Client Name:	
Date of Birth:	
Guarantor Name:	

CONSENT FOR SERVICES AND PAYMENT AGREEMENT

Please read and initial each item below to verify that you agree and will follow these rules and standards.

FINANCIAL AGREEMENTS

_____I hereby consent to receive the services that are available to me. I understand that I am responsible for all costs associated with treatment and that verification of insurance does not guarantee coverage.

_____I understand that I am expected to notify SeaView 24 hours in advance if I am unable to make my appointment; that I will be charged $30.00 for each non-canceled appointment I miss; and that services may be discontinued if three appointments are missed without cancellation.

_____ I understand that I may at any time, request a review of financial status and be re-evaluated for an adjusted payment schedule or sliding fee based on any financial hardships I may be experiencing during the course of my treatment with SeaView.

_____I understand that my insurance carrier may not pay for all of the services received by me and it may be necessary for me to pay part or all of the difference. Therefore I will assist SeaView in collecting from my insurance carrier. If my insurance pays me directly I agree to forward these payments to SeaView.

_____I understand that if at any time my Insurance/Medicaid lapses I am responsible to notify SeaView Community Services immediately and all future services may become self-pay until I provide verification of active coverage.

_____I understand that at the conclusion of my treatment, I am still responsible for all outstanding bills under SeaView's collection and payment policies.

_____I understand and agree that should my account become delinquent, I may be terminated from the program or services offered may be reduced until such time as my account is brought current. I may also be held liable for any collection expense or court cost that may be incurred by SeaView or its agents in the course of collecting past due fees.

AUTHORIZATION

_____I hereby authorize SeaView to bill my insurance carrier, Medicaid or Medicare. In doing so I understand that it will be necessary for SeaView to provide the insurance carrier with specific information about the clinical services I am receiving. In providing this information SeaView has no control over how that information is used or to whom it may be given.

***Please sign below to state that you agree with the above statements.**

Client/Guarantor Signature:_____Date:_____

Agency Representative Signature:_____Date:_____

Client Name:	
Date of Birth:	
Guarantor Name:	

CLIENT'S RIGHTS AND RESPONSIBILITIES AND GRIEVANCE PROCEDURE

SeaView Community Services will treat all clients with dignity, respect, individuality, with consideration for privacy, confidentiality and security. SeaView will provide all of its clients a process for addressing grievances in a respectful, timely, and impartial manner without fear of retribution. All grievances will be treated as genuine and a resolution pursued accordingly.

YOU HAVE A RIGHT:

- To take part in designing and evaluating and periodically reviewing your own treatment/service plan including requesting specific forms of therapy, being informed why requested forms of therapy are not made available, refusing specific forms of therapy that are offered, and being informed of treatment prognosis.
- To the confidentiality of all records except with your written consent.
- A client will be informed by the prescribing physician of the name, purpose, and possible side effects of medication prescribed as part of the client's treatment plan at the center;
- To inspect and copy, request restrictions and confidential communications, amend, and to receive an accounting of disclosures of your protected health information (PHI).
- To file a grievance.

YOU HAVE A RESPONSIBILITY:

- To actively take part in your treatment/service plan.
- To arrive on time for appointments, calling as far in advance as possible if you cannot keep an appointment.
- To maintain the confidentiality of other clients/consumers you may meet during your treatment/service.
- To carry out agreements made between you and your service provider including homework assignments.
- To keep this agency informed of events, emotions and plans that may affect your treatment or condition.
- To provide insurance forms, Medicaid information or other materials necessary for third party reimbursement.
- To be financially responsible for fees not paid by third parties.

The following steps will be followed in processing a formal grievance:

1, Clients are requested to thoroughly review the Client Rights and Responsibilities and Grievance Procedure policy and form presented for client signature upon entry to SeaView services.
2. Clients are encouraged to discuss any concerns they have about their care and treatment with their primary provider and/or that person's supervisor.
3. If the problem cannot be resolved as described in #2, the consumer should briefly describe the grievance in writing and submit it in a sealed envelope to the Team Leader. The client may also report a grievance orally in person or by telephone, if necessary, although written format is preferable to insure accuracy. The consumer must clearly state that the matter is a grievance so there is no misunderstanding about the seriousness of the situation.
4. Upon request, SeaView will provide assistance to clients who wish to file a grievance.
5. In the event there is a concern with the Team Leader or if they have already been involved, submit a grievance statement to the Executive Director.
6. Clients or family members may designate a representative/advocate to assist them and be present during any/all grievance proceedings. SeaView will inform clients interested in filing a grievance of advocacy resources including the Disability Law Center (see list attached).
7. A signed release of information will be required in order for SeaView staff to discuss the grievance with such an advocate. The consumer has the option to waive confidentiality.
8. The Team Leader/Supervisor or Executive Director will schedule an interview with the client together with indicated staff member(s) within five (5) working days of receipt of the grievance. If unable to respond within 5 days a written explanation will be made.
9. The status of findings and results will be communicated in writing to the client no later than five working days after the interview (s). If unable to respond within 5 days a written explanation will be made.
10. Grievances unresolved to the consumer's satisfaction within 30 days will be reported by SeaView to the division that funds the relevant program services.
11. SeaView will maintain separate grievance files, which contain all documents related to grievances, and record all actions resulting from grievances. All grievances will be reported to the advisory board and to the Governing Board. All reports will maintain consumer confidentiality.

I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THIS FORM:

_____

Signature of Client Date Witness/Guardian Date

8/95, 3/00, 8/01, 11/01, 8/04, 5/05, 3/06

Client Name:	
Date of Birth:	
Guarantor Name:	

Acknowledgement of Notice of Privacy Practices and Electronic Record

I acknowledge that I have received a written copy of the SeaView Community Services Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____

Date Signature of Patient or Authorized Agent

SeaView Community Services receives grant funds from the State of Alaska. As required by law, one of the conditions of Behavioral Health grant award requires this agency to submit data, via an electronic record, regarding individual service recipients within this agency.

_____

Date Signature of Patient or Authorized Agent

TO BE COMPLETED BY SEAVIEW COMMUNITY SERVICES STAFF IF NO ACKNOWLEDGEMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

- ❑ Patient (or authorized agent) refused to sign after being requested to do so.
- ❑ Other: (please describe)

  _____

  _____

_____

Date Signature of SeaView Community Services Staff

PERMANENT CHART COPY

4/03,12/06

Client Name:	
Date of Birth:	
Guarantor Name:	

TREATMENT AUTHORIZATION

IN THE CASE OF A MINOR CHILD (under age 18):

I _____, (Mother, Father, Legal Guardian), do hereby give my permission for SeaView Community Services to assess, evaluate, and/or provide Behavioral Health Services for my (son/daughter), _____. I understand that I may withdraw authorization for behavioral health services at any time and that any changes in diagnostic and/or treatment services will be discussed with me and are subject to my approval. If treatment services include substance abuse, abstinence from all mood-altering drugs is required. Random urinalysis (UA) testing is a part of the program. All UA's are observed.

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

IN THE CASE OF AN ADULT:

I _____, (adult consumer of services), do hereby give my permission for SeaView Community Services to assess, evaluate, and/or treat me. I understand that I may withdraw authorization for behavioral health services at any time. Any changes in treatment services will be discussed with me and may be subject to my approval. If treatment services include substance abuse, abstinence from all mood-altering drugs is required. Random urinalysis (UA) testing is a part of the program. All UA's are observed.

_____ _____
Adult Consumer/Guardian Date

_____ _____
Witness Date

11/96, 8/98, 11/02, 6/03, 1/05, 12/06. 8/08