Behavioral Health

Acknowledgement of Receipt

Member Name: _____

ACBHD Member #: _____ **Date of Birth:** _____

Admit Date: _____ **Program Name:** _____

Your signature on this document confirms that you consent to receiving services from this provider/agency.

If you are 18 years or older, please answer the following questions:

Have you already created an Advance Directive?	☐ Yes	☐ No
If not, did the provider offer you information about Advance Directives?	☐ Yes	☐ No

By signing this form,

- I agree that this packet was reviewed with me in a language or way that I could understand, and I was offered a paper copy of this packet.
- I consent to receiving voluntary behavioral health services from this agency/provider.

Member or Legal Representative's Signature: _____

Date: _____

----------*The section below is completed by provider, as applicable*----------

☐ Member/Member's legal representative verbally consented to receiving voluntary behavioral health services but declined or was unable to sign the form.
[Note: Please attempt to obtain a signature at a later date.]

Provider Signature _____ Date: _____