Member ID #. _____

EDWIN FAIR MENTAL HEALTH CENTER, INC.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____(have consumer write name), hereby acknowledge that I have received this Notice of Privacy Practices. I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** from time to time and that I may contact this organization at any time to obtain a current copy of the **Consumer Handbook.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

_____ *Initials of Consumer, Legal Guardian, or Parent of Minor Child*

SYNOPSIS OF CONSUMER BILL OF RIGHTS

The undersigned hereby acknowledges that as part of the intake process, he/she has received a copy of the Edwin Fair Community Mental Health Center's **Synopsis of Consumer Bill of Rights** and that intake personnel have reviewed the contents thereof with the consumer. You, as the consumer, may request a copy of the entire Consumer Bill of Rights from Edwin Fair staff and it will be provided to you.

_____ *Initials of Consumer, Legal Guardian, or Parent of Minor Child*

CONSUMER HANDBOOK ACKNOWLEDGEMENT

The undersigned hereby acknowledges that as part of the intake process, he/she has received a copy of the Edwin Fair Community Mental Health Center's **Consumer Handbook** and that intake personnel have reviewed the contents thereof with the consumer.

_____ *Initials of Consumer, Legal Guardian, or Parent of Minor Child*

APPOINTMENT AND TREATMENT CONTRACT

I understand that Edwin Fair Mental Health Center has a limited number of appointment times for treatment and that I must keep my scheduled appointments and follow through with my agreed upon treatment plan. If not, I understand that my treatment may be discontinued due to my lack of compliance to my treatment plan.

If I <u>must</u> miss an appointment, I will contact the Center prior to the appointment time.

_____ *Initials of Consumer, Legal Guardian, or Parent of Minor Child*

Consumer Orientation: ☐ Brochure ☐ Orientation to Building

I have reviewed and understand the above information.

_____ _____
Consumer Signature Date

_____ _____
EFCMHC Staff Date

THIS FORM IS TO BE COMPLETED AT INTAKE.