Equitas Health
Care for All

CONSENT FOR SERVICES FORM

I hereby give my consent for services by the staff and/or volunteers of the Equitas Health.
I authorize Equitas Health to contact me when appropriate by:

1.	Letter/Newsletter (plain envelope)	❑ Yes	❑ No
2.	Telephone contact	❑ Yes	❑ No
3.	May we leave a message on your answering machine?	❑ Yes	❑ No
4.	May we identify ourselves to persons who answer the phone, as Equitas Health staff or volunteers?	❑ Yes	❑ No
5.	May we send you an e-mail from an Equitas Health account? Your Email: _______________________________________	❑ Yes	❑ No
6.	My Chart _______________________________________	❑ Yes	❑ No

If you answered no to telephone contact, e-mail and letters, it is your responsibility to contact Equitas Health at least once every three (3) months. Failure to do so may cause a delay in receiving services.

Statement of Client Rights and Responsibilities

By signing and initialing this Consent for Services, I acknowledge that I have read and received a copy of the Client Rights and Responsibilities and agree to abide by them. **Initial:** ______

Grievance Procedures

By signing and initialing this Consent for Services, I acknowledge that I have read and understand the procedure for filing a grievance or complaint with Equitas Health. **Initial:** ______

Consent for Treatment Services

Equitas Health provides services to individuals and their families who have substance abuse/chemical dependency problems. The staff members are trained to provide appropriate treatment/services as needed in this area.

I agree to **substance abuse treatment** offered by Equitas Health. I have read and understand the information regarding consent to treatment/services. **Initial:** ______

Equitas Health provides services to individuals and their families who need mental health treatment. The staff members are trained to provide appropriate treatment/services as needed in this area.

I agree to **mental health treatment** offered by Equitas Health. I have read and understand the information regarding consent to treatment/services. **Initial:** ______

Notice of Privacy Practices

By signing and initialing this Consent for Services, I acknowledge that I have read and understand the procedure for filing a grievance or complaint with Equitas Health. **Initial:** ______

Signature: _______________________________________ Date: ______________

Witness Signature: _________________________________ Date: ______________