3615 2nd Ave, Suite A
Kearney, NE 68847

P: 308-233-3847
F: 308-233-5921

Consent to Treatment

Sarah Gierhan, APRN-C Rene Sykes APRN- C Holly Schmidt, LIMHP Sarah Rolfsmeyer, PMHP

Patient Name:_____**Date of Birth:**_____

Introduction:
Serene Mental Health Clinic, Kearney, Nebraska, is hereinafter referred to as "the Practice."

Any and all physicians, physician assistants, nurse practitioners, therapists providing care and treatment including consultation during the course of my admission to the Practice are hereinafter referred to as "the Clinicians."

1. **Consent to Treatment: I** may have a condition requiring diagnosis and treatment of which I have requested that a clinician assess or evaluate my condition as part of a routine checkup. I hereby consent to and authorize medical treatment, laboratory, routine diagnostic tests and therapeutic procedures by the clinician, his or her assistants or designees, including personnel of the Practice. I agree to the supervised participation of students (e.g., medical students, nursing students, and therapy/counseling students) in my care. I understand that no guarantees have been made to me concerning the results of this treatment or examination.
2. **Certification of Information/Authorization for Medicare and Medicaid Benefits:** I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act or under any other governmental health care program or from any other third-party payer is correct. Furthermore, I authorize anyone having medical or other information about me pertinent to my qualification for Medicare or Medicaid programs or benefits to release to and to secure from the Social Security Administration, the Nebraska Medical Assistance Program or to other agencies or entities administering the Medicare and Medicaid programs, or to intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf to the Practice, to the Clinicians, and to any other health care provider qualifying for reimbursement for such medical care and treatment, including consultations, provided to me.
3. **Financial Responsibility/Guarantee of Payment:** The undersigned authorizes, whether he/she signs as agent or as patient, billing by and direct payment to the Practice of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of the patient or the undersigned for these services at a rate not to exceed the Practice's regular charges. The term "insurance benefits" as used herein includes all insurance benefits including but not limited to health insurance, accident, worker's compensation benefits and motor vehicle insurance, casualty insurance, medical health coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for all charges. In consideration of goods and services provided, he/she gives the Practice an irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or in his/her behalf for services provided by the Practice or its employees and others working under an arrangement with the Practice. He/she directs all insurance companies, health plans, government agencies and programs and their agents or contractors, and attorneys to make such payment directly to the Practice. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient or the undersigned.

4. **Acknowledgement of/and Consent to Release of Information:** While I understand that my consent or authorization is not required to use and disclose my health care information for the following purposes and I acknowledge that such disclosure will occur, I also consent to such use and disclosure too:
   --Medical personnel or facilities for the purpose of providing treatment or evaluation of my condition.
   --any insurance company or third-party payer including governmental health care programs for utilization review purposes and for the purpose of processing my claim and obtaining payment of the account of the Practice and of the Clinicians for medical care and treatment provided to me.
   --to other entities as part of the payment activities of the Practice.
   --another health care provider for his/her payment activities.
   --to entities or persons to perform health care operations activities of the Practice such as, but not limited to, quality improvement, credentialing providers, medical review, general management and administrative activities; or
   --to another health care provided for limited use in health care operations including, but not limited to, its peer review of practitioners, credentialing of practitioners, training, accreditation and licensing activities and monitoring compliance with health care fraud and abuse laws.

5. **Acknowledgement of Receipt of Notice of Privacy Practices:**

   I have received a copy of the Notice of Privacy Practices and have indicated so by initialing here
   Patient's initials_____ Patient Representative's Initials _____

   Or

   The undersigned certifies that he/she a good faith effort to provide a Notice of Privacy Practices to the patient, but that the patient either was unable to or unwilling to acknowledge receipt of such Notice of Privacy Practice for the reason noted below:

   - Patient refused
   - Patient unable to sign because of medical condition
   - There was not a personal representative of the patient available to sign
   - Other (explain):_____

My signature below indicates that I have read this document or have had it read to me and that I (as the patient or the patient's representative) hereby accept and agree to the terms stated above.

_____	_____	_____
Signature of Patient, Relative or Legal Guardian	Date	Time
_____	_____	
If other than Patient, Relationship to Patient	Reason, if other than patient	
_____	_____	
Signature of Policy Holder/ Guarantor if other than Patient	Witness/Office Staff	

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