Prairie View
Behavioral & Mental Healthcare

Name:______________________________________

Prairie View Case Number:______________________

Consent To Outpatient Treatment

This form is to document informed consent to services at Prairie View including, but not limited to, evaluation, subsequent treatment, and care coordination. More information on each of the sections below is located in Prairie View's *Notice of Privacy Practices* and *Patient Rights and Responsibilities* under their corresponding headers. By initialing and signing the designated fields below, you agree to the following:

Communication Consent

_______ I acknowledge that I have been provided with Prairie View's *Notice of Privacy Practices, Patient Rights and Responsibilities, Missed Appointment Information Sheet,* and a *Prairie View Rate Sheet.* In the event of modifications to any of these documents, the revised documents will be prominently displayed and printed copies made available upon request.

_______ I consent to the use of email and/or text messages to communicate with Prairie View and its staff. I understand the risks associated with communication by email or text messages, and consent to the conditions outlined in Prairie View's *Notice of Privacy Practices.* In addition, I agree to the instructions that Prairie View may impose to communicate by email and/or text message.

Treatment Consent

_______ I consent to a psychiatric evaluation and subsequent treatment, subject to my ongoing involvement in providing consent. I understand that if I wish to accept treatment I have the right to have the risks and benefits of treatment options, including not having any treatment, explained to me to my satisfaction. I understand that I may at any time refuse any intervention in which I do not wish to participate.

_______ I consent to the use of telehealth services, including evaluation and treatment by a provider from a distant location. Participation in telehealth services is voluntary and you may decline participation at any time.

Financial Consent

_______ I certify that all information provided, including information regarding income and any third party medical coverage is accurate. Payment for all services is my responsibility and any deductible/co-pay amounts are due at the time of service. Prairie View may contact the responsible party of the patient concerning the financial account. Prairie View may utilize a collection agency to collect unpaid balances in the event I do not pay for services rendered that are my financial responsibility. If sent to collections, I understand that access to future services at Prairie View may be impacted.

_______ I understand that Prairie View provides eligible patients discounted medically necessary services at the Harvey, McPherson, and Marion county locations. I understand that I must apply for this program in order to be determined eligible.

____
Printed Name of Patient

____
Signature of Patient

Date: _______________ Time: _______________

____
Printed Name of Representative

____
Signature of Representative

____
Description of Representative's Authority
(e.g. Parent, Legal Guardian, DPOA, etc.)

Date: _______________ Time: _______________

____
Prairie View Representative

Date: _______________ Time: _______________