Lutheran Family Services
for the well-being of all people

LFS Mission: *Lutheran Family Services expresses God's love for all people by providing Quality human care services that build and strengthen individual, family and community life*

Client Consent for Treatment/Service

___________________________	________	____________________	_______________________
Client Name	**Initials**	**Date of Birth**	**EHR/Client Number**

_______ **Authorization for Treatment:** I hereby authorize Lutheran Family Services (LFS) to provide care, support and/or behavioral health services and/or treatment as may be necessary or advisable in treating my, or the individual for whom I am legally authorized to provide this consent's, symptoms, diagnosis, mental health concerns and/or supportive needs. I am aware the practices authorized hereunder are not an exact science and I acknowledge no guarantees of any particular outcome or result have been made to me related to the services or treatment I am authorizing LFS to provide. I also understand that LFS may provide me with referrals for additional services.

_______ **Acknowledgement of LFS Clients Rights and Responsibilities:** I acknowledge I received and read LFS Clients Rights and Responsibilities. My rights and responsibilities have been adequately explained to me and my consent given herein is with full knowledge of the content of these rights and responsibilities.

_______ **Acknowledgement of LFS Privacy Practices:** I have been given the opportunity to read LFS's Notice of Privacy Practices and seek clarification on any part I do not understand. I have been offered a copy of their Privacy Practices.

_______ **Emergency Medical Treatment:** I understand LFS staff will call 911 for me or the individual's treatment pursuant to this consent in the case of an apparent medical emergency, whether physical or emotional, while in the LFS office or during face to face services provided to me or the individual treated pursuant to this consent outside of an LFS office.

_______ **Authorization for Transportation**: I hereby authorize LFS to provide transportation to me and family members listed on this consent form if transportation is offered by the program and/or service I am participating in. (**STAFF**: If not applicable, note NA and initial on line)

Please list Family Members and their Date of Birth (DOB) who may be transported:

Name: ____ DOB: ____________________

Name: ____ DOB: ____________________

Name: ____ DOB: ____________________

Name: ____ DOB: ____________________

Name: ____ DOB: ____________________

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_______**Authorized Representative:** I hereby authorize LFS, its service provider(s) and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided by LFS. I understand that I am responsible for all co-pays, co-insurance and deductible amounts determined by my insurance provider at the time of services unless other payment arrangements are in place.

_______**Acknowledgement of Contact Information:** I hereby agree to inform LFS of any changes to my contact information.

I hereby acknowledge that, when appropriate, LFS staff may collaborate regarding my case for the purposes of referral, treatment and/or coordination of care.

The undersigned certifies that he or she has read and understands the above mentioned and is the client, client's guardian, power of attorney, parent, or is duly authorized by or on behalf of the client to execute the above and accept its terms.

______________________________	______________________	______________
Signature of Client or Guardian	**Relationship to Client**	**Date**
______________________________	______________________	______________
Signature of LFS Staff	**Title**	**Date**
______________________________	______________________	______________
Signature of Interpreter	**Title**	**Date**