Recovery Pathways, LLC
Informed Consent

.Thank you for choosing Recovery Pathways, LLC. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Please sign after each segment to indicate your agreement

1. CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for a) information shared with consultants; b) information (diagnoses and dates of service) shared with your insurance company to process your claims; c) information you and/or your child(ren) report about physical or sexual abuse (in these instances we are obligated by Michigan State Law to report this to the Department of Children and Family Services); d) where you sign a release of information to have specific information shared; e) if you provide information that informs us that your are in danger of harming yourself or others; f) information necessary for case supervision and consultation; g) or when required by law. In the unlikely event we are unable to provide ongoing services, appropriate referrals will be made for your continued treatment, and we will maintain your records for a period of 7 years. If the client/guardian feels immediate attention is needed for an emergency situation, please call the office to have the doctor paged. If your call is not returned within 15 minutes the client/guardian understands they are to contact the emergency services in the community (911) or local emergency room for those services. We will follow those emergency services with standard counseling and support to the client or the client's family as indicated.

Signature_____**Date**_____

2. FINANCIAL/INSURANCE ISSUES:

- It is your responsibility to know your eligibility and benefits coverage
- As a courtesy, we will bill your insurance company, HMO, responsible party, or third party payer for you if you wish
- You must pay your co-pay prior to service being provided
- If you have not met your deductible, the full fee is due at each session until the deductible is satisfied
- If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time
- Balance due is expected at the time services are rendered
- Refusal to pay your bill is grounds for service termination
- In the event the account is overdue and turned over to our collection agency, you or the named responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that you authorize payment of medical benefits directly to Recovery Pathways, LLC
- You may put a credit card on file to pay for charges
- Please see the staff for a copy of updated fee schedule
- If you have financial difficulty, please see office staff for discussion of payment plans, sliding fee scale, and funding assistance

3. CANCELLATIONS: You must give 24 business hours advance notice, or you may be assessed a $25.00 fee which must be paid before future services will be provided.

Signature_____**Date**_____

4. TELEPHONE CONTACTS/TELEHEALTH:

- ☐ Yes, Recovery Pathways, LLC may leave a message at my home phone or cell phone
- ☐ No, Recovery Pathways, LLC may not leave a message at my home phone or cell phone
- ☐ Yes, I do consent to confidential telehealth* visits with Recovery Pathways, LLC via HIPAA-Approved audio/visual device
- ☐ No, I do not consent to confidential telehealth* visits with Recovery Pathways, LLC via HIPAA-Approved audio/visual device

*Telehealth visits are not the primary source of treatment provision and are only available as determined by treatment provider

Signature_____**Date**_____

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5. COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you do not have a primary care physician, it is your responsibility to establish with one as we do not provide primary care services. Please list your primary care physician information below:

PHYSICIAN NAME:_____**PHONE:**_____

ADDRESS:_____

Signature_____**Date**_____

6. TERMINATION: I understand that successful termination of treatment is determined when my provider and I agree that the treatment goals have been substantially completed. I understand that I may be discharged by my provider for the following reasons:

- I have successfully completed the treatment program as initially agreed upon
- I choose to terminate treatment
- I need to withdraw due to medical, financial, or legal problems, or geographic relocation
- My lack of attendance/motivation prevents further progress toward goal achievement. If I have not appeared for face-to-face contact for forty-five (45) days, I will automatically be terminated.
- I demonstrate inappropriate behavior relative to self, staff, or other clients which is disruptive to the therapeutic process (i.e. threatening and/or intimidating behavior).
- I refuse to make appropriate financial arrangements to pay for therapeutic services (when I have the financial ability to do so, and this is seen as a treatment issue)
- I fail to comply with any provision of this Agreement and/or the Treatment Consent Contract
- Any reason outlined on the Substance Use Disorder Treatment Agreement

Signature_____**Date**_____

7. PROCESS TO FILE A GRIEVANCE: A grievance is an action you can file about a concern, question or complaint about services provided by your mental health or substance abuse service provider. You can file a grievance at any time about anything. Someone else, such as a provider, can file a grievance for you as long as they have written consent to do so. To file a grievance call Recovery Pathways, LLC at 989-928-3566 or Dan Dedloff, MA, LPC Customer Service & Rights Specialist for the Mid-State Health Network at 517-657-3011. Once a grievance is filed, you will receive an acknowledgement letter within 5 days. You will also receive a letter telling you the decision made about the grievance. This letter will be mailed in no more than 60 days. If you receive Medicaid and get a Disposition letter after the 60 days, you will have the right to file for a State Medicaid hearing.

Signature_____**Date**_____

8. ACKNOWLEDGEMENT: By my signature below I acknowledge that I received all of the following documents/information:

- ☐ Treatment Contract
- ☐ Informed Consent
- ☐ Financial Agreement
- ☐ Client Rights and Responsibilities
- ☐ Notice of Privacy Practices
- ☐ Medication Handout and Instructions (as indicated)
- ☐ New Patient Introduction Letter
- ☐ Process to File a Grievance
- ☐ Brochures: Advanced Directive, Know Your Rights as provided by LARA, Medicaid Fair Hearing, Communicable Disease

Signature_____**Date**_____

9. ADVANCE DIRECTIVES: I have executed advance directives: ☐ Yes ☐ No If yes, please provide documentation.

Signature_____**Date**_____