Signature™ HEALTH

# Signature Health Consent To Care

Personal Information:

| Patient Name: |
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| Patient Date of Birth: |
| Name of Patient's Legal Representative: |
| Relationship to Patient: |

Consent to Care:

I hereby give consent to Signature Health, Inc. and its affiliates to provide treatment and care for me, which may include, but is not limited to, administering assessments, providing mental health services, alcohol and drug addiction services, psychiatry services, primary care services, reproductive health or Title X services, urine screening, and evaluations. It is the policy of Signature Health, Inc. that staff shall explain the risks and benefits of each proposed treatment, of alternative treatments, and of no treatment. All treatment provided by Signature Health is voluntary and receiving services from any department, including Title X services, is not required to obtain care from another department. Should a patient, or a personal representative of a patient, refuse or withdraw consent for care, staff shall reaffirm the patient's right to refuse and shall make efforts to develop alternative approaches collaboratively with the patient serviced that ensure that the patient receives needed services in compliance with state regulations. Staff shall also make efforts to ensure that the person served understands the implication and potential consequences of refusing or withdrawing consent. I understand that staff shall document consent, refusal to consent, or the withdrawal of consent in my record.

In the event that I choose to participate in telehealth services, I agree that video and auditory technology will be used as a means of accessing services, which may include assessment and treatment, pharmacological management, primary care, and counseling. Telehealth services may include the use of agency or my own equipment such as computer and webcams or smartphones, as well as secure internet transmission. I understand that there may be additional risks or benefits to receiving services by telehealth, which I will discuss with my provider before beginning telehealth. I retain the right to be seen face to face by a similar level provider.

Financial Responsibility:

I hereby assume all financial responsibility for treatment and services. I understand that I am responsible for payment for services, including co-pays, rendered by Signature Health, Inc. at the time services are rendered. If Signature Health is in-network for your insurance provider, Signature Health will bill your insurance for you. In the event that I am insured or entitled to benefits through Medicare, Medicaid, or third party insurance, I hereby assign such benefits to

Signature Health, Inc. I authorize the release of any medical information necessary to process claims to any third party payor.

I understand that I am responsible for keeping any appointments scheduled for me, and for calling at least 24 hours in advance if it is necessary for me to cancel or reschedule an appointment. I understand that failure to give at least 24 hours' notice of cancellation may result in a session charge depending on the type of appointment that was missed.

Release of Information:

I hereby authorize Signature Health, Inc. and its subsidiaries to release to and obtain from my insurance company, the Ohio Department of Job and Family Services Medicaid Division, Ohio Bureau of Worker's Compensation, the Centers for Medicare and Medicaid Services, and/or state and county agencies any medical information needed for the purposes of evaluation, treatment, consultation, care coordination and follow up, and claims processing. I understand that Signature Health, Inc. may exchange my medical information with other health care providers for the purpose of continuity of care and in emergency situations. Signature Health, Inc. will endeavor to provide only the minimum necessary information to meet the needs of the situation.

I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. This consent expires automatically 90 days after my case has been closed unless an earlier date or condition is specified.

Electronic Prescriptions:

It is the policy of Signature Health, Inc. to transmit prescriptions electronically whenever possible. I hereby consent to the use of electronic prescriptions and the release of all pertinent information, including but not limited to, diagnoses, prescribed medication, and insurance information necessary to process prescriptions via Signature Health, Inc.'s electronic prescription vendors.

| Signature: |
| --- |
| Printed Name: |
| Date: |