Minnesota
Mental Health Clinics

Consent for Services

Guarantee of Account: I agree to pay Minnesota Mental Health Clinics for all charges for services not covered by any third party payer. I understand that I am responsible to comply with the rules and regulations of my insurance company regarding pre-certification and prior-authorization requirements. I agree if a pre-authorization of service is required, unauthorized visits are my responsibility for payment. We will assist you in keeping a count of your number of sessions used.

Insurance Consent: I request that payment of authorized benefits be made directly to Minnesota Mental Health Clinics, and the facility's participating physicians and therapists, for any services furnished to me. I authorize this facility to release to Medicare, and other accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies.

Transportation: I authorize Minnesota Mental Health Clinics to release to my transportation company information regarding my appointment attendance.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider working for this facility involved with my current treatment. I understand that other agency personal involved in billing, medical records and other necessary duties may see my medical records. I understand that a facility representative who is conducting a Rule 29 case consultation or a quality of care review may access my record. I further understand that a representative may contact me after discharge, and that information from my medical record has been made available to that representative. The representative will seek your opinion about the helpfulness of services and about any problems you may have had. We will follow any direction you may have had for us to contact you on the "Treatment Agreement" form.

Consent for Personnel in Training: I am aware that clients at this facility may be attended by medical, nursing, and/or other mental health care personnel in training, who may be present during client care as part of their education.

I hereby agree to the above and that a photographic copy of this authorization is as valid as the original. This authorization expires after one year but may be revoked or limited in writing by me at anytime, but such revocation will not apply to information already released. I may disagree with the use of my medical record for any purpose listed above by crossing through the paragraph and initialing in the left margin. I understand that if I refuse or revoke consent to release information, this may change my providers' ability to continue providing services.

Client Name (please print) _____

Signature _____ Date: _____

Parent or Guardian Signature _____ Date: _____