BAYCARE BEHAVIORAL HEALTH SERVICES

Patient Agreement and Consent

Last Name:	First Name:	MI
MR#	CC#:	Date:

As a condition of my admission to BayCare Behavioral Health, I hereby agree to the following:

CONSENT TO TREATMENT: I hereby authorize the physician/clinician in charge of my care and BayCare Behavioral Health to oversee my treatment plan and monitor my behavioral health medication as required by my behavioral health symptoms. I understand that, under the direct supervision of my treating physician, an Advanced Registered Nurse Practitioner may be utilized in my care and treatment.
I voluntarily consent to treatment.

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION: I hereby authorize BayCare Behavioral Health and or/any treating physician/clinician to obtain, use and/or release information (current and historical) for the purpose of treatment, payment and/or operations as outlined in the Notice of Privacy Practices. This may include collection agencies and credit bureaus and will be limited to the minimum amount necessary (including psychiatric, drug abuse, alcohol or HIV status). I hereby authorize BayCare Behavioral Health and/or the treating physician/clinician to release information from my medical records to other healthcare facilities/providers to which I may be transferred for emergency services.

MEDICARE / MEDIGAP / MEDICAID / PATIENT CERTIFICATION / RELEASEOF INFORMATION & PAYMENT REQUEST:
I certify that the information given to apply for payment under title XVIII and/or XVIII and/or Title XIX, of the Social Security Act is correct. I authorize and holder of behavioral health information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare, Medigap or Medicaid for payment to me. I understand that I am responsible for any health insurance deductibles and co-payments. An itemized statement is available upon request.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, grant and transfer to BayCare Behavioral Health, now and in the further, all my right and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payor for those costs I incur in receiving services from BayCare Behavioral Health. and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to BayCare Behavioral Health was or is to be incurred. I agree that should the amount received by BayCare Behavioral Health be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by BayCare Behavioral Health is not covered by said insurance policy, I am responsible to Baycare Behavioral Health for payment of the entire bill.

GUARANTEE OF PAYMENT: For value received, the undersigned does agree to guarantee and promise to pay BayCare Behavioral Health and/or any treating physician all charges and expenses incurred in the treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. If any action at law or inequity is brought to enforce this agreement, BayCare Behavioral Health understanding that all bills are payable and become due upon presentation. I understand and agree that if BayCare Behavioral Health is required to bring claim or file an action to enforce this agreement, BayCare Behavioral Health shall be entitled to recover from me its reasonable attorney's fees, court costs, and any other costs of collections, in addition to the amount owed BayCare Behavioral Health for its services.

DENIAL OF PAYMENT AUTHORIZATION: BayCare Behavioral Health will make every effort to obtain payment authorization/preauthorization for all managed care contractual agreements. If, however, a denial is received, the patient/guarantor will be responsible for all incurred charges and penalties, payable and become due upon presentation.

PATIENT

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RELEASE OF RESPONSIBILTY AND LIABILITY FOR PERSONAL VALUABLES: I understand and agree that BayCare Behavioral Health is not responsible for personal valuables or belongings brought into, or claimed to have been brought into the facility, by named patient/client or his/her agent. Personal valuables or belongings include, but are not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devises (such as hearing aides, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money. I understand that a locked safe is available for securing my personal valuables small enough to fit in a security envelope.

DISCLOSURE OF ADMISSION FOR TREATMENT

BayCare Behavioral Health will neither confirm nor deny your admission status without your consent /authorization, except when required by the Florida's Mental Health Act (Baker Act), S.394.4597 AND S. 394.4599, F.S.

RECEIPT OF PATIENTS RIGHTS & RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES, AND ORIENTATION GUIDE: By my signature on this document, I acknowledge receipt of a patient's rights and responsibilities pursuant to Florida statute 381.026, a Notice of Privacy, and a copy of the Orientation Guide, prior to or at the time of admission.

I HEREBY AGREE THAT THE TERMS OF THIS AGREEMENT HAVE BEEN COMPLETELY READ, FULLY UNDERSTOOD AND ARE VOLUNTARILY ACCEPTED; THAT I HAVE VOLUNTARILY AND WITH FULL UNDERSTANDING EXECUTED THIS AGREEMENT; THAT I HAVE ACCEPTED ITS TERMS AND CONDITIONS; THAT I WILL RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST; AND THAT I AGREE THAT A COPY OF THIS AGREEMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

_____	_____	_____	_____
Patient/ Client Signature	Parent/Guardian Signature	Date	Time
_____		_____	_____
Signature of Patient's Authorized Representative		Date	Time
_____		_____	_____
Witness Signature		Date	Time

PATIENT