HOPE FAMILY HEALTH SERVICES
12124 HWY 52 Bypass
Westmoreland, TN 37186
615-644-2000

Authorization For and Consent to Mental Health Services - Child

Patient's name: _____ DOB: _____

I hereby authorize Hope Family health Services (HFHS) to provide my child, _____, with mental health services, including assessment, psychotherapy, and referral. I understand that assessment may result in child being assigned a mental health diagnosis. I hereby give consent for HFHS to disclose such information as may be necessary to obtain payment for services from third party payors.

By signing this consent I affirm that I have legal custody of the child; that I understand the nature of the services being provided; that I understand my right to consent or decline services. I further affirm that I understand that no records shall be released by HFHS without my prior written permission, as evidenced by a mental health release, signed and dated by me, except, where disclosure is permitted by law without prior consent in cases where my child may be deemed a danger to herself or others or unable to discern objective reality (e.g. as in a psychotic state). I further understand that any information revealing abuse of a child or a dependent adult (e.g. disabled or incapacitated by age) is not protected from disclosure and is subject to mandatory reporting laws.

By signing this consent I affirm my understanding that psychotherapy services may deal with sensitive matters; that my child's mental health provider will provide services in accordance with the standards of care governing mental health, but cannot guarantee any specific outcome from treatment; and that my participation as a parent or legal custodian in treatment is vital to its success. I understand that my child will be given an individualized treatment plan; that I as the parent will need to specify the goals I wish to work toward; and that my child's provider and I will periodically review progress towards those goals, including updating this treatment plan at least every six months.

Signature: _____

Relationship to the child: _____

Date: _____

PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT DATE OF BIRTH

HI003a

authorization for the disclosure of health information

BEHAVIORAL HEALTH

I AUTHORIZE HOPE TO COMMUNICATE WITH ME ABOUT MY BEHAVIORAL HEALTH

BY SIGNING BELOW I AGREE TO ALLOW HOPE FAMILY HEALTH TO COMMUNICATE WITH ME IN PERSON, PHONE, VOICE MESSAGE, EMAIL, DIRECT MAIL AND/OR TEXT MESSAGE WHENEVER AND USING WHICHEVER METHOD IS APPLICABLE, APPROPRIATE AND AVAILABLE.

I UNDERSTAND THAT IF I WISH FOR HOPE TO COMMUNICATE WITH ME IN A SPECIFIC WAY OR WISH FOR HOPE TO NOT COMMUNICATE WITH ME USING A SPECIFIC METHOD, I MUST COMPLETE FORM Hi002a5: ***"Patient Request for Privacy Through Alternative Communication"***

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

I AUTHORIZE HOPE TO COMMUNICATE WITH MY LOVED ONES ABOUT MY BEHAVIORAL HEALTH

BY SIGNING BELOW I AUTHORIZE HOPE FAMILY HEALTH TO DISCUSS MY BEHAVIORAL CARE, MENTAL HEALTH HISTORY, DIAGNOSIS INFORMATION & TREATMENT OPTIONS WITH THE FOLLOWING INDIVIDUALS:

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

HOPE Family Health

HOPE
Family Health

HOPE Family Health
1124 New Highway 52 East
Westmoreland | TN | 37186

615.644.2000 | OFFICE
615.644.2078 | FAX
info@hopefamilyhealth.org | EMAIL
hopefamilyhealth.org | ONLINE

1. Who is the patient?

Patient Last Name	Patient First Name	Patient Middle Initial

Patient ID Number (SSN)	Patient Date of Birth (MM/DD/YYYY)	Patient BEST Phone Number (with area code)

Patient Address	City	State	Zip Code

CHECK ONE: ☐ I am the patient Filling out this form OR ☐ I have the legal right to act for the patient. *(If not the patient, check one below:)*
I am the patient's: ☐ Parent OR ☐ Guardian OR ☐ Other
If other, describe relationship to patient: _____

2. This authorization is for which SERVICE TYPE of health information?

☐ MEDICAL ☐ DENTAL ☐ PHARMACY ☐ INSURANCE ☑ MENTAL/BEHAVIORAL HEALTH ☐ OTHER

3. Provider(s) authorized under this RELEASE or REQUEST

Name of health care provider including SPECIFIC staff provider managing your care, if one exists		Provider's Phone Number (with area code)
HOPE BEHAVIORAL HEALTH		615 · 644 · 2000
Provider's Address	**City, State, and Zip Code**	**Provider's Fax Number (with area code)**
1124 NEW HWY 52 East	Westmoreland, TN 37186	615 · 644 · 2078

