PARTIAL HOSPITALIZATION/INTENSIVE OUTPATIENT PROGRAM
CONDITIONS OF ADMISSION/ADMISSION CONSENT

CONDITIONS OF ADMISSION/ADMISSION CONSENT	Initials
APPLICATION FOR VOLUNTARY ADMISSION TO PARTIAL HOSPITAL OR INTENSIVE OUTPATIENT PROGRAM I request to admit myself as a patient to the Partial Hospitalization Program/Intensive Outpatient Program for diagnostic observation, care, treatment, and services (which in this document will be referred as the "Care").	
CONSENT FOR TREATMENT IN THE PARTIAL HOSPITAL OR INTENSIVE OUTPATIENT PROGRAM I agree to accept the Care for myself as ordered by the Program physician or practitioner. I understand that I may refuse certain treatments and agree to discuss the refusal with the attending physician. The Program explained, and I consented to, the proposed Care. The Program told me of reasonable alternatives to the proposed Care, as well as the risks, benefits, and side effects related to those alternatives, including the risks of refusing any care. The Program told me that I have the right to revoke this consent at any time, which could result in my discharge from the Program, unless the Hospital has a legal obligation to treat me on an involuntary basis.	
CONSENT TO TRANSFER FOR TREATMENT I authorize my attending or covering physician to order my transfer to another healthcare facility for emergency care, medical treatment, acute psychiatric treatment, or medical procedure, as my attending physician deems advisable and necessary during my Care here. I have read and fully understand this consent for transfer, and agree that I will not seek to hold the referring physician, the Program, or its staff liable as a result of the transfer.	
ASSIGNMENT OF INSURANCE BENEFITS I understand that the Program files health benefit claims as a courtesy to patients. I authorize my health insurance or health benefit plan(s) ("Health Plan") to pay the Hospital or attending physician directly, up to the maximum of the Program's and physician's regular charges for the Care. I understand and agree that I am financially responsible to the Program for any charges related to my treatment and not covered by my Health Plan unless otherwise dictated by applicable law. I irrevocably assign and convey to the Program all rights, title, and interest in any benefits under the terms of the Health Plan and I promise to remit to the Hospital any payment that I may inadvertently receive from my Health Plan for the Care. I also designate, authorize, and convey to the Program to the fullest extent permissible under the law and any applicable Health Plan the right and ability to act on my behalf: (1) in connection with any claim, right, or cause of action, including to bring litigation against my Health Plan, that I may have under the Health Plan (including, but not limited to, naming me as a plaintiff in such an action); and (2) to pursue such claim, right, or cause of action in connection with the Health Plan, including but not limited to, with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act ("ERISA") – as provided in 29 CFR § 2560.5031(b)(4) – in relation to any expense incurred as a result of the Care, and to claim on my behalf any relevant benefits, claims, or reimbursement, and any other applicable remedy, including fines. I expressly and knowingly assign and convey to the Program all rights, title, and interest in any and all causes of action I may have under ERISA for breach of fiduciary duty or to recover benefits, as well as any other legal and/or administrative causes of action.	
RIGHT TO SEARCH I agree that the Program may search my belongings and remove any items that the Program believes may be potentially dangerous to me or others.	
CONSENT TO PHOTOGRAPH I permit the Program to take photographs of me as identification.	
SATISFACTION SURVEY The Program may give me a Satisfaction Survey around the time of discharge. The Program will not publicize my responses to the survey in a way that identifies me as a patient or as the source of the survey results. The Program may contact me by telephone or in writing to follow up on that survey, or for any other reason post-discharge.	
RECEIPT OF NON-DISCRIMINATION NOTICE I have received the Program Nondiscrimination policy. The Program has explained the policy to me during the admission process in a language that I understand.	
RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES INFORMATION I have received my Patient Rights and Responsibilities information.	
RECEIPT OF THE PATIENT GRIEVANCE INFORMATION I have received the Program Patient Grievance information. The Program has explained process to me during the admission process in a language that I understand.	

PATIENT IDENTIFICATION STICKER

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INTERPRETERS (As applicable) Patients with language, vision, hearing, or speech barriers have a right to special arrangements designed to enhance communication and comfort. The Program will furnish, at no cost to the patient, interpreters and auxiliary aids. I hereby give my permission for the Program to use a language interpreter for the purposes of communicating treatment information. I understand the interpreter will have access to my medical/psychiatric information only through the interpretation of this information. I understand the interpreter will NOT have access to my medical records.	
NO PHYSICIAN AVAILABLE 24/7 NOTIFICATION I understand that a physician is not present 24 hours/day, seven days a week. If an emergency medical condition occurs, a Registered Nurse will assess the situation, provide basic life support, and call the on-call physician and/or EMS-911.	
HIPAA - CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS: I understand and have been provided with a Notice of HIPAA Privacy practices and provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance, thereon. I understand by signing below I was given or asked if I wanted a copy of my HIPAA rights.	

My initials on the items show that I have read, understood, and agree to them.

Patient:	**Legal Representative (if applicable):**	**Program Staff Member:**
_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Date Time	Date Time	Date Time

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