CLIENT ACKNOWLEDEMENT & CONSENT TO TREAT

Consent to Services: I voluntarily consent that I will participate in healthcare services (which may include, but is not limited to, behavioral health, medical care, psychiatric, and/or substance use treatment) at Solvista Health. All services will be provided by appropriately qualified staff and may include a care team to provide individualized services by a coordinated group of integrated professionals.

Potential Benefits of Treatment: Solvista Health's goal is to provide best in class, quality care that utilizes evidence-based practices to guide individualized care decisions. Reaching goals and improving quality of life often requires change, which can be hard. Research shows that likelihood of success is more often achieved when I am an active participant. It is important to keep my care team informed of any changes, barriers, or difficulties that I am experiencing as it relates to my treatment.

Billing and Payment Obligation: Solvista Health does not believe anyone should be denied care because of their ability to pay. As a client, I am required to maintain up to date, accurate information regarding my insurance or payment preference, and I agree to assist Solvista in submitting claims for payment and/or helping obtain payment. I agree to follow Solvista Health's Financial and Collections Policies. This includes, but is not limited to, paying any copays at the time of service and/or paying any deductibles in a timely manner. If I am unable to pay or am having difficulty making payment, I understand Solvista Health has financial assistance programs available that I can apply for.

Telehealth Services: I consent to receive services via telehealth, where I would interact with a provider in a live format but who is not physically present with me. I understand and agree neither party will record the service without consent of the other party and that the provider is only responsible for limited HIPAA protections at my location. I will let staff know if I would prefer to receive services in person and Solvista Health will attempt to accommodate my request. I understand that I may change my preference to receive telehealth services at any time for any reason.

Acknowledgements: Information regarding Solvista Health policies and procedures is provided as part of this informed consent. Please review these documents carefully and initial below. My initials indicate that I have read, understand, and agree to each of the following documents.

_____ Client Rights and Responsibilities

____ Notice of Privacy Practices

____ Grievances and Non-Discrimination

____ Emergency Service and Procedures

____ Information on Advanced Directives

____ Financial and Collections Policies

Limits of Participation in Custody and Court Proceedings: Solvista Health reserves the right to decline to participate in court proceedings. I agree not to subpoena Solvista Health in any proceeding that may jeopardize the therapeutic relationship between me and my provider. This includes, but is not limited to, requests to testify in court, write reports to the court, and/or make custody recommendations.

Duration of Consent: This consent is valid for the duration of time I receive services at Solvista Health or unless I notify Solvista of my intent to discontinue services. I understand if I withdraw consent my services with Solvista Health will end.

I have read and understand the above information, have had an opportunity to ask questions about this information, and I consent to receive healthcare services from Solvista Health. If applicable, I also attest that I am the legal guardian and have the right to consent for the treatment of this minor.

Client Signature: ________________________ **Date:** ___________

Client Name (printed): ______________________________________

Parent/Guardian Signature: ________________________ **Date:** ___________

Relationship to Client: _____________________________