4. What health information is HOPE authorized to RELEASE or REQUEST

HOPE will only RELEASE or REQUEST the health information that you AUTHORIZE. Provide those details below:

PROVIDER WHO MANAGED THE CARE:	DATE RANGE OF CARE:	DESCRIPTION OF HEALTH CARE INFORMATION

Do you AUTHORIZE for any of the following information to be included in this RELEASE or REQUEST:

☐ HIV/AIDS Status ☐ Alcohol/Substance Abuse History ☐ Sexual/Physical/Mental Abuse History

Be advised that this AUTHORIZATION may include prescribing history, both past and present. If applicable, this AUTHORIZATION may also include health information about any alcohol and/or drug treatment. If mental/behavioral health records are being AUTHORIZED, they will NEVER include your provider's psycho-therapy notes, which by state and federal law are securely maintained SEPERATE from your medical record.

5. Why are you authorizing this RELEASE or REQUEST?

Simply state what the reason for this authorization. Is it for OR from a referral of another health care provider or specialist? Is it for diagnostic testing or imaging? Is it to request records from a hospital stay?

_____

_____

SECURELY RELEASE RECORDS BY EMAIL TO: records@hopefamilyhealth.org
OR IF FAX IS THE SENDERS ONLY OPTION RELEASE BY FAX TO: 615-644-2078

6. When does my AUTHORIZATION end?

Your authorization given by completing and signing this form ends when you inform HOPE that you wish for revoke your permission to use it. Otherwise, this authorization will self-expire by law one year from the date the authorization was given.

- *I wish for this authorization to expire on _____/_____/_____*
- *Special instruction I wish to give specific to this authorization: _____*

_____

7. Your RIGHTS and other Important Information

1. Giving your authorization to RELEASE or REQUEST your health information is your choice. You do not have to share your health information.
2. You are not required to to give this authorization for this purpose. You will still get benefits and treatment at HOPE that can be provided to the extent your health care provider is comfortable with making decisions without this authorization.
3. If you choose to revoke your consent authorized by this form, you must do so by notifying HOPE in writing. You must express this by writing to: HOPE Family Health | Attn: Health Records | 1124 New Hwy 52 E | Westmoreland | TN | 37186
4. If you revoke this authorization, be aware that it will not take back the health information we have already shared or received. HOPE will however stop any additional REQUESTS or DISCLOSURES.
5. If we share your health information with the authorized parties you names above, HOPE has no ability to insure they act responsibly within the confines of state and federal patient privacy laws.
6. You have the right to receive a copy of this form after it is complete, in addition to any and all health information that is RELEASED or DISCLOSED in accordance with this authorization. Please do so in writing by using the process outlined in #3 above.
7. If you have questions or need help completing any of this information, simply call 615-644-2000 and select the option to speak to an operator. Explain the assistance you need, and a member of our team will assist you.
8. If you have an authorized representative, legal proof must be given showing this individual can act for this person. A representative signs for a patient who may not legally sign on his or her own behalf.
9. If the patient is less than 18 years old, a parent or guardian should sign for the minor.

NOTICE TO ANY RECIPIENT OTHER THAN THE PATIENT: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. TC 03/13/15 Puede obtener estas hojas en español. Visite nuestro sitio web en www.hopefamilyhealth.org.gov/privacy O bien, llame al HOPE Family Health al 615-644-2000 X 2.

8. Patient's signature of AUTHORIZATION?

I give my AUTHORIZATION to HOPE Family Health to RELEASE or REQUEST my health information for the purposes and to/from the parties indicated on the first page of this form. By completing and signing, this form expires when you inform HOPE that you wish to revoke your permission to use it. Otherwise, this authorization will self-expire by law one year from the date the authorization was given. Indicate your AUTHORIZATION by signing below:

Signed by: _____ *and/or* _____

Signature of Patient or Legal Guardian *(if patient is under the age of 18)* — Authorized Patient Representative Relationship to Patient

Patient Name: _____ _____

Printed Name of Patient — Printed Name of Authorized Patient Representative

Legal Guardian: _____ _____

Printed Name of Legal Guardian *(f patient is under the age of 18)* — Authorized Patient Representative's Relationship to Patient

Today's Date: _____

Printed date this form was signed

SECURELY RELEASE RECORDS BY EMAIL TO: records@hopefamilyhealth.org
OR IF FAX IS THE SENDERS ONLY OPTION RELEASE BY FAX TO: 615-644-2078

HOPE
Family Health

Behavioral Health Program

Patient Notice of Cancellation Policy

THIS NOTICE DESCRIBES IN DETAIL THE CANCELLATION GUIDELINES OF HOPE FAMILY BEHAVIORAL HEALTH SERVICES. PLEASE REVIEW AND SIGN.

