

Client Name _____ Medicaid # _____

Birthdate _____ Insurance # _____

Permission for treatment/services

Freedom of Choice

I understand that the choice of providers is my responsibility and right as the client or guardian. I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Informed Consent

I understand that participation in treatment does not guarantee anticipated outcomes. I understand that there may be unintended results of treatment affecting the client and other family/household members. I understand that providers are legally bound to report suspected abuse of the client or of other family members. I also understand that the providers have a duty to warn any intended victim of a threat to harm.

Persons Participating in Home and Community Based Services

I understand that I am giving permission to include in the client's treatment sessions any persons present in the home, school or community at the time of service. This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates. I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

Privacy Practices

I understand that Transformations adheres to the Health Information Privacy Act and I agree to these practices. I agree that this information has been made available to me for review.

Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in client wellbeing, 2) to keep all appointments and to give 24 hour notice of a need to reschedule, 3) to maintain the client's insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

Permission is hereby given to Transformations staff and its service providers to render screening, assessment, treatment and support services to the above named client and under the above named conditions.

Signature of Client

Signature of Parent or Legal Guardian

Relationship to Client

Witness

Date