TIDES FAMILY SERVICES
WE NEVER GIVE UP ON A KID... NEVER!

Client Informed Consent

Client:

Date: **End Date:**

I have chosen to receive services from Tides Family Services. My choice has been voluntary and I understand that I may terminate or refuse treatment at any time.

I understand that there is no assurance that I will feel better or that the issues, which have resulted in my participation in services, will be solved. Since my treatment is a cooperative effort between my service provider(s) and myself, I will work with my service provider(s) in a cooperative manner to resolve my difficulties.

I understand that during the course of my involvement with Tides Family Services, material may be discussed which will be upsetting in nature and this may be necessary to help resolve my problems.

I understand that a client record is the means by which multiple providers communicate a chronology of care. Therefore, it is the policy of Tides Family Services that providers communicate clearly and effectively throughout the duration of client care. Clients and families involved with more than one program, or more than one provider should understand clearly that in order to provide the most effective service, all providers in all programs with which they are involved will have access to the client's information to the extent that it is necessary to provide the best treatment or service.

I understand that it is the policy of this agency that every client's treatment is subject to a Utilization Review and clinical case record review process. I understand that this process is a significant part of the Agency's Quality Improvement Program and is necessary to monitor the quality of the services provided to me.

I understand that confidentiality of information about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that the agency will at times provide services via electronic media such as telephones, computers and fax machines. I understand that the agency takes precautionary measure to protect client confidentiality when using such electronic media, however given the current state of electronic media, it is possible that electronic communication will be seen or heard by others who know how to intercept or "eavesdrop" electronically.

I understand that state and local laws require that my service provider report all cases of abuse/neglect of minors, the elderly or other vulnerable persons.

I understand that state and local laws require that my service provider report all cases when there exists a danger to self and/or others.

I understand that there may be other circumstances in which the law requires my service provider to disclose confidential information. This may include any illegal activity in which I engage while involved in a Tides program.

I understand that I may be contacted by my insurance company to insure continuity and quality of my treatment, after the completion of my treatment, or to assess the outcome of my treatment.

I understand that my service provider may disclose any and all records pertaining to my treatment to my insurance company if such disclosure is necessary for claims processing, case management, coordination of services, quality

assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance to this consent, and that if I do not revoke this consent it will expire automatically one year after all claims for treatment have been paid, or after termination of services.

I understand that Tides Family Services, Inc. will bill me monthly for any co-pay charges required by my insurance company. I understand that if I am unable to make these payments, I will contact the billing department to make payment arrangements.

I have read and understand the above.