_____ **I. What This Is**

This notice describes in detail, the cancellation guidelines for the Behavioral Health Program at HOPE Family Health.

_____ **II. Our Guidelines**

If you must cancel an appointment we ask that you provide a minimum of a 24 hour notice prior to your scheduled appointment. This will prevent gaps in our providers' schedules and allow consumers on our waiting list to be seen. Should you miss your appointment or fail to cancel prior to the respective notice more than 3 times annually, we may provide you with up to 3 alternative providers in your region, but may no longer be able to provide services through HOPE's Behavioral Health Program.

_____ **III. Why do we have this policy?**

HOPE strives to provide highly qualified and skilled healthcare providers to better serve you as our consumer. In order to ensure the best use of our providers' time as well as to better serve all of our consumers, we have a waiting list of those who wish to come in should a cancellation occur. We need all consumers' cooperation and compliance regarding our cancellation policies to better serve all who enter HOPE.

_____ **IV. What if I have an emergency?**

HOPE Behavioral Health recognizes that emergencies or other unplanned events do arise (i.e. flat tire, sick children, family emergencies, etc.), which is why we provide 3 unplanned cancellations. We ask that you make every effort to contact our office as soon as possible to reschedule.

We value each of you as our consumers and continue to make efforts to improve on the overall efficiency of care provided at HOPE.

_____ _____

PATIENT OR GUARDIAN *SIGNATURE* DATE

HOPE FAMILY HEALTH SERVICES
FINANCIAL POLICY

Hope Family Health appreciates the confidence you have shown in choosing us to provide for your health care needs. **HOPE Family Health** seeks to improve access to primary health-care in rural Middle Tennessee, with an emphasis on vulnerable populations such as the uninsured, under-insured, poor, homeless, children, migrant workers, and those addicted to substances. We seek to restore dignity, faith, HOPE, and health in those we serve by making them partners in the healing process and providing them with loving, compassionate care. **It is the policy of HOPE that all patients will be provided a copy of HOPE's financial policy package.** ***The Purpose:*** **is to assist patients in understanding their financial obligations to HOPE.** We are pleased to participate in your family's health care and look forward to establishing a lasting relationship as your primary health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. ***Please review and sign the following financial policy prior to your office visit.***

Patient Registration
It is the policy of HOPE to maintain a system for patient registration and for gathering, maintaining, and reporting patient data. **All patients are required to complete or update patient demographic and insurance information at each visit with the front desk staff.** *The purpose:* To ensure the accuracy of patient data for HOPE's billing system.

Payment Responsibilities
The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our already discounted fees. HOPE Family Health serves all patients regardless of ability to pay. Patient payments will be applied to the oldest balance on the account. All patient or insurance payments received via mail will be processed through the finance office. In the event the patient is unable to make full payment, the patient will be required to execute a Request for a Payment Plan.

Sliding Fee Program
HOPE Family Health Services ("HOPE Family Health") will not deny requested health care services and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid for by Medicare, Medicaid, TennCare, or State Children's Health Insurance Program ("SCHIP"). As a general rule, HOPE will charge persons receiving health services at the usual and customary rate prevailing in this area. **HOPE offers a sliding fee scale discount (SFSD) program to all individuals and families with annual incomes at or below 200% of current DHHS Federal Poverty Guidelines.** Patients must bring required information for verification of family size and income at their first visit in order to qualify for the SFSD. However, if the patient does not have the information, they can be seen for the first visit as a Category A patient but will be required to pay full charges if not certified for their next visit. Primary Medical Services, Mental Health Services, Laboratory Services, provided at HOPE Family Health are eligible for the sliding fees. Co-pays, previous charges, supplies, external medical and dental lab charges, off-site medical x-rays and any other outside services are NOT ELIGIBLE for a sliding fee discount. Deductibles ARE eligible for sliding fee.

Insurance Claims
Patients must complete and sign information and insurance forms prior to seeing the provider. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** You will receive reimbursement from Hope Family Health if your insurance pays the claim, at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. According to **Tennessee Code 56-7-109,** insurers are required to pay a properly submitted claim within 30 days (submitted on paper) and (21 days by electronic submission). You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf with 90 days, because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date, you will be reimbursed by Hope Family Health. All payments received from third-party payers will be applied to specific charges associated with a specific date of service and patient.

