THIS PAGE IS TO BE RETAINED BY ROBERTS GROUP COUNSELING AND PLACED IN THE CONSUMER RECORD.

J. CONSENT FOR FOLLOW-UP

Upon termination of services from this program, we may want to contact you regarding your status and for you to answer some questions concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide Roberts Group Counseling with pertinent statistical information. You may revoke permission for follow-up at any time by giving this agency a written notice or by refusing to participate in any follow-up questionnaire. Follow-up with be the same with all persons served regardless of referral status.

CONSENT: **I hereby: GIVE DO NOT GIVE (Please circle one)**

Permission for Roberts Group Counseling to contact me by telephone or letter for follow-up and to answer questions concerning my satisfaction with services and my current status.

☐ E-mail: _____ ☐ Survey

K. ACKNOWLEDGEMENT OF RECEIPT OF CONSUMER HANDBOOK

Please INITIAL to verify receipt of the following:

_____ Code of Ethics

_____ Consumer Rights

_____ Confidentiality of Consumer Records

_____ HIPPA Notice

_____ Complaint/Grievance Procedure

_____ Orientation Information

_____ Consumer Expectations

_____ HIV/AIDS/STD Education Session

_____ HIV/AIDS/STD Referral Information

Is Consumer under the age of 21?	YES	NO
If yes, does Roberts Group Counseling have permission to see him/her at school?	YES	NO
Does Roberts Group Counseling have permission to transport consumer for services?	YES	NO

Participated in a face-to-face (circle one) Biopsychosocial or Client Assessment Record. Initials_____

Roberts Group Counseling is a Medicaid fee for service provider and all fees are covered by Medicaid if consumer is eligible. The undersigned acknowledges that he/she has received a copy of the Consumer Handbook which has been communicated to him/her in a meaningful way. Furthermore, he/she has read and understand this document in its entirety and further certified that he/she agrees to the terms and provisions stated herein.

Consumer Name: _____ Medicaid #:_____

_____ _____

Client Signature (if over 14) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date