VANGUARD
MENTAL HEALTH & WELLNESS CLINIC, LLC

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Woodbury, MN 55125
Office: (651) 283-3794
Fax: (651) 738-1881
www.vanguardmhclinic.com

CONSENT FOR TREATMENT

I consent to and authorize Vanguard Mental Health & Wellness Clinic, LLC (Vanguard Clinic) to perform appropriate behavioral and mental health care as necessary by their professional training and judgment. If my child's provider is a post-doctoral fellow or an intern, I acknowledge that I have been informed of this.

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Vanguard Clinic is required to explain your child's rights and responsibilities for behavioral health treatment. During your child's treatment, Vanguard Clinic will collect and create information about your child. This information is called Protected Health Information. Vanguard Clinic is required by law to maintain the privacy of your child's protected information and provide you with a copy of this information.

- You may request to review or receive a copy of your child's records, unless the law otherwise protects the information you are requesting. This request should be made in writing. Vanguard Clinic will act upon your request within 30 days.
- If you have given authorization for use or sharing of your child's health information, you may take back that authorization in writing at any time. Vanguard Clinic cannot take back information already shared prior to your revocation.
- Your signature provides consent for behavioral health treatment, payment and also provides other general information.

PAYMENTS FOR SERVICES / RELEASES OF INFORMATION AND PAYMENT

I understand that I am responsible for any charges that are not covered by my insurance, health plan, or government programs. To get payment from insurance, health plan, or government agencies, Vanguard Clinic has to provide them information from my child's record. I realize I must cooperate with Vanguard Clinic to get payment for my child's care. This includes clearing up any disputes about charges. Payments are usually made directly to Vanguard Clinic. If I am without insurance and will be paying out of pocket, I will be given a separate form to review and sign, which details a Good Faith Estimate, under The No Surprises Act.

NO SHOW OR CANCELLATION FEE

If my child fails an appointment or cancel the appointment less than 24 hours prior to the scheduled appointment, I understand that I am expected to pay a fee of $50 (unless agreed that the late cancellation was due to circumstances beyond my control). ** If my child fails three appointments in a row, Vanguard Clinic reserves the right to close my child's case and terminate care.

CONTINUATION OF SERVICES

I understand that Vanguard Clinic will not schedule any additional appointments if my child's account is 60 days past due and/or if there is an outstanding balance of $300 or more.

EMERGENCY SITUATIONS

Vanguard Clinic is not a 24-hour clinic and will often not be available immediately by telephone. In case of a mental health crisis, please contact 651. 774.7000 for Ramsey County (children), 651.266.7900 Ramsey County (adult), 651.777.5222 Washington County (Adult and Children), 612.596.1223 Hennepin County (adult), or 612.348.2233 Hennepin County (children).

HIPAA PRIVACY REGULATIONS

As required by privacy regulations, I acknowledge that I have reviewed a copy of the privacy practices and may obtain my own copy if desired. I understand my rights to privacy, confidentiality, and any other rights/responsibilities as a client while in treatment. I also recognize that these privacy practices are adhered by Vanguard Clinic.

Cont'd on next page

Patient Name: _____

Date of birth: _____ Rev2023

COVID POLICY FOR IN-PERSON SERVICES:

CDC has lifted the Public Health Emergency effective May 11, 2023. Our clinic's policy on covid precautions for in-person sessions have changed. Mask wearing is recommended, but no longer required. If you've been exposed to Covid or test positive, please cancel your appointment to minimize exposure and follow current CDC guidelines on quarantine.

My signature here means I have read this information and understand it.

Signature: _____ Date: _____

Print name: _____ Relationship to patient: _____