Informed Consent Acknowledgement

Please initial and sign the following statements after reviewing our office policies and overview of services.

I, _____ _____

(Name of client or authorized representative acting on behalf of the client) *Date of Birth*

Request to receive mental health/behavioral health services from CHOICES, Inc., and its clinical/rehabilitation staff. Such care may include routine diagnostic procedures and/or related services that CHOICES, Inc. clinical/rehabilitation staff may recommend as appropriate for me.

(*Place your initials next to the statements below if you agree*)

☐ I voluntarily consent to such care and services which may be rendered by the clinical/rehabilitation staff of CHOICES, Inc. as may be necessary in his/her professional opinion. No guarantees have been made to me as to the result of services or examinations by CHOICES, Inc.

☐ I understand that data may be collected during the time I am receiving services through CHOICES, Inc. I understand that the data collected may be used for evaluation and research purposes and that if the data is used for evaluation/research that my identity will be protected, and data will only be reported in aggregate form.

☐ I understand that CHOICES, Inc. will file a claim with my insurance company, Medicare or Medicaid, but that I am responsible for paying for the services received at CHOICES, Inc.

☐ I understand that as part of my healthcare, this organization originates and maintains health records that are used and may be disclosed to other entities for treatment, payment, and health care operations. These records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

☐ I understand that I have the right to file a grievance if I am dissatisfied with the services I have received or if my legal rights have been infringed upon. I understand that a grievance should be reported in writing and by personal interview to the appropriate supervisor. A grievance may be filed with the Executive Director if it involves a supervisor. I understand that every grievance reported shall be thoroughly investigated according to the procedures developed by the Board of Directors of CHOICES, Inc.

☐ I acknowledge that I have read, or have been read to, the CHOICES, Inc. Informed Consent for Treatment Services which includes my Rights and Responsibilities. I also acknowledge that I have received a copy of said documents, understand their content, and have been afforded the opportunity to ask any questions that I have concerning those policies as well as my rights and responsibilities.

Applicant Signature *Date*

Witness (For "X" signatures only) *Date*

Guardian/Authorized Representative Signature *Date*

For Internal Use Only

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Client was unable to sign ☐ Client Refused to sign ☐ Other _____