TREATMENT AGREEMENT
BEHAVIORAL HEALTH HOSPITAL
(Consent-Hospital Treatment)

I understand that the term “Hospital” in this document is inclusive of all treatment programs, both inpatient and outpatient, that are included under the hospital’s behavioral health treatment programs.

Medical Consent: I consent to such routine services and treatment as are generally provided to patients in the Hospital and to any other services under the direction of my physician. I understand that my treatment is under the control and supervision of my physician(s) who are responsible for discussing with me the nature of care and treatment I will receive and who will provide me with information concerning the benefits of the treatment proposed, the way it is to be administered, the expected side effects and risks of the treatment and medication, alternative treatments and the possible consequences of not accepting treatment.

I understand that the staff of the Hospital want me to be aware of my rights as a consumer of the behavioral health services provided in this Hospital and want to insure I give my informed consent for treatment. The recommended treatment is provided through group and/or individual sessions by nursing staff, therapy staff and medical staff. My signature below indicates that I have received, reviewed and am in agreement with the following:
1. I have been informed of the results of the initial assessment.
2. I have also been informed regarding all of the following:
   a. Treatment alternatives.
   b. Potential risks or side effects of the proposed treatment plan which include but are not limited to:
      • Discouragement if progress is not as quick or as substantial as anticipated
      • Upsetting insights and feelings
      • Changes in relationships
      • Medication sides effects if medications are prescribed (These will be discussed with your prescribing provider)
   c. The potential benefits of treatment recommendations which include but are not limited to:
      • Diminished and /or discontinuation of symptoms
      • Improved understanding of self and others
      • Progress toward goals and objectives
      • Increased perception of control over thoughts, feelings and behaviors
      • Increase in positive self-regard and independent behaviors
      • Increase in assertive behaviors
   d. The approximate duration and desired outcome of the treatment recommended in the treatment plan.
3. I understand that if I refuse offered services, I am acting against medical advice and that my refusal may result in a worsening of my medical condition.

I understand that invasive treatments or psychotropic medications will be fully explained and a separate consent form will be present for review and signature. I authorize the Hospital to provide nursing and/or medical consultation when serious health problems develop and to arrange for and obtain urgent or emergency services at the recommendation of a physician. (In the event the patient is a minor, the parent/guardian will be notified of an urgent or emergency occurrence.) This consent shall remain in effect until treatment is terminated but not longer than 15 months with the understanding that I may revoke my consent to treatment, except to the extent that action has been taken in reliance thereon, at any time. I UNDERSTAND THAT MY PHYSICIAN(S) IS PROBABLY NOT AN EMPLOYEE OF THE HOSPITAL AND THAT THE HOSPITAL IS NOT RESPONSIBLE FOR THE ACTS AND OMISSIONS OF NON-EMPLOYED PHYSICIAN(S).

This consent indicates acceptance of student participation in my treatment unless otherwise revoked. I also give the Hospital my permission to obtain photographs or recordings of me so that the Hospital can identify, diagnose, or treat me, or for what the Hospital calls internal health care operations purposes. I understand that I may also change my mind and revoke the permission I gave to the Hospital up until a reasonable time before the photographs or recordings are used.
Voluntary Admission: For individuals who are receiving inpatient treatment, I understand that as a voluntary admission to a Hospital, I have the right to request discharge at any time. I understand the Hospital staff will make available to me the form used to make a request for discharge and assist me in preparing such a request.

I understand my physician has the right and responsibility to make an assessment of my condition related to danger to myself or others following my request, and determine by the end of the next business day whether to discharge me or issue a Treatment Director Affidavit. I understand if a Treatment Director Affidavit is issued, I will receive no further treatment without my written consent except to sustain life or provide safety for myself and others.

Personal Valuables: (For patients who reside overnight). I understand that the Hospital maintains safe storage for patients’ valuables such as money, jewelry, documents or other articles of unusual value during hospitalization. I also understand that it is recommended that articles of value not be retained at the Hospital and the Hospital will not assume liability for any loss or damage to valuables not deposited in the Hospital safe. I understand that if I do not send home medications I have brought with me, the doctor may order that for my well being, these medications not be released to me at the time of discharge.

Disclosure of Sensitive Information: As I am being cared for in the Hospital it is important that those people caring for me have access to sensitive information about me. The Hospital needs my permission for those people to look at my records and talk about my care and me. This “Sensitive Information” may include items such as:
- Treatment records related to mental health
- Developmental disabilities
- Alcohol and drug abuse assessments
- HIV test results.

I give the Hospital my permission to disclose my Sensitive Information to other Advocate Aurora Health affiliated entities for treatment and health care operations purposes. I also give my permission to the Hospital to share my Sensitive Information, as necessary, with Advocate Aurora Health’s billing office and its employees, my health insurance plan and any others who would need to be included in order to bill for the services I received and collect the payment. I give my permission to use my Sensitive Information for as long as needed for these purposes.

Regarding Charges: Advocate Aurora’s daily rate is comprised of multiple charge types. The programming charges (BH Psych) are for a menu of services that includes the patient’s direct involvement (for example, group therapy), but also care that is indirect (for example, dietary planning specific to the patient). The programming charges do not cover the same services as do room and board charges. Therefore, both charges are applicable for an inpatient stay and will be reflected on the bill.

