OMHS Oregon Mental Health Services, LLC

Acknowledgement of Receipt of Clinic Procedures

Patient's Name: _____Date of Intake: _____

My signature on this form acknowledges that I have been offered a copy of the following informational forms describing the policies of Oregon Mental Health Services, LLC:

Notice of Privacy Practices
Payment Policy
Client Rights and the Grievance Procedure
Client Rights and Informed Consent
State of WI Client Rights brochure
State of WI Rights of Children and Adolescents
Policy for Discharge from Treatment
Notice of email Risk

I understand that these documents provides an explanation of OMHS use/disclosure of Protected health information, my consumer rights with respect to my protected health information and the grievance process, how insurance and personal payments are handled, the conditions for termination of treatment and the risk of using email. I have been provided with the opportunity to discuss any concerns I may have regarding the conditions of my treatment at OMHS.

By signing below, I authorize the disclosure of information to my insurance company for billing for services and for direct payment for services to OMHS. I also agree to be treated by OMHS clinical staff and to receive email notification of appointment reminders.

_____ _____

Patient's Signature Date

_____ _____

Clinician Signature Date

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