Coos Health & Wellness
Together, Inspiring Healthier Communities

CLIENT INFORMED CONSENT FOR SERVICES

- Acknowledgment of Information Provided -

Please Review
and *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 & Wellness (CHW).

_____ By Signing below, I acknowledge that in support of the services provided to me, CHW may involve a third-party Individual Placement and Support (IPS) provider. I also acknowledge that CHW has explained the purpose and extent of the IPS provider's involvement and given me an opportunity to object.

_____ By signing below, I hereby acknowledge I may request to receive a copy of the Coos Health & 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 Form. The Declaration for Mental Health Treatment, if filled out and signed, would direct my mental health care if I were mentally incapacitated. The Advance Directive 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 Complaint / Feedback Form YES ☐ NO ☐

I have been provided an opportunity to complete Voter Registration YES ☐ NO ☐

Client Name _____ Date of Birth _____

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