



## Drug Medi-Cal: Multiple Acknowledgment Receipt Form ( )

Client's Name:

ID#:

SSN#

### ADVANCE HEALTH CARE DIRECTIVE

#### Background

In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directive and be informed of his/her right to make decisions about his/her medical treatment.

The client was given a copy of the Advance Health Care Directive Fact Sheet at the first face-to-face contact or clinic visit

Client has an Advance Health Care Directive currently in place, and a copy is placed in the chart

### NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Los Angeles County Health Agency Notice of Privacy Practices which explains how my health information is protected and describes other rights that I have regarding my Protected Health Information.

--Please select--

External Signature of:

Name:

Signature

Signed:

### EDUCATION MATERIALS FOR: AIDS/HIV, TUBERCULOSIS, STDs, HEPATITIS B AND C

I acknowledge I received these educational materials.

N/A

External Signature of:

Name:

Signature

Signed:

### Consent for Follow-up

I give permission to Didi Hirsch to contact me as a follow-up to services via survey or other means up to one year after discharge to inquire about how well the program helped me meet my personal goals.

--Please select--

External Signature of:

Name:

Signature

Signed:

### AUTHORIZATION TO LEAVE A MESSAGE

Didi Hirsch staff are authorized to leave a detailed message at the contacts listed below if I cannot be reached.

Client/Guardian Name

Client/Guardian Email

Client/Guardian Contact #

Name

Relationship

Contact #

-- Select One --

Name

Relationship

Contact #

-- Select One --

### OUTPATIENT NO SHOW CANCELLATION POLICY

Name:

Diag:

MIS #:

Svc Date:

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In order to assure a consistent focus in the therapy process and to assure regular use of therapy time I/We agree to the following Didi Hirsch Mental Health Services policies:

1. I understand that if I/we have an appointment with a Didi Hirsch staff member, and an emergency arises where I/we cannot make the appointment, I/we will call to cancel the appointment as soon as possible, preferably at least 24 hours before the scheduled appointment.

2. Treatment Policy: I understand that if I miss 2 consecutive substance use treatment sessions without prior notification to my counselor or therapist, that I may be terminated from services in the program. I also understand that if I do not attend a minimum of 2 hours a month, I may be terminated from substance use treatment. If I am absent from services for 30 days, my services will be terminated. (I may reapply for services at a later date).

3. Medication policy: I understand that if I reschedule, cancel or miss 2 consecutive or 3 doctor's appointment in a one-year period, I may be terminated from medication services and/or be referred to a medication clinic (if available).

External Signature of:

Name:

Client/Guardian

Signed:

Signature/Printed Name

**RESIDENTIAL SERVICES ACKNOWLEDGMENT RECEIPTS**

I acknowledge that I have been offered, or received a copy each document below, and understand and agree to each.

RELEASE AND WAIVER OF LIABILITY AGREEMENT COMPLETED:

VALUABLE PERSONAL ITEMS AGREEMENT COMPLETED:

External Signature of:

Name:

Signature

Signed:

**SEX OFFENSE – ARSON RELATED CHARGES**

I attest to the following information:

CHECK ONE:

I have never been convicted of a sex offense against a minor.

I have been convicted of a sex offense against a minor.

CHECK ONE:

I have never been convicted of arson and/or an arson-related charge.

I have been convicted of arson and/or an arson-related charge.

External Signature of:

Name:

Signature

Signed:

I swear the information I have given is true and correct. Individuals giving false statements are guilty of a misdemeanor.

Telehealth Verbal Consent

Due to the COVID-19 crisis and use of telehealth, a copy of the Notice of Privacy practices and educational materials was sent via mail/email at client's request

Due to the COVID-19 crisis and use of telehealth, client is unavailable to provide physical signatures where required. Content of this document was reviewed verbally with client/guardian whose consent and understanding was affirmed verbally.

Rendering Provider's  
Signature

Rendering NPI #/License

Name

Date Submitted:

**Agency:** Didi Hirsch Mental Health Services / **Site:**

This confidential information is provided to you in accordance with State and Federal laws and regulations, including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards.

Duplication of this information for further disclosure is prohibited without prior written authorization of the participant/authorized representative to whom it pertains unless otherwise permitted by law.

**Name:**

**Diag:**

**MIS #:**

**Svc Date:**

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