



Consent to Treat/Bill & Privacy Information Form

Thank you for choosing Zen Life Mental Wellness, LLC. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

CONSENT FOR TREATMENT

By signing this form, I consent to and authorize my provider(s) at Zen Life Mental Wellness (ZLMW) to treat me or my dependent. I understand this could include lab tests, radiographic tests, mental health evaluations and treatments, medication prescription and/or administration, education, other diagnostic tests, or behavioral health interventions. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect as long as I attend any of the clinics at ZLMW.

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize ZLMW to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical, dental, and/or behavioral health information to my insurers as necessary for determination and payment of benefits; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY

ZLMW complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the ZLMW Notice of Privacy Practices and Ohio Patients' Bill of Rights.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT

I authorize ZLMW to file a claim with my insurance carrier for services rendered. I authorize ZLMW payment of benefits directly to ZLMW, for services provided to my dependent or me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.

** If you are uninsured, please note that your account is your responsibility.**

ACKNOWLEDGEMENT OF PERSONAL PROPERTY

I understand that ZLMW shall not be liable for loss or damages of any personal property.

BENEFITS/RISKS OF BEHAVIORAL HEALTH TREATMENT

Potential benefits include better relationship, solutions to specific problems, improved understanding of yourself, and relief from unpleasant emotions. There may be some risks including, but not limited to addressing painful emotional experiences, being challenged or confronted on a particular issue, or being inconvenienced due to costs of services.

MENTAL HEALTH CRISIS/EMERGENCY

If you have a mental health crisis or need to speak to someone, please call Suicide Prevent Lifeline at 800-273-TALK (8255) at any time, or call 911, or go to your nearest hospital emergency department; they are there to help you.

LIMITS OF CONFIDENTIALITY

We are permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization: suicidal urges (being a danger to yourself), homicidal urges (being a danger to others), court order/subpoena, child abuse/neglect, and elder or vulnerable adult abuse/neglect. Please see the Consent to Treat form you have been provided.

SIGNATURES

I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent. I agree that a copy of this consent may be used in place of the original. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me.

My signature below indicates that I understand and accept the content of this form.

Signature _____ Date _____

Patient or Patient Representative (print name) _____
If not the patient: Relationship to Patient: _____