Name:

Case#:

RUTGERS
University Behavioral
Health Care

GENERAL CONSENT FOR SERVICES

Date:____/____/_____

Authorization for Services: I hereby give consent and authorization to the staff of University Behavioral Health Care to provide clinical services to me, including such diagnostic, radiological, and/or therapeutic procedures and treatment, case management, residential, outreach and support services, are deemed necessary or advisable in my care. This includes without limitation all routine tests and procedures. I recognize that University Behavioral Health Care is a teaching facility of Rutgers, The State University of New Jersey, a body corporate and politic of the State of New Jersey, a public entity, and that medical students, physicians, and other health professionals in training may observe and be involved in the treatment and care. I understand I have the right to be informed of the presence of and to refuse participation in treatment by medical, psychology, social work, nursing, or other students and/or interns.

I authorize University Behavioral Health Care to call and/or e-mail or text me in advance to confirm my scheduled appointments:

Home:	Yes	☐	No	☐
Office:	Yes	☐	No	☐
Cell:	Yes	☐	No	☐
E-mail:	Yes	☐	No	☐

If Admitted as Inpatient: I agree to participate in the treatment on the unit and acknowledge that I must give 48 hours' notice in writing if I wish to be discharged against medical advice. I understand that University Behavioral Health Care is not responsible for my personal belongings and release University Behavioral Health Care and its staff from responsibility for all loss or damage to personal property.

Assignment of Benefits: I hereby irrevocably assign and authorize direct payment to University Behavioral Health Care of any insurance or governmental program benefits otherwise payable to me on account of services provided by University Behavioral Health Care. Except where otherwise provided by law, I understand I am financially responsible to University Behavioral Health Care for charges not covered by my insurance carrier and agree to pay such charges.

Release of Information: I hereby authorize University Behavioral Health Care to use and release to insurance carriers, representatives of insurance carriers, Medicare, Medicaid, government agencies and other guarantors, my protected health information (including but not limited to mental health information) for purposes of my care, coordination of care, obtaining payment for services (including without limitation to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes), and for health care operations, including quality improvement. I understand that I have a right to request a restriction on how my protected health information is used. However, I also understand that University Behavioral Health Care is not required to agree to the request.

I understand that if the information contains references to alcohol or drug abuse, that information will be released. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have also placed my initials here __.

This authorization becomes effective on the date signed and may be revoked by me in writing at any time by making a written request, except for information already used or disclosed. I understand I am entitled to a copy of this authorization form for my records.

Acknowledgement of Receipt of Notice of Privacy Practices: By signing below, I acknowledge that I already have received and/or reviewed the University Behavioral Health Care Notice of Privacy Practices which outlines how health information about me may be used or disclosed. I understand that University Behavioral Health Care has the right to change its Notice of Privacy Practices at any time and that the revised notice will be posted and made available to me on the University Behavioral Health Care website https://ubhc.rutgers.edu/.

Acknowledgement of Receipt of Patient Bill of Rights and Complaint Procedure: By signing below, I acknowledge that a copy of the Patient Bill of Rights and Complaint Procedure was made available to me which explains my rights as a patient and procedure for addressing a complaint.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OR OUTCOME OF TREATMENTS, SERVICES, TESTS, OR EXAMINATIONS THAT MAY BE DISCUSSED OR PERFORMED.

I AUTHORIZE RUTGERS UNIVERSITY BEHAVIORAL HEALTH CARE AND ITS AFFILIATES TO RELEASE ALL RECORDS CONSISTENT WITH THIS CONSENT. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Signature of Parent, Legal Guardian or Authorized Representative in Lieu of Patient
(if patient is under 18years of age)

_____
Signature of Witness