agree to pay any collection costs and/or legal fees incurred by Newport Integrated Behavioral Healthcare, Inc in attempts to collect the balance owed on my account. Consent to receiving auto-dialed and or artificial or pre-recorded message calls to me cellular or and line telephones.

5. **HEALTHCARE PRACTITIONERS IN TRAINING:** Patient recognizes that among those who may attend Patient at Newport are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their clinical education.

6. **PERSONAL VALUABLES AND PROPERTY DAMAGE:** Patient acknowledges that Patient has received a copy of Patient Rights and has verified the information utilized during this registration and confirms its accuracy. Newport shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures, unless properly secured and placed within the facility Locker.

7. **CONSENT TO PHOTOGRAPH**: I consent to have my photograph taken and used for identification during my treatment, and then maintained in my medical record, as requested by Newport Integrated Behavioral Healthcare, Inc.

8. **WEAPONS/ CONTRABAND SEARCH:** I understand that Newport Integrated Behavioral Healthcare, Inc policy prohibits the introduction of firearms and weapons on facility property by other than Sworn Police Officers. Any weapon now in my possession will immediately be removed for the facility and Dekalb Police Officers will be called immediately. I understand that based on certain criteria for the safety of all staff and patients, if I have certain conditions or behaviors I may have my person and belongings searched.

9. **AUTHORIZATION TO RELEASE INFORMATION:** Newport is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. Newport, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of he behavioral health expenses incurred or authorized by representatives of Newport, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post- care. PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL NEWPORT PROVIDERS, AND TO REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.

10. **PATIENT SURVEY:** Patient authorizes Newport and/or its authorized representative to contact Patient after discharge for the purpose of conducting patient satisfaction surveys and other studies.

11. **CONSENT TIMEFRAME AND APPLICABILITY:** The above consents are applicable to all residential and outpatient based services, as well as all physician office based services. With respect to residential based services. The consents shall be valid for a term of one (1) year from the date of signature below.

12. **KNOW YOUU INSURANCE AND YOUR PAYMENT RESPONSIBILITY:** In order to accommodate the needs and requests of our patients we have enrolled in numerous manage care insurance programs. While we are pleased to be able to provide this services to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and even more importantly, where those services may be performed. Even within the same insurance company the plan may differ depending upon what type of contract your employer has negotiated. Manage care insurance companies are not prompt with their payments. Some companies pay in two weeks while others may take six weeks. Please follow up with insurance to ensure claim is paid timely. **COORDINATION OF BENEFITS IS THE INSURED'S RESPONSIBILITY.** Providing quality medical care for our patients is our primary concern. We are more than willing to provide your care within your insurance contract guidelines if you let us know at each time of service what those guidelines are. Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work that are not covered, we or the selected provider will have no choice but to bill you directly for those non-covered charges. Payment for those charges is then your responsibility. With your cooperation and help, you should be able to receive all of the benefits offered to you by your chosen insurance plan, and we will be able to concentrate on caring for your medical needs. **ALL MEDICARE PART B Patients with no other coordinating benefits are responsible for 20% of all services rendered according to Medicare guidelines patient responsibility.___(Initial Here)**

13. **DISCLOSURE OF PROTECTED HEALTH INFORMATION:** Newport Integrated Behavioral Healthcare, Inc **NOTICE OF PRIVACY PRACTICES** provides a more complete description of such uses and disclosures. I have the right to review the notice if privacy practices prior to signing this consent. Newport Integrated Behavioral Healthcare, Inc reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to: Newport Integrated Behavioral Healthcare, Inc 1810 Moseri Rd, Decatur GA 30032.

I have read and understand the above guidelines. I understand that charges deemed non-covered by my insurance and/or any charges applied to my deductible or deemed as coinsurance company are my responsibility. I understand that late/billing fees $10 per month are applied to my account beginning 60 days after charges are turned over to patient responsibility and are to be paid by me. I understand that Newport Integrated Behavioral Healthcare, Inc utilizes the services of a collection agency when deemed necessary.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon prior consent, If I do not sign this consent, or later revoke it, Newport Integrated Behavioral Healthcare, Inc may decline to provide treatment to me.

Validity of Form

Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original.

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family or others having knowledge about Patient, in determining whether to perform or recommend the Procedures; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions.

Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

Patient/Patient Representative Signature	Patient Name (**PRINT**)	Date	Time
Relationship to Patient	Reason Patient is unable to sign		
Newport Integrated Behavioral HC Representative Signature	Newport Integrated BH Representative Name (**PRINT**)	Date	Time

Rev. 09/16