CONSENT FOR SERVICES

Patient name: _____ Date: _____

INITIAL

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that I have been made aware of my rights and responsibilities as a patient and I understand them. I have been informed about how the agency will use and disclose my Private Health Information and was provided with a HIPPA Notice of Privacy. ☐

AUTHORIZATION FOR INFORMATION COLLECTION

I hereby give my permission for authorized personnel of your agency to collect the necessary data requested by **Thrive Behavioral Sciences**. Some of the information requested may result in the need for a physician appointment, nursing or physical therapy assessment and/or other diagnostic screening or test. I understand I may refuse and/or terminate services at any time. ☐

RELEASE OF INFORMATION

I hereby consent to and authorize the organization to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payers, utilization review and professional standards review organizations, regulatory review entitles and any other organizations and companies that may/will assist me to meet my healthcare needs. ☐

ADVANCE DIRECTIVE

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advanced Directive (Living Will/Durable Power of Attorney for Healthcare) so that my wishes may be known when I am unable to speak for myself. I have received information from the agency regarding my rights under the above Act and the agency's policy regarding implementation of these rights. ☐

I have an Advance Directive: YES NO I will provide a copy to the agency: YES NO

I have designated a Health Care Surrogate/Durable Power of Attorney for Health Care: YES NO

If yes, Name: _____ Phone: _____

Address: _____

Your signature below confirms your understanding and agreement with all of the above.

Patient signature: _____ Date: _____

Responsible party or Legal Guardian Signature: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

Reason patient is unable to sign: _____

_____

Verification of Patient Identification: ☐ Driver's License ☐ Social Security Card ☐ State/Federal ID ☐ Other

ID #: _____ ID #: _____