Financial Agreement: I hereby agree to pay or cause to be paid all charges by the Hospital for my own/child’s medical care, maintenance, and medical attention and all other expenses and liabilities incurred during the course of treatment by the Hospital and to be responsible for all acts done or committed by the patient on or in the Hospital’s premises. Should the account be referred to an attorney or collection agency for collection, I agree to pay actual attorney’s fees and collection expenses. I understand that submission to my insurance company is a courtesy and the Hospital does not accept responsibility for collecting claims from my insurance company or any third party payer. I recognize that I am responsible for obtaining referrals or notifying my insurance company for any pre-authorization requirements. I am financially responsible for payment directly to the Hospital for the services provided.

Assignment of Benefits: I hereby authorize my insurance carrier or other third party financial guarantor to pay the health insurance benefits otherwise due and payable to me directly to the Hospital. I understand that I am financially responsible for any charges not paid by my insurance carrier or other third party financial guarantor. Any overpayment will be refunded to me only when all my obligations to the Hospital have been met. This assignment cannot be revoked without the Hospital’s written consent.
Disclosure of Demographic Information for Community Education and Fund-raising Purposes: As a patient of the Hospital, I give the Hospital my permission to access, use and disclose to Hospital employees and other employees of Advocate Aurora Health who are responsible for community education and fund-raising ("Foundation Personnel") four things about me; my name, my address, my e-mail address and my telephone number. I give my permission to use and share my name, address, e-mail address and phone number for the purpose of informing me of community education and fund-raising/philanthropic opportunities for Advocate Aurora Health. I am giving my permission to do this for as long as my name, address, e-mail address and phone number are needed for these purposes. If I decide to revoke my permission, I understand I need to provide that request in writing. I also understand that if I do later change my mind, the Hospital may have already shared my name, address, e-mail address and phone number because I originally provided my permission. I know that anytime I ask, I may say that I do not want to receive community education and fund-raising communications. I also understand that written community education and fund-raising communications that I receive will tell me how I can Opt-Out.

Patient Rights: I acknowledge receipt of the document that describes patient rights and responsibilities. I acknowledge that I have been informed verbally of the Patient Bill of Rights and conditions under which I may be discharged from the Hospital. I certify that I have read and understand this statement, have had the opportunity to study it and seek additional information, and I consent to the terms and conditions contained within it.

Release of Information to Insurance Companies:
I authorize the Hospital to provide information from Hospital records relating to my diagnosis and treatment to:

________________________________________________  ________________________________________________
(insurance company)          (insurance company)

________________________________________________
(insurance company)

who is responsible for payment for the services provided to me by the Hospital and physician(s) and to review the agency(ies) under contract with such third party payer(s) to provide concurrent and retrospective review of treatment. It is understood that the information to be disclosed either by verbal exchange or in the form of a copy of the medical record is for the purpose of coordinating and obtaining payment for services rendered to me. It is understood that the specific type of information to be disclosed includes the Psychiatric/Psychological Evaluation, Discharge Summary, History and Physical, Progress Notes, Physician Orders and other related diagnostic and treatment material. It is further understood that this authorization is revocable at any time, except to the extent that action has been taken and for a reasonable time to effectuate the purpose for which it is given.

Financial Advocate Assistance: I understand that a Financial Advocate is available and will assist me in understanding what my insurance may or may not cover and the personal financial responsibilities I may have prior to receiving these services.

Medicare and Medicaid Related Claims: I authorize the Hospital to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for the related service either by verbal exchange or in the form of a copy of the medical record for the purpose of coordinating and obtaining payment for services rendered to me. This consent to release information shall remain effective until the Hospital has been reimbursed for all services provided. I authorize the assignment of Medicare benefits payable to the Hospital.

I am financially responsible for my Medicare deductible for inpatient services provided.
Camera Monitoring: I voluntarily authorize Advocate Aurora to use security camera monitoring and digital taping without audio in the common areas of the unit for the purposes of safety and facility operations. Common areas do not include my sleeping room or my bathroom, which are designated areas where I may opt out of security camera monitoring or taping during my inpatient stay. I understand that I may specify periods during which I may not be digitally taped by submitting a request verbally or in writing. However, I understand that if the hospital cannot accommodate my request not to be digitally taped during specified time periods, I may be discharged from care or transferred to another facility where my request can be accommodated. I understand that in advance of the release by Advocate Aurora of any digital tape including images of me, I may request to review the digital tape, subject to the rights of other patients under State and Federal privacy laws. Advocate Aurora will make reasonable efforts to notify me in the event that any digital tape including images of me is scheduled for release. This consent may be revoked at any time either verbally or in writing. Otherwise, if my consent is not withdrawn, it will automatically expire 2 days after I am discharged from inpatient care. Notwithstanding the above, I understand that I may be filmed in treatment areas without my consent in situations in which I must be continuously observed to ensure the safety of myself or others or I am otherwise engaged in dangerous or disruptive behavior.

Notice of Privacy Practices:
I acknowledge that Advocate Aurora Health has provided me a copy of their Notice of Privacy Practices.

Date ___________________ Time: ___________________ Patient Signature over age 14

Date ___________________ Time: ___________________ Witness Signature

Date ___________________ Time: ___________________ Patient/Guardian Signature

Relationship to patient ___________________

Interpreter Assistance: If an interpreter assisted, please complete the following: Language: ___________________

Date: _______________ Time: ___________ Interpreter Name: ___________________ ID #: ___________________

For Aurora Personnel Use Only
Brochures Offered:
Notice of Privacy Practices: ☐ Accepted ☐ Declined Patient Rights: ☐ Accepted ☐ Declined
Payment Policy: ☐ Accepted ☐ Declined No Surprise Billing Disclosure: ☐ Accepted ☐ Declined

Date: ___________ Time: ___________ Signature: ___________________