Client Name: _____ MR#: _____ Medicaid#: _____ DOB: _____

AUTHORIZATION TO RECEIVE TREATMENT-FBC and DAY TREATMENT

AUTHORIZATION FOR TREATMENT: I voluntarily request and consent to routine diagnostic, prevention and therapeutic services and procedures by DAYMARK Recovery Services 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. I have received the Orientation to Services brochure.

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

AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize DAYMARK Recovery Services 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.

Should any medical or dental services become necessary while under the care of DAYMARK Recovery Services, requiring you to receive treatment from another facility, you or your legally responsible person are fully responsible for ALL fees/charges incurred for services you receive (for example ambulance bill, hospital bill, urgent care bill, radiology bill, etc.)

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. I agree to keep all information about other consumers confidential and will not disclose or discuss with any person or agency outside of DAYMARK.

NOTICE OF PRIVACY PRACTICES: I have also received, and had the opportunity to read, DAYMARK's *Notice of Privacy Practices* that explains how confidential information about me is used and disclosed by DAYMARK. 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.

ELECTRONIC PRESCRIPTIONS: DAYMARK offers the ability to electronically send prescriptions to the pharmacy of your choice. Electronic prescribing is an important element in improving quality services. You may elect to not participate in this service.

NOTICE OF RESTRICTIVE INTERVENTION PRACTICES: DAYMARK may use restrictive interventions specifically to Child and Adolescent Day Treatment and Facility Based Crisis Programs. DAYMARK may utilize Physical Restraint, Isolation, Time Out, or a combination of either of the above, only on emergency basis after less restrictive measures have been exhausted. These interventions are only applicable in response to those in need of emergency intervention as evidenced by extreme behavior that may result in injury to the consumer or others. I understand that as a legally responsible person of a minor client or incompetent adult, I shall be notified immediately after any use of physical restraint.

Please be aware that there are services that some centers may be able to best provide through video-conference. These services might include an assessment or ongoing psychiatric Medical services

If I reported having no Primary Care Physician, I was given a copy of a list of free clinics and/or Primary Care Physicians.

I understand it is my responsibility to inform DAYMARK, in writing, when I desire changes in the method of contacting me.

_____ _____

Signature of Client 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)*