

## Acknowledgement of Receipt & Consent to Services

Member Name: \_\_\_\_\_

ACBHD Member #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Program Name: \_\_\_\_\_

Please check each box 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 **18 years or older**, 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: \_\_\_\_\_