CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Spero, for the purposes of this consent, includes all facilities, programs, and locations where services are provided.

CONSENT TO TREATMENT

1. I, ________________________ (print name) on behalf of ___________________________ (client name and relationship) consent to the provision of treatment that may include diagnostic assessments, case management, therapy, substance use disorder (SUD) treatment, and/or psychiatry, which my care providers consider necessary or advisable. I understand special consent forms may need to be signed for specific services.
2. I understand that my care may include examinations, diagnostic tests, urine drug screens, and treatment planning that may be used for my care and/or by Spero for education, as well as health care operations purposes.
3. I understand and agree that under the supervision of my provider, others may observe or provision services to me at Spero. These individuals may include but are not limited to interns, clinical trainees, and students.
4. I acknowledge that no guarantees have been given to me as to the outcome of any treatment.
5. I understand and agree that Spero may at its discretion provide certain services to me by means of "telehealth" all of which are covered by this authorization. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time. The provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that a separate consent may be required to provide specific "telehealth" services.

RECEIPT OF NOTICE OF PRIVACY PRACTICES/RELEASE OF INFORMATION

1. I have been provided the Spero Notice of Privacy Practices, either now or previously. **Client Initials:** _______
2. I give Spero and its designees permission to use my information as described in the Spero Notice of Privacy Practices, which may include my substance use disorder treatment information.
3. Spero may store information regarding me and my care in a variety of ways, including on computer systems, electronic media, paper, etc. Such information may include sensitive information such as HIV information, mental health information, and substance use disorder treatment information.
4. To the extent permitted under state and federal law, Spero may access and share my medical and other information as is necessary for Spero to provide treatment to me, seek payment for services it provides, or for Spero's own healthcare related operations.
5. I understand that Spero may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent for Spero to release certain types of sensitive information including HIV information, mental health information, and substance use disorder treatment information. I also give permission for Spero to release client and educational information to my home caregiver.
6. I understand that my information may be released if required by local, state, or federal law.

FINANCIAL ARRANGEMENTS

1. I authorize Spero to bill my insurance carrier and request such payments to be made directly to Spero. I certify that the information I have given about my insurance coverage or other payment sources is correct and will inform Spero if my coverage changes.
2. I understand that it is my responsibility to contact my insurance carrier to verify coverage for any service(s).

3. I assign to Spero all rights to insurance payments or benefits to which I may be entitled for services provided to me by Spero. I authorize Spero to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
4. I authorize Spero to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also authorize Spero to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.
5. I understand and agree that any charges not paid by my insurance are my responsibility. I understand that final billing will be made upon determination of all charges incurred, less any payments received, and/or allowed adjustments from insurers contracted with Spero. I understand that it is my responsibility to pay Spero for all charges so incurred within 30 days of receipt of my statement. If payment arrangements are needed, I will contact the Patient Account Representative at Spero. I understand that Spero has a collections policy and will utilize a collections agency should my account become delinquent. **Client Initials:** _______
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services. **Client Initials:** _______
7. I understand that, should SUD treatment be a requirement of a probation sentence, employment reinstatement, or any other mandate, I will not be in compliance of program obligations until any outstanding balance is paid in full and until such time confirmation of successful completion will be sent from Spero to such parties.

SPERO OPERATIONS

1. I understand that Spero may use my information for administrative, financial, legal, quality improvement and compliance activities that are necessary to run its business and to support the core functions of treatment and payment.
2. I understand that some Spero programs utilize note-taking technologies to allow providers to be more engaged in my treatment sessions. I understand that I can request my provider not to use this technology for specific services.
3. I understand I may be contacted by Spero by cellular phone, which may include the use of pre-recorded messages and/or an automated dialing service or by text message or email in connection with any communication made to me or related to my accounts.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

1. I understand that Minnesota law allows minors to consent to Substance Use Disorder Treatment Services, and that the consent of no other person is required. Federal law expands on this stating that ONLY the minor can consent to SUD services. (MN Stat 144.343, 42 CFR 2.14)
2. I understand that Minnesota law allows minors, who are 16 or older, to consent to Outpatient Mental Health Services, and that the consent of no other person is required. (MN Stat 144.3431)
3. As a minor, I understand that if I do not complete an Authorization for my parent(s) or legal guardian, Spero will be unable to submit claims to my insurance if my parent/guardian is the policy holder and therefore I will be financially responsible for the cost of any services provided. **Client Initials** ________ **(required if appropriate)**

I have read this Consent for Treatment, Payment, and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment, and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all Spero locations and facilities.

______________________________	______________
Client Signature	Date
______________________________	______________
Signature on behalf of Client and Relationship	Date