INFORMED CONSENTS FOR TREATMENT AND SERVICES

*(If applicable, please initial next to each **bolded** item to confirm that you have received explanation and agree to the statement)*

_____ **CONSENT FOR TREATMENT:** I hereby request evaluation and/or treatment from NEW DIMENSION GROUP. If the evaluation indicates a need for services, I consent to such services as may be recommended and discussed with me.

_____ **NOTIFICATION OF CONSUMER RIGHTS:** I have received a copy of Consumers' Rights Form outlining an overview of program rules, policies, and procedures for NEW DIMENSION GROUP. In addition, I have had the opportunity to ask questions of any program restrictions and have received an explanation of the consumer rights. My signature below indicates my receipt of both verbal and written explanation of consumer rights within the Agency.

_____ **NOTIFICATION OF CONFIDENTIALITY**: I have received Notification of Confidentiality indicating that State and Federal laws protect the confidentiality of consumer information and allow for the release of information only with my written consent except as the law may require or permit. There may be instances by which pertinent information may be disclosed without my expressed written consent, such as medical emergencies or in assuring you receive appropriate continuing care (such as a hospital, Department of Social Services and/or Department of Public Health). Further details will be explained at my request. My signature below indicate my understanding of the NOTICE and hereby agree that information disclosed should be made under such conditions as regulated by State and Federal laws, and acknowledge receipt of written notice.

_____ **HIPAA:** I have received a copy of NEW DIMENSION GROUP's HIPAA Practices and understand that NEW DIMENSION GROUP has the right to revise its HIPAA/privacy practices, as necessary, and will inform me of the changes.

- I acknowledge that I have been informed of Privacy Practices for the New Dimension Group
- I understand that the Privacy Practices brochure discusses how my personal health care information may be used and/or disclosed, what my rights with respect to health care information are, and how and where I may file a privacy-related complaint.
- I understand that I may obtain a copy of this brochure by requesting one from the agency
- I understand that this brochure may be changed in the future, and these changes will be posted in the waiting room of the agency. I may also request a copy of the new brochure by contacting any agency staff.

_____ **INTERVENTIONS:** I agree to allow NEW DIMENSION GROUP staff to implement professionally accepted methods of intervention as indicated by the comprehensive PCP or treatment plan that both the staff and I have mutually agreed upon.

_____ **MISSED APPOINTMENTS:** I understand that the appointment times given to me are assigned to me alone. I will make every effort to make the scheduled appointment. If I need to cancel an appointment, I will call New Dimension Group 24 hours in advance. I also understand if scheduled appointments are missed without giving 24 hours prior notice of cancellation, I may be subject to a "No-Show" charge for that appointment and the possible lost of future services being provided for multiple "No-Shows".

INFORMED CONSENTS FOR TREATMENT AND SERVICES (page 2)

*(If applicable, please initial next to each **bolded** item to confirm that you have received explanation and agree to the statement)*

_____ **VOICE MESSAGES:** I hereby grant permission to NEW DIMENSION GROUP to leave messages on my home or answering machine regarding appointments, if I am not available.

_____ **FIRST AID:** I authorize NEW DIMENSION GROUP to provide and render first aid assistance to the as deemed necessary by trained and certified staff.

_____ **EMERGENCY CARE:** I authorize NEW DIMENSION GROUP to obtain emergency medical, dental, or mental health care. Permission is granted for emergency services to be completed at the nearest location available.

_____ **FEE SCHEDULE:** I have reviewed the proposed Fee schedule and understand that Fees vary depending on the service rendered and terms of the insurance plans. If the services received are not covered by my insurance, I will need to make a payment to NEW DIMENSION GROUP.

_____ **REFERRAL INFORMATION:** I have been informed by NEW DIMENSION GROUP of my right to select my Service Provider. I understand that I may change Service Providers at any time, but that if possible, a reasonable notice should be provided to the Service Provider.

_____ **AMENDMENTS:** I understand that this document may be amended on an "as needed" basis, and that any such amendment will require my signature and/or the legal guardian's signature.

ACCEPTANCE: I (we) have read and/or have been clearly explained the terms, conditions, and agreements of the INFORMED CONSENTS FOR TREATMENT AND SERVICES agreement and voluntarily signed and accept them, as stated above. This agreement may be withdrawn, at any time, and will not exceed one (1) year after the date it has been signed.

Consumer Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____