MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION (BHD) CONSENT FORM

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Patient's Name Date of Birth

CONSENT FOR TREATMENT: *GENERAL*

I, the undersigned, do hereby authorize and consent to any services rendered to me by the Milwaukee County Behavioral Health Division Service System, including, but not limited to, Inpatient Services, Outpatient Services, the Community Services Branch, the Community Access to Recovery Services (CARS), and Wiser Choice Alcohol and Drug Abuse (AODA) Treatment Services. I hereby consent to such care and treatment as may be deemed proper in the judgment of the clinical staff of BHD.

CONSENT FOR TREATMENT: *PSYCHIATRIC CRISIS SERVICES (PCS)*

I, the undersigned, do hereby authorize and consent to any services of an emergency nature, including, but not limited to psychiatric interview and other diagnostic procedures, laboratory procedures, medical, and other hospital services which are deemed necessary or advisable by the attending physician(s) and rendered to me under the general or special instructions of said physician(s).

I acknowledge that the care which will be furnished to me in PCS will be limited solely to emergency treatment. I understand that I may be released before all of my medical or psychiatric problems are known or treated, and that it will be necessary for me to make arrangements for follow-up care. I do also hereby release BHD, all of its agents, employees, and attending physician(s) from responsibility for anything but such emergency treatment.

BILLING & ASSIGNMENT OF BENEFITS

I hereby permit billing by and assign payment directly to BHD for the benefits otherwise payable to me by any third party, including major medical benefits, but not to exceed the regular charges for this period of hospitalization/emergency treatment/outpatient treatment. I understand that I am financially responsible for bills from BHD, including any regular charges not paid by a third party.

NOTICE OF DISCLOSURE

Information from your medical record will be shared, as permitted by law, with the Milwaukee County Department of Health and Human Services and the State of Wisconsin Department of Health and Family Services.

NOTICE OF PRIVACY PRACTICES

I acknowledge that BHD has provided me a copy of its Notice of Privacy Practices. Patient Declines. ☐

RELEASE OF INFORMATION

I, authorize BHD and its contractual agencies free exchange of information for the purpose of continuing care and health services review. I authorize BHD to use the information regarding my care and treatment in conjunction with any and all educational training programs under affiliation agreements, and to the extent necessary to obtain and/or maintain licensure, accreditation, or certification. I further authorize BHD to relay to its Business Agreement Associates 42 CFR Part 2 information as necessary to carry out payment and/or healthcare operation activities or for a Medicare, Medicaid or CHIP audit or evaluation including civil investigation or administrative remedy.

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Patient's Signature (including minors over 14) Date/Time Patient Declines. ☐

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Patient's Agent, Parent, or Guardian's Signatures Date/Time Patient Declines. ☐