Acknowledgement of Receipt & Consent to Services

Member Name: _____

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

Admission Date: _____ **Program Name:** _____

Please check <u>each box</u> if you agree with the statement, then sign and date the form to confirm receipt of the required information and your consent to receiving voluntary services.

☐ **I agree to receiving voluntary behavioral health services from this agency/provider**.

☐ **Member informing materials, including the Member Handbook, Provider Directory and Notice of Privacy Practices,** were reviewed with me in a language or way that I could understand, and I was offered a copy of the documents.

☐ **I agree to receiving services via telehealth (audio and video) or telephone (audio only) from this provider. I understand that:**

- I have the right to access Medi-Cal covered services in person.

- The use of telehealth is voluntary, and I may withdraw my consent to, or stop, receiving services through telehealth at any time without affecting my ability to access covered services in the future.
- Non-medical transportation benefits are available for in-person visits.
- Potential limitations or risks related to receiving covered services through telehealth were explained to me and my questions were answered to my satisfaction.

If you are <u>18 years or older</u>, please answer these two questions:

1. Have you already created an Advance Directive? ☐ Yes ☐ No
2. If not, have you been offered information about Advance Directives? ☐ Yes ☐ No ☐ N/A

Member or Legal Representative's Signature: _____

Date: _____

This section is completed by provider, as applicable

☐ Member/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:* _____