ROSECRANCE AND AFFILIATES
Assessment Registration Form

Client Name: ____ Client ID: __________________ Client DOB: __________

RECEIPT & ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and have been given an opportunity to read a copy of Rosecrance's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 1021 N. Mulford Road, Rockford, IL 61107, at (815) 387-5600, or via email at privacy@rosecrance.org.

RECEIPT & ACKNOWLEDGEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received a copy of the Rosecrance and Affiliates Client Rights and Responsibilities Form and that my rights and responsibilities have been explained to me. I understand my rights and responsibilities and know that if I have any questions, I may contact the Director of my program or speak with a Patient Advocate.

CONSENT FOR ASSESSMENT

I consent to an assessment by Rosecrance to determine my need for treatment. I have been given information about the nature and purpose of the assessment and the opportunity to ask questions. The potential risks and benefits have been explained to me. I understand that Rosecrance will rely on the information I provide during the assessment and I agree to provide thorough and accurate information. I understand that I have the right to withhold my consent; however, if I withdraw my consent prior to the completion of the assessment, Rosecrance will be unable to complete the assessment and will not be able to give any diagnosis or treatment recommendations.

CONSENT TO TELEHEALTH SERVICES

I consent to receive an assessment through telecommunication systems. I understand that the potential risks of some communication platforms include unsecure or unencrypted transmission; audio and video interruptions; access by unauthorized persons; or unexpected disruptions or distortions from technical failures. Although it is unlikely, I understand that my health information may be breached if someone tampers with the technology. I understand that I have the right to revoke my consent at any time by notifying my provider. This consent will remain in effect until revoked. I understand any technology or data charges incurred while using telecommunication systems will be my responsibility. I understand that I may not record any telehealth services without written permission from everyone participating in the services.

CONSENT FOR ELECTRONIC COMMUNICATIONS

I consent to Rosecrance communicating with me electronically via email, voicemail, or text message. I understand and acknowledge that there are risks inherent in the electronic transmission of unencrypted information over the internet or cellular networks and that such communications may be lost, delayed, intercepted, corrupted, or otherwise not delivered. I understand that I may revoke this consent at any time by sending written notification to the Medical Records Department at Rosecrance. In the case of a crisis or emergency, email and text message communication is not an appropriate method of reaching Rosecrance staff.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I agree to be financially responsible for any charges resulting from the assessment. I agree to pay the charges required by my Insurance Plan, such as co-payments or deductibles or other charges not covered by insurance. I assign my right to receive payment of authorized benefits to Rosecrance. I also assign and convey to Rosecrance all rights, powers, authority, and standing to pursue amounts owed under my health insurance plan.

AUTHORIZATION TO DISCLOSE INFORMATION TO MY INSURANCE COMPANY

I authorize Rosecrance to disclose information to my insurance company to secure payment for services provided to me. I consent to the disclosure of the following information: *presence in treatment; demographic information; assessment, diagnosis, dates of service, and type of service received; financial information; and any other information that is necessary to obtain authorization for services, to determine benefit eligibility, to coordinate benefits, to submit health care claims, and to obtain reimbursement from a third-party payer or funding source.* The purpose of this disclosure of information is for Rosecrance to obtain authorization and payment for services. I understand that I have a right to revoke this authorization at any time by sending written notification to the Medical Records Department at Rosecrance. I further understand that a revocation of the authorization is not effective if Rosecrance has already relied on the authorization. Unless sooner revoked, this consent expires one year after the last date on which services were provided, or until all claims relating to my treatment are paid in full, whichever is later.

I certify that I have read the above form, that I understand its contents, and that I have asked all questions I have about this form. I agree to be bound by the terms of this consent form.

____ ________________

Client / Parent / Guardian Signature Date