Intake Consent Form

Consent and Privacy Rights

☐ **CO-PAY:** It is my responsibility to pay my co-pay at the time of each session. Should my private insurance pay me directly, I understand I will be billed the full cost of service.

☐ **Cancellation and No Shows:** I understand that I may be charged a $25 no-show fee for missed appointments, or if I fail to cancel my appointment within 24 hours.

☐ **Insurance:** I understand that changes in monthly income and insurance coverage may occur and that my co-payment may change as a result. I will notify Davis Behavioral Health of any changes immediately.

☐ **Billing Information:** I agree that my family member, guardian, or person acting on my behalf may talk with DBH about my billing information and other billing matters related to my treatment at DBH.

☐ **Collections:** If for any reason your account has not been paid in full at discharge, an 18% collection fee will be added, and the account will be turned over to collections.

☐ **Privacy and Clients Rights:** I have been made aware that the DBH Notice of Privacy Practices and Client Rights Statement can be found on the DBH Website.

☐ **Advance Directives:** I have been provided with information regarding Advance Directives and know that I may ask a therapist about any questions I may have.

☐ Yes ☐ No I currently have Advance Directives and a copy has been provided to DBH.

☐ Yes ☐ No Medicaid Transportation: I am aware of how to access alternative methods of transportation (for clients enrolled in the Prepaid Mental Health Plan.

☐ Yes ☐ No Grievance/Appeals: I am aware of how to access Davis Behavioral Health's grievance and appeals process.

☐ Yes ☐ No I give permission to Davis Behavioral Health to treat me for my behavioral health problems.

☐ Yes ☐ No Jail Evaluation, if Applicable, can be found in jail record.

☐ Yes ☐ No I agree to let DBH share my medical records with my other medical providers through the Health Information Exchange HIE.

☐ I have fully considered the benefits and risks of participating in Telehealth and have had the opportunity to ask questions of DBH staff. **I consent to participation in Telehealth services from DBH by one or more of the following methods: 1) signing this form electronically, 2) signing and mailing a hard copy, OR 3) (if one of the previous two methods is not feasible such as during the COVID-19 outbreak), by connecting with my healthcare provider via technology at which time the provider will note my verbal consent.**

Cash Price at time-of-service		**Full Fee**
MH Evaluation	$93.00	$177.32/hour
Medical Evaluation	$175.00	$177.32/hour
Individual Therapy	$76.00	$163.14/hour
Group Therapy	$30.00	$48.52/hour
Med Management	$76.00	$102.45/visit
Injection	$40.72	$40.72/visit

Signature: _____ Date: _____

Please Print Client Name: _____