HDC
Human Development Center
Comprehensive Behavioral Healthcare

INFORMED CONSENT AND AUTHORIZATION

Consent for Treatment I give my consent to Human Development Center (HDC) providers and support staff to provide, coordinate, and/or manage behavioral health services for me.

Authorization for Disclosure of Protected Health Information (PHI) As explained in the Notice of Privacy Practices, I authorize disclosure of my protected health information for the purpose of HDC's Treatment, Payment, and Healthcare Operations.

Examples: • HDC providers from whom I accept services or treatment may share my information with other HDC providers involved in my care. • I understand that for various services HDC providers are required to or designed to function as a team and will share my information within that team in a confidential manner. • I understand the Consultation process between members of an HDC multidisciplinary team may include confidential discussion about a client. This case Consultation is good practice and helps to ensure high quality care for me.

Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits, or benefit payments from other sources for claims for my care originating from HDC to be paid directly to HDC. I agree to pay the balance due for any services received that are not covered by insurance or grant funding.

Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I understand the laws, rules, and regulations of these programs shall apply. I may contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118 if I have questions.

Client Information I have received the Client Information booklet informing me of HDC policies and my rights as a client.

HDC Financial policies exist that: A client is required to pay the applicable co-pay amount due at the time of each visit.

I acknowledge I have received the HDC **NOTICE OF PRIVACY PRACTICES** that explains how my health information will be handled in various situations. I understand that I can request a copy of the Notice of Privacy Practices from HDC. I understand an electronic copy of the HDC NOTICE OF PRIVACY PRACTICES can be found at https://www.humandevelopmentcenter.org/.

I have been given the opportunity to discuss my concerns and questions about the privacy of my health information, or I may contact the HDC Privacy Officer at 1401 East First St., Duluth, MN 55805 or toll-free 888-412-9764.

This authorization is valid for one year from the date of signature. I may revoke this consent and authorization at any future time upon written notice to HDC.

Signature: _____ **Date: _____**

Printed Name: _____

If I am signing as an authorized representative of the client, I am: (Check one)

☐ Parent of a minor ☐ Court Appointed guardian/conservator ☐ Power of Attorney for Healthcare

Must provide documentation of guardianship, conservatorship, power of attorney for healthcare.
Staff must document any refusal to sign.

Client Name: _____

 Client #: _____