Oliver Behavioral Consultants, LLC

Client/Patient Rights and Consents

Patient Name: ___________________________________

I acknowledge as the Patient or the Parent/Guardian/GAL of the Patient, the following:

________ **(INITIALS)**	1) A copy of HIPAA has been made available to me. I may discuss this with my provider if desired.
________ **(INITIALS)**	2) A copy of my rights under CO law as a person who may have an identified disability or vulnerability has been made available to me. I may discuss this with my provider at any time, or contact the State of Colorado to learn more.
________ **(INITIALS)**	3) I give consent for myself or my son/daughter to received evaluation and/or treatment services from OBC. I further understand that I can revoke this consent at any time without retaliation.
________ **(INITIALS)**	4) I understand that all providers at OBC are mandatory reporters of suspected or identified abuse of a child or vulnerable adult. If abuse is identified or suspected, this information will be shared with legal authorities.
________ **(INITIALS)**	5) I understand that all Mental Health providers at OBC are mandatory reporters of determined imminent risk for suicidal and imminent or credible risk of homicidal behaviors to relevant authorities and intended victim if known.
________ **(INITIALS)**	6) I understand and consent to payment of all services requested by me if they are not covered by my Medicaid, Commercial Insurance or otherwise. A) I further understand that all insurance copays, cost-shares and deductibles, if any, are my responsibility to pay at time of service. B) Commercial plans often specify that authorization of services does not constitute a guarantee of payment for those services. C) Efforts will be made to align your or your child's provider(s) to credentialing requirements; however, if your insurance carrier indicates we are a provider in-network with them, then changes their position, we are required by law to charge you as an out-of-network provider. And notify you as soon as we know this. D) Likewise, OBC will attempt to verify your insurance coverage and personal costs prior to service delivery. However, regardless of what is conveyed to you at that time, you are bound by your health insurance carrier to pay your identified portion by law. E) Should you have a change in health coverage for any reason, you must report that to OBC as soon as known. Any services provided during or after such a change are still your responsibility to pay, if they are not paid in their entirety by the new carrier.
________ **(INITIALS)**	7) I consent to send OBC a credit card to have on file to bill any and all owed charges in full as soon as they are identified by OBC. Form to be provided later. All information will be stored in a safe and protected space, only accessible by billing agents.

By initialing the above items and signing below, I understand and agree to all of the above items.

_____________________________________ _____________________________________ _______________

Printed Name of Patient if of Age or Signature Date

Legal Representative if Appropriate