Payment Plans
If a patient has a past due balance and they cannot pay, the account will be reviewed and a payment plan offered with the account tracked by billing and collection staff. Typically, the minimum payment allowed will be $25, but if a patient falls at or below 100% of the Federal Poverty Level, a lower amount, such as $5 or $10, may be offered so as not to present a barrier to care.

Discounts Available _____ Initial here
It is the policy of HOPE to encourage patients to pay old balances due; therefore, HOPE offers a discount for the payment of amounts due if they are paid in full at an office visit or by contacting the billing company. *The purpose:* to improve cash income to HOPE. **For primary care services the system of discounts is 25% off the old balance due.** Discounts for essential services are offered depending upon family size and income. You may apply for a discount at the front desk. As a courtesy, we are providing you with this payment plan. However, you are ultimately responsible for payment of your bill.

Advance Beneficiary Notice (ABN)
It is the policy of HOPE that all non-covered Medicare services be communicated to the patient prior to treatment and all documentation of his/her acceptance of financial responsibility will be obtained prior to providing the service. *The purpose:* to be certain patients are informed of non-covered Medicare services and their responsibility for Payment.

Returned & Post-Dated Checks
Checks that are returned due to Non-Sufficient Funds will be turned over to the Finance department. HOPE does not accept or automatically write off checks previously deposited on patient accounts and returned for "non-sufficient funds" (NSF) reasons. Two NSF checks received from the same patient or account will result in the patient being placed in a **"cash only"** status for all future visits. **Post-dated checks will be permitted as payment for HOPE services for up to 5 days (post-date hold status).**

Copies of Medical Records
It is the policy of HOPE Family Health to establish, maintain and protect a health record on each and every patient that has been established at HOPE Family Health. This record shall comply with all other policies and procedures of HOPE Family Health as well as Federal and State laws and regulations. Creation, destruction, storage, access to and maintenance of this record shall remain HIPAA compliant at all times as well as compliant with all other health center policy, as well as Federal and State laws and regulations. **PUBLIC CHAPTER NO. 865 - HOUSE BILL NO. 3049, By Representative Favors** - Substituted for: Senate Bill No. 2959, By Senator Watson. An ACT to amend Tennessee Code Annotated, Title 63, Chapter 2, Part 1, relative to charges for copying and certifying medical records. "(a) The party requesting the patient's records is responsible to the provider for the reasonable costs of copying and mailing such patient's **records. For other than records involving workers' compensation cases, such reasonable costs shall not exceed twenty dollars ($20.00)** for medical records five (5) pages or less in length and fifty cents (50¢) per page for each page copied after the first five (5) pages and the actual cost of mailing. Any third-party provider of record copying and related services shall be subject to the reasonable cost limits contained in this section and shall not impose any charge or fee for such services in excess of such cost limits. The costs charged for reproducing records of patients involved in a workers' compensation claim shall be as defined in § 50-6-204. A health care provider shall not charge a fee for copying or notarizing a medical record when requested by the department pursuant to a complaint, inspection or survey as set forth in § 63-1-117".

Referrals
It is the policy of HOPE Family Health to follow a formal, standardized procedure for setting up referrals to other health care providers such as specialists and diagnostic centers, and for following up afterwards to ensure the patient received the care ordered by the HOPE provider. HOPE staff will guide patients through the referral process, at each step ensuring that they have everything they need to complete the plan of care if they choose to do so. **Patients must pay the entire amount of outside referrals if needed.**

Minors & Dependents
Parents and guardians are responsible for payments for their dependents at the time the service is rendered. **The Parent or guardian of minors and dependents must present a valid insurance card at each visit if a claim is to be filed.** See item **Insurance Claims** above if an insurance card is not presented.

Collections
HOPE will make every effort to collect all monies due from services provided to patients by offering payment plans, as well as cash discounts for payment of accounts that are significantly in arrears. Patients that qualify for the sliding fee scale are established at a level of payment that is based on their ability to pay for services. In the collections process, as in all other aspects of HOPE's operations, patients will be treated with dignity and respect. HOPE will make all reasonable attempts to collect past due accounts using a procedure that is consistent with all patient types. **If a patient does not make any attempt to make payments after 150 days or defaults on the payment plan, charges for medical services will be on a *cash basis only*. However, HOPE will not refuse care to its patients due to their inability to pay.**

The financial policy package will be explained to patients upon their registration at HOPE. Staff will address any questions patients have on the policies and will encourage them to pay in full at the time of visit. The patient must sign that they understand and acknowledge receipt of the policy.

Printed Name: _____ ***Signature:*** _____ Date: _____
Patient/Guardian Patient/Guardian