

**PM Form 10.17.2
UNIVERSAL CONSENT TO TREAT FORM**

Client:

ID#:

Date:

**Community Behavioral Health Services
Community Bridges of Arizona
Community Counseling Centers
Child & Family Support Services
Hopi Guidance Center
Little Colorado Behavioral Health Centers**

**Mohave Mental Health Clinic
Southwest Behavioral Health
The Guidance Center
Verde Valley Guidance Clinic
West Yavapai Guidance Clinic**

The above listed agencies have agreed to utilize this form as a method of expediting member transfers between Responsible Agencies. This Universal General Consent to Treatment Form will serve as documentation of a client's agreement for services, during the transfer process. The Transfer TO agency may wish to have the client sign their own General Consent to Treatment Form on the date of the initial appointment.

Any person, aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the person's or legal guardian's signature on a general consent form, before receiving behavioral health services except in an emergency situation or pursuant to a court order.

For persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services, except in an emergency situation or pursuant to a court order.

Consent to Treatment:

I authorize (name of Transfer TO agency) to provide (name of client) with all medically necessary covered behavioral health services, which are required in order to facilitate my transfer from (name of Transfer FROM agency) to (name of Transfer TO agency). I understand the risks and benefits of behavioral health services, including the risks associated with declining a specific service or procedure, and have been informed of alternative services that may be available.

Insurance/Payer Release:

I authorize (name of Transfer TO agency) to disclose diagnosis, dates of service, treatment plan, prognosis and other information requested by my insurance carrier(s) or payer source(s), including the Social Security Administration for Medicare insurance, as is necessary to process and submit insurance claims for service(s) provided to me by their agency.

I authorize payment of medical benefits directly to this agency, for service(s) provided to me not to exceed the benefits payable under this medical insurance plan. **I further acknowledge that I will be financially responsible** for incurred charges that are not covered by my medical insurance carrier (i.e. deductible, co-pay, co-insurance, policy limitations) **and this includes AHCCCS.**

Client, Parent or Legal Guardian's Signature: _____ Date: _____

Insured Person's Signature if Different from Above: _____ Date: _____

Notice to Insurance Carrier in case of alcohol/drug diagnosis: The information contained on the insurance claim has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical information is not sufficient for this purpose. Effective 8-2-07 / Revision date 7-15-09