COOS HEALTH & WELLNESS

Acknowledgment of Notice of Privacy Practices form and Client Consent

Please
***Initial* below**

_____ By signing below, I hereby consent to receive the services available to me and acknowledge I have received a copy of my Rights and Responsibilities as a client of Coos Health and Wellness.

_____ By signing below, I hereby acknowledge receipt of Coos Health and Wellness Notice of Privacy Practices and agree to the terms described within. I understand this includes my consent to the use and disclosure of health information about me by CH&W for the purpose of treatment, payment and health care operations. This consent specifically authorizes CH&W to accept such payment directly from my insurance carrier. I also understand that if I object to the use or disclosure of my mental health information for treatment, payment or health care operation purposes, I have the opportunity to submit a written request for a restriction on the use or disclosure of my mental health information. I understand that this consent to release information expires when no longer needed for treatment, payment, or health care operation purposes.

_____ By signing below, I hereby acknowledge I have received a copy of the Coos Health and Wellness Fee Chart and my assigned fee information. I understand I will be charged my assigned fee for each service if my insurance or assistance benefit does not cover the full cost of the service. I understand that in addition to office or home visits, my assigned fee will be charged for telephone calls when therapeutic issues are discussed, and consultations with other professionals, agencies and family members. I understand that payment is due at the time of each service if my insurance or assistance benefit does not cover the services.

_____ FOR ADULT CLIENTS: By signing below, I hereby acknowledge I have been provided with an opportunity to complete both a Declaration for Mental Health Treatment and Advance Directive for Health Care. The Declaration for Mental Health Treatment, if filled out and signed, would direct Mental Health Care if I were mentally incapacitated. The Advance Directives would provide information regarding the type of care I want for physical health problems if I am unable to speak for myself.

_____ I hereby acknowledge:
I received a copy of the CHW Grievance and Appeal Process Yes ☐ No ☐
I have been provided an opportunity to complete Voter Registration Yes ☐ No ☐

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient (***or Personal Representative***) Date of Signature