Medicaid No:

Consumer: Record Number:

AUTHORIZATION TO RECEIVE TREATMENT

AUTHORIZATION FOR TREATMENT: I voluntarily request and consent to routine diagnostic, prevention and therapeutic services and procedures by COUNSELING1-2-1, LLC physicians, healthcare providers, or its contract agencies. I authorize the performance of appropriate treatment, including diagnostic and therapeutic treatment that may be determined necessary or beneficial by the physician or provider in the care of the consumer. I understand that the practice of behavioral medicine is not an exact science and acknowledge that no guarantees have been made as to the results of treatment or care.

FOLLOW-UP: I agree to be contacted after the consumer leaves services in order for COUNSELING 1-2-1, LLC to inquire about the consumer's condition and satisfaction with services.

AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize COUNSELING 1-2-1, LLC or its contract agency staff to obtain emergency treatment from the consumer's family physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum necessary health information, written or verbal, may be released to emergency treating providers to meet the needs of the emergency.

CONSUMER RIGHTS AND RESPONSIBLILITIES: I have received *Your Rights and Responsibilities* information that explains consumer rights and responsibilities. I have also received additional information that explains the consumer grievance process, search and seizure, and suspension and expulsion. I understand that I may ask questions for clarification if I have questions or concerns. If I happen to have any grievance/dispute with COUNSELING 1-2-1, LLC, I will attempt to have the issue resolve with the practice and if no adequate solutions are provided within two weeks that I may choose to contact the local governing body or DHHS. You may look up the phone number in the consumer handbook. I agree to keep all information about other consumers confidential and will not disclose or discuss with any person or agency outside of COUNSELING 1-2-1, LLC. I also have the right refuse/or withdraw my consent for treatment at anytime. I can do this verbally or written to COUNSELING 1-2-1, LLC.

NOTICE OF PRIVACY PRACTICES: I have also received, and had the opportunity to read, COUNSELING 1-2-1, LLC's *Notice of Privacy Practices* that explains how confidential information about me is used and disclosed by COUNSELING 1-2-1, LLC. I understand that I should ask questions or discuss any concerns at the time of my first contact with my provider or other designated staff. I understand that I may request restriction(s) on how confidential information is used and disclosed, and that in specific situation my request for restriction(s) may not be honored because of the State and Federal laws or other special situations. ***My signature below indicates receipt of a copy of the Notice of Privacy Practices.***

I understand it is my responsibility to inform COUNSELING 1-2-1,LLC, in writing, when I desire changes in the method of contacting me.

_____ _____

Signature of Consumer Date

_____ _____

Signature of Legally Responsible Person (Relationship) Date

_____ _____

Print Name of Legally Responsible Person Signature of Witness (*required only if signature is an 'X', mark or symbol)*