STARR COMMONWEALTH
Driven to Heal

For Office Use Only
Location: Harper Woods
Med Record #: N/A
Date:

Consent Information

(Please Print)

Patient's Name *First* *Last*	**Birthdate**

Consent to Evaluation and Treatment

Starr Commonwealth is dedicated to providing comprehensive Behavioral Health Services to Michigan residents. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you high quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care. Some services at Starr Commonwealth may involve interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet, or saved in any way.

I, _____ understand, that if I am 14 years of age or older, I may consent to twelve sessions or no more than four months of mental health services. If I am 18 years of age or older, I may consent to all health services. Otherwise my parent or legal guardian will need to consent to services.

By signing this form, (parent or legal guardian signature, if required) I, _____ agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child (ren) as set forth above, including any studies or procedures that Starr's professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

In the event of Joint Legal Custody Starr Commonwealth requires both parent's signature as well as a copy of the Legal Custody agreement. Unfortunately, we cannot provide custody evaluations and/or legal advice regarding parental fitness. Also, we're mandated to report any form of Domestic Violence and/ or Abuse.

Patient's Signature (or legal guardian, if applicable) **X**_____	Date _____
Type or Print Name **X**_____	Date _____
Witness **X**_____	Date _____

Statement of Privacy Practices/Client Rights	
My initials below serve as my signature confirming I was provided materials listed.	
I have received Starr's *Statement of Privacy Practices*.	Patient Initials **X**_____
I have received Starr Commonwealth's *Client Rights* and understand my rights will be explained to me upon request.	Patient Initials **X**_____
I understand that if I am 14 years of age or older, I may consent for certain types of health services, including mental health services	Patient Initials **X**_____
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☐ I, _____ Acknowledge the child is 16 years or older and may consent for mental health services	

Patient's Name *First* *Last*	**Birthdate**

Contact Information

Emergency Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

I authorize Starr Commonwealth to leave messages on the answering machine(s) at my contact number(s).

☐ Y ☐ N

I give my permission for my provider(s) with Starr Commonwealth to communicate {orally or written (i.e. summary letter)} with the following individual(s) in regard to:

☐ Examination ☐ Diagnosis ☐ My Treatment ☐ Specific Purpose:_____	Contact Name:	Relationship to Patient:
	Contact Name:	Relationship to Patient:

By signing below, I authorize Starr Commonwealth to release information concerning me, my minor child, or legal charge as indicated above. I understand that I may revoke this consent to release confidential information at any time with written consent, but that it will not affect any communication prior to notification of cancellation **This authorization does not serve as consent to release documents.**
Unless I revoke this authorization, this authorization shall remain in effect for one (1) year.

Patient's Signature (or legal guardian, if applicable) **X** _____	Date _____

Consent to Receive Text and/or Email Messages

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, and/or to provide general health reminder/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Starr Commonwealth.
By initialing below, I consent to receive text messages from Starr Commonwealth at my cell phone and any number forwarded or transferred to that number to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/health information unless I request a change in writing (see revocation below).

Patient Initials **X**_____

The **cell phone** number I authorize to receive text messages and the **email address** I authorize to receive email messages for appointment reminders and/or general health reminders/information are:

Cell Phone Number:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **text messaging**. Patient/Patient Representative Signature:
Email Address:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **email**. Patient/Patient Representative Signature:

Patient's Name *First* *Last*	**Date of Birth**

Financial Information	
As a patient of Starr Commonwealth, you may be eligible for discounted services. Money, or a lack of money, should never keep you from getting the care you need. Our services are available on an "ability to pay" basis, which means we consider your income and family size and charge a nominal fee based on that information. We simply ask that you provide us with accurate information, below, now and in the future, and if you qualify for discounts that you try your best to pay your lower fees on the day you get your services. Thank you for choosing us as your health care partner. ***Proof of Income is required to be eligible for discounts***. *Before a discount can be arranged, our funders require that you provide written proof of your total household income. You may use paycheck stubs for at least three consecutive pay periods, benefits check stubs, W-2 forms, a copy of your most recent federal income tax forms, or a copy of applications for any other agency benefits if they include household income (i.e., applications made at DHS, Helping Hands applications or cards, etc.*)	
You may choose to decline providing financial information; however you would not be eligible for discounted services should you choose to do so.	☐ I choose to decline sharing my financial information

Household Income (include all income from person included in the count below):			
Number of people in your household:			
Sources of Income	**You**	**Others in your home**	**Total**
Wages from Employment			
Self-Employment			
Other Sources of Income	**You**	**Others in your home**	**Total**
Social Security			
Public Assistance			
Pensions			
Rental Income			
Child Support/Alimony			
Other (specify)			
		Grand Total:	

Authorization for Insurance Billing/Release of Information

There are fees for all services provide by Starr Commonwealth. It is expected that patients pay on the day they are seen or you may enroll in a payment arrangement. Health insurance policies may cover a portion of the fees and Starr staff will assist you in making claims. It is expected that you will inform us of changes in your family status or health insurance coverage. Please read the *Authorization for Insurance Billing/Release of Information* section below, fill in the name of your insurance company(s), and sign.

By signing below, I authorize Starr Commonwealth to assist me in obtaining third party benefits, to file benefit claims on my behalf, and to release any information necessary for the processing of my claim(s) to: *Name of Insurance Company, Behavioral Health Organization, or Other Third Party Benefit Agents(s).* I understand that such information may include diagnosis, dates of service, and types of treatment. **No Therapy Notes will be provided to your Insurance carrier per (HIPAA).** This release shall remain in effect until all claims filed on my behalf have been processed.

I authorize and request direct payment of my health insurance benefits to Starr Commonwealth. This authorization shall apply to all covered health services that I receive at the Center. If requested, I have been provided with a copy of the fee scale

Primary Insurance Name:		**Primary** Insurance ID#	
Secondary Insurance Name:		**Secondary** Insurance ID#	
Tertiary Insurance Name		**Tertiary** Insurance ID#	

Patient's Signature (or legal guardian, if applicable) **X** _____	Date _____
Witness _____	Date _____