Client Name:

Medical Record number:

Medicaid Number:

1. Complete at screening or admission
2. Update as necessary

I, ,(client/parent/legally responsible person) give my consent for **Name of Agency** to provide assessment, treatment and/or other services for the above named client. I reserve the right to withdraw consent at any time. I also reserve the right to refuse, at any time, any services offered to me.

If treatment is refused, the qualified professional shall determine whether treatment is some other modality is possible. If all modalities are refused, the voluntarily admitted client may be discharged.

A minor may seek and receive periodic services from a physician without parental consent in accordance with NCGS§ 90-21.5.

In a medical or health emergency, I authorize the agency to administer first aid as needed and contact:

 Name Relationship Telephone Number

 Name Relationship Telephone Number

Additionally, pursuant to G.S. 122C-57(d), in an emergency, a voluntarily admitted client may be administered treatment or medication, despite the client or the legally responsible person’s refusal, even if the client’s refusal is expressed in a valid advanced written instruction.

I choose the following hospital, medical doctor, and dentist to provide services to me:

 Hospital Preference Address Phone Number

 Medical Doctor Address Phone Number

 Dentist Address Phone Number

If the above medical doctor or dentist cannot be reached, I give my permission to be seen and treated by a licensed physician or dentist or I may be taken to the nearest emergency room by ambulance if necessary. I will not hold this provider/agency accountable for these expenses.

Client or Legally Responsible Person Signature Relationship to Client Date

Witness Signature Date