PEOPLE
INCORPORATED
MENTAL HEALTH SERVICES

# Consent for Services

This consent applies to all People Incorporated programs, locations and providers where I (or my child) may receive care now or in the future.

**Consent for Treatment:**
I understand that I (or my child) have a condition that requires diagnosis and treatment. I will have a chance to discuss with the People Incorporated staff working with me (or my child) the treatment that People Incorporated and its staff believe is needed. To provide this care, People Incorporated and its staff may collect information about my (or my child's) health, including information such as family health history. Neither People Incorporated nor its staff can promise any specific results based on a proposed treatment, but People Incorporated and its staff will answer my questions about treatment. I may refuse any recommended treatment by communicating this to the staff I am working with (or who is working with my child) at any time.

**Assignment of Insurance Benefits and Release of Information for Payment:**
People Incorporated may bill my insurance and I authorize that my insurance payments be made to People Incorporated for any services provided to me (or my child).

I consent and authorize People Incorporated to release information about me, including, but not limited to mental health service documentation, progress notes, admission or discharge status, and residential status, to my insurance provider or other entity that is paying for the services that People Incorporated provides to me (or my child). By consenting and authorizing People Incorporated to release this information, I understand and agree that this information may be released to the Minnesota Department of Human Services, Prepaid Medical Assistance Program Managed Care Organizations, county social services agencies, Medicare, commercial health insurance entities, or other similar or related entities.

Additionally, I authorize People Incorporated to appeal any denial of any claim for services provided to me (or my child) by People Incorporated to the Minnesota Department of Human Services or to any other applicable regulatory oversight entity.

**Payment Responsibility and Financial Assistance:**
I understand that while People Incorporated will make all attempts to bill my insurance for services provided to me (or my child), I am ultimately responsible for payment of all charges for services provided by People Incorporated – including any co-payments, deductibles, co-insurance, spend-downs or any services not covered under my health plan. I understand that future access to People Incorporated services may be discontinued due to nonpayment of these charges.

If I do not have the ability to pay these charges, I can notify People Incorporated staff at any time, and they will help identify options that can allow me (or my child) to continue to receive services, which may include one or more types of financial assistance depending on my current situation.

**Concerns and Revocation:**
If I have questions or concerns with this consent, I may discuss them with the People Incorporated staff member who has provided me with this form. The authorizations I am providing on this form will not expire on a specific date, and will continue forever, unless I revoke them by submitting a written request to:

People Incorporated
Attn: Legal and Compliance
3000 Ames Crossing Road, Suite 600
Eagan, MN 55121

However, any actions already taken while my consent or authorization was in effect will remain valid (cannot be undone).

**By signing below, I am agreeing to provide my consents and authorizations as described above**:

_____ _____
**Print Client Name** **DOB**

_____ _____
**Client Signature** **Date**

If parent/guardian is signing on behalf of a client, please complete the following information:

_____
**Print Name of Parent (custodial and non-custodial) or Guardian**

_____ _____
**Signature of Parent (custodial and non-custodial) or Guardian** **Date**