Consumer Name: ____________________
Identifier: ____________________

THIS PAGE IS TO BE RETAINED BY HOPE REVEALED AND PLACED IN THE CONSUMER'S RECORD.

CONSENT FOR FOLLOW-UP:

Upon termination of services from this program, we may want to contact you regarding your status and for you to answer some question concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care to provide HOPE REVEALED with pertinent statistical information. You may revoke permission for follow-up at any time by giving this agency a written notice or by refusing to participate in any follow-up questionnaire. Follow up will be the same with all persons served regardless of referral status.

CONSENT: I hereby Give Do Not Give (Please circle one)

Please initial to verify receipt of the following

____ Code of Ethics

_____ Consumer Bill of Rights

____ Confidentiality of Consumer Record

____ HIPAA Notice

____ Complaint/Grievance Procedure

____ Orientation Information

____ Consumer Expectations

____ HIV/AIDS/STD Education Session

____ HIV/AIDS/STD Referral Information

Do you or significant other wish to receive:

Information on HIV/AIDS/STD Education, and/or Counseling?

___ Yes ___ No

Do you want to receive the full Bill of Rights? ___ Yes ___No

Is Consumer under the age of 21? ___ Yes ___ No

Does HOPE REVEALED have permission to transport child for the purpose of receiving services?

___ Yes ___ No If Yes, please fill out addition school permission form located at front desk.

In the event that a medical emergency occurs while my child is with a HOPE REVEALED representative, and it's not possible for me to consent to medical treatment, I hereby authorize any HOPE REVEALED representative to seek appropriate medical treatment for my child. I also give permission for attending personnel to execute on my behalf, permission forms or other medical documents, and to act on my behalf if I am unable to do so.

The undersigned has read the above consent release and acknowledges that this document has been signed voluntarily.

HOPE REVEALED BEHAVIORAL HEALTH CENTER INC. is a Medicaid fee for service provider and all fees are covered by Medicaid if consumer is eligible.

On occasion it may be necessary for a licensed person to reassess and/or update clinical information regarding your plan or treatment. Your signature below acknowledges your permission for this licensed person to see you.

The undersigned acknowledges that he/she has received a copy of the Consumer Handbook which has been communicated to him/her in a meaningful way. Furthermore, he/she has read and understands this document in it entirely and further certifies that he/she agrees to the terms and provisions stated herein.

Consumer Name: ____ Medicaid #: _________________________________

Signature of Consumer: ___________________________________ Date: _________________

Signature of Parent or Guardian: ____________________________ Date: _________________

Witness: ____ Date: _________________