THE REHABILITATION CENTER, THERAPEUTIC SOLUTIONS FOR CHILDREN AND ADULTS
1216 Hillcrest . 2009 Texoma Pkwy . Sherman . Texas . 75092 . (903) 893 -7457

Print Name:____ Social Security #:________________________________

CONSENT FOR SERVICES

→ I voluntarily request The Rehabilitation Center, associates, and assistants, as deemed necessary, to evaluate and treat my/my child's condition. I understand that procedures or therapies will be planned for me/my child and I voluntarily consent and authorize these actions.

→ I understand that other or different conditions may arise which might require additional or different procedures or therapies. I authorize such other procedures as deemed advisable in my treatment team's professional judgment. I understand that I have the opportunity and obligation to ask questions about my condition, alternative forms of therapy and treatments, risks of nontreatment, the procedures to be used, and any risks and hazards involved.

→ I believe, at this signing, I have sufficient information to give informed consent for services. I understand I may withdraw or withhold this consent at any time by giving written notice without compromising access to care. Doing so will not affect any action taken on the prior consent. Withdrawing or withholding consent however may influence the overall effectiveness of care of which I will be fully informed.

→ I understand that no warranty or guarantee has been made to me as to results or cure. I further understand that my attendance must be regular and consistent if I am going to adjust to and benefit from therapy. I understand that if my attendance falls below 80% of scheduled appointments and/or if I have 3 consecutive unexcused absences within any 30 days that I shall be considered for termination of services.

→ I understand and agree that the Center uses conservative methods of behavior management/modification, when needed. The goal is often to prevent injury to the consumer and/or others. Examples of this include but are not limited to "time outs", redirection, and curtailing activities. If I have questions or concerns, I will inquire further about Center policies and practices.

→ I understand that The Rehabilitation Center is an educational and corporate setting and that treatment may be viewed by others.

***Acknowledged by my signature below, I certify that I have read the "Consent for Services" and/or that this has been fully explained to me and that I understand its contents.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

→ Federal regulations (HIPAA) allows The Rehabilitation Center to use or disclose protected health information (PHI) from your records in order to provide treatment to you, to obtain payment for the services provided and for other professional activities known as "health care operations". PHI that is released may be subject to redisclosure by recipients and is no long protected by HIPAA's privacy rules.

The Center asks your consent, to make permission explicit, to acquire/release PHI from/to your physician(s) and/or other professional personnel or agencies involved in the evaluation and management of requested and/or potential services and others as are named here:

_________________________________, ______________________________________, ____

The Center's "Notice of Privacy Practices" describes these acquisitions and disclosures in more detail. You have the right to review the Notice before signing this consent. We reserve the right to revise the Notice at any time. If we do so, the revised Notice will be posted for your review. You may ask for a printed copy at any time.

→ You may ask to restrict use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, the agreement is binding.

→ This consent shall remain valid for one year or as indicated here ____________. You may revoke this consent at any time by giving written notice. Such revocation will not affect any action taken on the consent prior to revocation. This consent is voluntary; you may refuse to sign it without compromising access to care. However, this action may influence the effectiveness of care of which you will be fully informed.

→ I hereby release The Rehabilitation Center from all liability that may arise from disclosure made pursuant to this authorization.

*** Acknowledged by my signature below, I provide the above consent and acknowledge the receipt of the "Notice of Privacy Practices.

RIGHTS AND RESONSIBILITIES OF PERSONS SERVED

→ As someone receiving services at The Rehabilitation Center, you have rights which are guaranteed. Staff will assist you in exercising your rights which do not conflict with the rights of others. Perceived infringement of your rights will be investigated and resolutions sought. You also have responsibilities. Both your rights and responsibilities will be made known to you and a copy provided to you.

***Acknowledged by my signature below, I have received a copy of the Rights and Responsibilities of Persons Served"

EMERGENCY TREATMENT RELEASE

→ In the event of medical emergency, The Rehabilitation Center will implement emergency services by dialing 911. In the event of a minor medical emergency I give permission to The Rehabilitation Center to transport my child/self to the closest medical facility for treatment. If I am unable to give permission for medical treatment, I will leave the decision up to The Rehabilitation Center staff.

***Acknowledged by my signature below, I understand and agree to the Emergency Treatment Release.

GRIEVANCE POLICY

→In case of dissatisfaction with services rendered, I will be referred to my treatment providers/team. If issues are not resolved, I may submit, in writing in 7 days, my concerns to the Compliance Committee. If still dissatisfied, I may appeal in writing to the Executive Director in 3 days. If resolution is not been brought about, I may wish to seek mediation from an external entity. A more detailed policy and procedure state is available in "Patient's Rights" brochure.

***Acknowledged by my signature below, I have received a detail copy of the Center Grievance Policy and understand it.

Signature: _______________________________ Date: ______________ Staff Signature: _________________________________