Valley Oaks Health Admission Agreement
CONSENT TO TREATMENT AND PATIENT RESPONSIBILITY AGREEMENT

Authorization to Consent and Treat: I hereby authorize Valley Oaks Health, its agents, employees, and Physicians to provide me with medical and mental health care. This includes, but is not limited to tests, blood tests, exams, procedures, and medications. I agree that no one can guarantee results or cures. I understand that I may withdraw consent for treatment at any time.

Infectious Disease Testing: I agree to follow Valley Oaks Health policy regarding the testing for infectious diseases, including but not limited to hepatitis and human immunodeficiency virus (HIV) if one of VOH caregivers is exposed to my bodily fluid.

Release of Information: I authorize VOH to release copies of my medical records, including but not limited to, mental health records, drug and alcohol abuse records and records containing information regarding communicable diseases, if necessary, to my insurance carrier, the Social Security Administration or its intermediaries or carriers including Medicare and Medicaid, third party payers, or others responsible for insurance claims and investigations for the purpose of investigating and adjudicating a claim. This authorization specifically includes electronic and facsimile transmissions of information**.** I agree to allow any provider that has provided care in the past to provide my medical records to Valley Oaks Health and that Valley Oaks Health may use the minimal necessary medical records for my care. I understand that I may revoke this authorization at any time (except to the extent that action has been taken based upon this authorization) by notifying VOH in writing.

Electronic Communication: I hereby consent to engage in electronic communication with Valley Oaks Health for matters related to my healthcare, medical records or appointments. I understand that Valley Oaks Health utilizes secure electronic communication platforms and encryption methods to protect confidentiality and privacy of my health information. I will maintain the security of my electronic devices and promptly report any suspected breaches or unauthorized access. I will ensure that my contact information provided to Valley Oaks Health for electronic communication is accurate and up to date. I understand that electronic communication may not be appropriate for all healthcare matters, and I will seek in-person or emergency care for urgent or sensitive situations.

Advance Directive and Family Education/Involvement/Resources: I have received or have been offered a copy of "Your Right to Decide" and the contents have been explained to me. I hereby state I have the following or have been offered the two documents: an Appointed Health Care Representative; Psychiatric Advance Directives. If such documents exist, I have been requested to provide a copy of the document(s) to be included within my medical record at Valley Oaks Health. If I don't have a Psychiatric Advance Directive, I've been offered a copy of the" Psychiatric Advance Directives" flyer.

Valley Oaks Health encourages family/advocates to be involved in treatment. I have been given or offered a copy of the resource document "Family Education/Involvement/Resources".

Notice of Privacy Practices: I agree that I have been given or offered Valley Oaks Health Notice of Privacy Practices.

Permission to Photograph: I understand that photographs taken for program use purposes will reside in my file and will be used to help staff identify me for medication administration, and in emergency situations, and will not be used for other purposes.

Assignment of Benefits & Payment Responsibility: I hereby assign my rights to insurance payments for treatment provided to me by Valley Oaks Health and further authorize such payment to be made directly

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to Valley Oaks Health. I agree to pay all charges by Valley Oaks Health for all treatment rendered and to remit any insurance payments made to the "insured" for services rendered. I understand that financial assistance with this fee may be available based on my income and family size. It is my responsibility to inform Valley Oaks Health of any changes which affect the billing or charges to my account. Failure to do so will result in my becoming responsible for payment of total charges. I shall be responsible for any cost and attorney fees required to collect for these services.

Electronic Medication Prescribing: Valley Oaks Health uses electronic prescribing while providing medication evaluation and management services. As a part of this service, our prescribers have access to your medication history from other healthcare providers. I understand that I have been informed of this practice.

Consent to Telehealth: I hereby consent to participate in telehealth with Valley Oaks Health. I understand that telehealth is the practice of delivering clinical health care services including but not limited to diagnosis, consultation, treatment or education via technology assisted media or other electronic means between the provider and patient who are located in two different locations.

I understand the following with respect to telehealth:

I understand that the privacy laws protect the confidentiality of my protected health information also apply to telehealth services. Information obtained during telehealth that identifies me will not be given to anyone without my consent except for the purpose of treatment, billing and healthcare operations.

I understand that while psycho-therapeutic treatment of all kinds has been found to effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that Valley Oaks Health services or other communication by Valley Oaks Health providers to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telehealth treatment is different from in-person services and that If my therapist and medical providers believe I would be better served by another form of psycho-therapeutic service or physical health service, such as in-person treatment, I will be referred to a Valley Oaks Health provider in my geographic area that can provide such services.

I have read and understand the information above. I have the right to discuss any of this information with my behavioral and physical health providers and have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to telehealth communications by providing written notification to any Valley Oaks Health staff.

My signature on this form indicates that I have read this Agreement and agree to its terms.

_____ _____

Client/Guardian Date