|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **WestCoast Children’s Clinic** | Beneficiary’s Name: |  | | | |
| Birth Date: |  |  | |  |
| Program: |  |  | |  |
|  |  | |  | |

**Informing Materials -- Your Rights & Responsibilities Acknowledgement of Receipt**

**Consent for Services**

As described on page one of this packet, your signature below gives your consent to voluntary mental health care services from WestCoast Children’s Clinic. If you are a beneficiary’s legal representative, your signature gives that consent.

**Informing Materials**

Your signature also means that the materials marked below were discussed with you in a language or way that you could understand, and that you were given the packet for your records. You may request an explanation and/or copies of the materials again, at any time.

**Initial Notification:** Please mark the boxes below to show which materials were discussed with you at admission or any other time.

* Consent for Services
* Freedom of Choice
* Confidentiality & Privacy
* Advance Directive Information (for age 18+ & when client turns 18)

*Have you ever created an Advance Directive? 􀂅Yes 􀂅No*

*If yes, may we have a copy for our records? 􀂅Yes 􀂅No*

*If no, may we support you to create one? 􀂅Yes 􀂅No*

* Grievance Resolution Policy
* Maintaining a Welcoming & Safe Place
* Notice of Privacy Practices

|  |  |
| --- | --- |
| Beneficiary Signature:  (or legal representative, if applicable) | Date: |
| Clinician/Staff Witness Initials: | Date: |

**Annual Notification:** Your provider will remind you each year that the materials listed above are available for your review. You may sign a new copy of this agreement or you may put your initials and the date in a box below to show when that happens.

|  |  |  |  |
| --- | --- | --- | --- |
| Initials & date: | Initials & date: | Initials & date: | Initials & date: |

Use one box every year (see above) for the ***beneficiary’s*** initials & date (or their legal representative).