Bloom Behavioral Health
Autism Treatment to Maximize Potential

ACKNOWLEDGEMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

Name: _____ Phone: _____

Address: _____ City/State/Zip_____

☐ I have received, read, and accept the Member Rights and Responsibilities.

☐ **I DO NOT** need an interpreter to read and understand the Member's Rights and Responsibilities.

☐ **I DO NEED** an interpreter to read and understand the Member's Rights and Responsibilities.

Name: _____ Date:_____

Signature: _____ Relationship to the patient _____