SMA Healthcare
Authorization for Services with Informed Consent

Client Name: _____ MR #: _____ DOB: _____

Program: _____ RU: _____ Date: _____

General Consent for Treatment:
I authorize the staff of SMA Healthcare (SMA) to provide recommended services and treatment including those identified on my service/treatment plan. I have been informed of the nature and purpose of the services, possible alternatives, approximate length of care, and fees and method of payment. I understand that SMA staff members may discuss my diagnosis, treatment, health history, and progress, with other personnel who are members of the multidisciplinary team. I agree to participate in SMA approved recreational activities and will disclose all medical and physical conditions that may prohibit my participation. If medications are prescribed for me I will be educated on the reason why, possible side effects, possible drug and/or food interactions that could occur, and the possible effects if the person taking the medications becomes pregnant. I understand that SMA will contact me based on my communication preference and that my photograph will be taken for personal identification. My photograph may be released to the appropriate persons in the event of an emergency or elopement from the program. I further understand that audio and video recording will only be used for clinical purposes, following all confidentiality guidelines.

Orientation:
I confirm that I have been oriented to the program in which I'm being admitted to by a staff member and understand that additional orientation can be provided at any time upon requesting it. Staff reviewed and offered me a copy of the Client Rights and Program Handbook that includes but is not limited to the following: services offered in the program; review of overdose prevention information; importance of family/support system involvement; grievance process; parental or legal guardian's access to information and/or treatment; limits of confidentiality; safety and infection control practices; fees and financial responsibilities; rights as a client; review of a safety plan and advance directive; responsibilities as a client and of SMA staff; and program's admission and discharge criteria, benefits, risks, expectations and rules. I or a family member may receive a copy of the Client Rights and Program Handbook at any time upon requesting it from a staff member.

Urinalysis and Breathalyzer Testing:
I understand that I will be required to provide urine samples and/or breathalyzer for analysis upon request, as urinalysis and/or breathalyzer sampling is used to detect drug and/or alcohol use as part of SMA's treatment programs.

Transportation:
I understand SMA may provide transportation when applicable.

Search:
I understand that I may be required to submit to a search of my person and personal property by SMA staff during treatment for security reasons. Searches may involve disrobing partially or completely, depending on security violation or incident.

Confidentiality:
I understand that all communication between me, and/or the person I represent, and SMA staff will be treated as strictly confidential, and no information will be released without my written permission unless there is an exceptions to confidentiality that is mandated or implied by Florida law. Limits of confidentiality are detailed in the Client Rights and Program Handbook.

Notice of Privacy Practices:
I confirm that I have received or have been given the opportunity to receive a copy of SMA Healthcare's Notice of Privacy Practices. This notice describes how my Protected Health Information (PHI) may and may not be used and what my rights are as a client are with respect to PHI. I understand that SMA has the right to change its Notice of Privacy Practices and I may obtain a current copy of the notice by requesting it from staff or by visiting SMA's website at any time.

Electronic Health Sharing:
SMA participates in Electronic Health Information Exchanges (HIE) and Electronic Referral Management systems to obtain and provide episode of care and clinical information. I authorize SMA to provide my demographic and personal health information (PHI) to participants in these electronic systems. This information will only be used for the purpose of evaluating my need, status updates, transportation, coordinating care, and/or providing services to me and any other treatment needs or concerns. I understand that my information will be shared under the minimum necessary standards in accordance with HIPAA 25 CFR 164.502(b), 164.514(d). Information may be disclosed by the following methods: electronic upload, encrypted email, verbal, faxing and U.S. mail.

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Termination:
I confirm that I have been informed of the termination of services policy which includes lack of cooperation and/or refusal to participate in treatment/services.

Release of Medical Information and Assignments of Benefits:
I understand that if I am paying for services through an insurance benefit, I authorize SMA to release any clinical information from my medical record to my insurance carrier(s) or government agency for the processing of claims for medical benefits; including records of client if a minor, which may include psychiatric, substance abuse and/or HIV/AIDS information needed to obtain insurance or other payer benefits on my behalf. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to SMA for services provided.

Financial Responsibility:
I agree to report any income changes, including insurance coverage, within 15 days of its occurrence. I am aware that failure to provide complete, accurate and current information may affect my fee discount if applicable. I understand that if my insurance is accepted I will be billed for co-insurance and deductible. I understand that my insurance company, state agency, or other payer source may request information with respect to care at SMA.

No Shows or Late Cancellations:
I understand that in order for treatment to be successful I must commit to attendance of service(s) and treatment specified on my Treatment Plan. If I need to cancel an appointment, I will contact SMA at least 24 hours prior to the time of my appointment. If I do not provide adequate notice, I understand that SMA reserves the right to charge a $25 no show fee.

Post Discharge Survey:
☐ Yes, I agree that I may be contacted based on my communication preference for a follow-up survey for 18 months. Agreeing to the post discharge survey includes being contacted to provide SMA on how I am doing and if I need further assistance. Information given will be put into SMA's data system and may be shared with the Department of Children and Families, and/or other SMA staff including receiving information from SMA and SMA Foundation.
☐ No, I do not wish to be contacted for a follow-up survey or receive information from SMA or SMA Foundation.

Revocation of Consent:
I understand that my consent may be revoked at any time in writing except to the extent that SMA has taken action in reliance on the consent.

Enrichment Program: ☐ Yes ☐ No/Not Applicable
I confirm that I have been informed that by participating in Enrichment it does not guarantee gainful employment in the community. I understand that income earned may affect my benefits (e.g. SSI, SSDI, AFDC, OSS, Food Stamps). I am responsible for monitoring my income and changes to my benefits. I agree to follow all safety rules of Enrichment.

By signing this document, I attest that I have read and/or received explanation, understand, and consent to the disclosures, terms and condition contained above. No guarantee or assurance has been made to me regarding the outcome for any treatment received at SMA or of those services identified on the treatment plan that are not provide by staff members of SMA. If the client is unable to consent to treatment, I attest that I am the legal guardian of this individual and am authorized to initiate and consent to treatment and/or am legally authorized to initiate and consent to treatment on behalf of this person.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian, if applicable Date

_____ _____ _____
Signature of Staff Credentials ID# Date

_____ _____ _____
Signature of Staff (witness, required if verbal obtained) Credentials ID# Date