STATEMENT OF CLIENT'S RIGHTS

Client Name: _____ **ID/DOB #:** _____

1. You have the right to maintain all your legal and civil rights. A client's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5].
2. You have the right to receive all services regardless of your sex, race, ethnic background, handicap, disability, religion, national origin, age, financial status, sexual orientation and/or medical status.
3. You have the right to access services that shall be provided to you in the least restrictive environment available and with non-discriminatory implications as specified in the Americans with Disability Act of 1990 (42 USC 12101).
4. You have the right to have disabilities accommodated as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].
5. You are entitled to adequate and humane care and services. You have the right to considerate and respectful treatment in an environment free of harm. Every individual has the right to be free of physical, verbal, psychological, and fiduciary abuse, humiliation, exploitation, and neglect.
6. You have the right to be free from the use of seclusion and restraint. Violation of these rights, by anyone, will be reported to the appropriate authorities.
7. You have the right to communicate with other people in private, without obstruction or censorship by staff. These rights include mail, telephone calls and visitors.
8. You have the right to personal property.
9. You have the right to participate in the development of your own individual treatment service plan and attend any team meetings regarding you and your treatment service plan.
10. You have a right to expect your treatment here will be kept confidential as outlined in the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110); HIPAA (45 CFR 160 and 164) governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996; HITECH; and in the federal law governing the confidentiality of drug and alcohol abuse patient records (42 CFR).
    The following are specific and limited exceptions to this confidentiality:
    - ❖ When there is risk of imminent danger to self or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
    - ❖ When there is risk of imminent danger to self or to another person with access to a firearm, the clinician is legally bound to report the client to the Illinois Firearms Owner Identification (FOID) Mental Health Reporting System, as outlined by the FOID Act (430 ILCS 65).
    - ❖ When there is suspicion that a child or elder is being sexually, physically or financially abused/neglected or is at risk of such abuse/neglect, the clinician is legally required to take steps to protect the identified individual and to inform the proper authorities.
    - ❖ When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
    - ❖ When there is a need for clinical reviews or case consultations with a supervisor, team staffing or agency audits, clinical records and client documentation are subject to review within the confines of the event.
11. You have the right to review your clinical records.
12. You have the right to purchase and use the service(s) of private physicians, other mental health professionals and developmental disability professionals of your choice. This information shall be recorded in your chart.
13. You have the right to refuse or terminate treatment at any time, and you have the right to be informed of the resulting consequences when you refuse treatment.
14. Any information regarding HIV status, results of treatment for medical complications will be maintained strictly confidential and in a separate record. Your confidentiality rights are protected by the AIDS Confidentiality Act [410 ILCS 305] (AIDS Act), and the AIDS Confidentiality and Testing Code (77III Adm. Code 697) AIDS Code).
15. You also have the right to contact the Department of Human Services (DHS), Department of Healthcare and Family Services (HFS) or any of the other agencies listed on the following page, if you fail to arrive at a satisfactory resolution in regard to any of the above-stated rights with the organization's grievance procedures, and you have the right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
16. The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights.

DEPARTMENT OF HUMAN SERVICES – Local Office
2753 West North Avenue
Chicago, IL 60647
Phone: (773) 292-7200
TTY: (866) 439-3721

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES – Local Office
401 South Clinton Street
Chicago, IL 60607

GUARDIANSHIP & ADVOCACY COMMISSION
NORTH SUBURBAN REGIONAL OFFICE
9511 Harrison Ave., W 300
Des Plaines, IL 60016 847-294-4264 http://gac.state.il.us/osg/

DIVISION OF SUBSTANCE USE, PREVENTION & RECOVERY
401 South Clinton Street, Second Floor
Chicago, IL 60607
(phone) 312-814-3840 (fax) 312-814-2419 http://www.dhs.state.il.us/page.aspx?item=29725

ILLINOIS OFFICE OF CHILDREN & FAMILY SERVICES
1 800 25 ABUSE (800) 252-2873 http://www.state.il.us/dcfs/index.shtml

ILLINOIS OFFICE OF DEVELOPMENTAL DISABILITIES
319 E. Madison, Ste. 4N
Springfield, IL 62701 217-524-7065 http://www.dhs.state.il.us/page.aspx?item=32253

ILLINOIS OFFICE OF INSPECTOR GENERAL
32 West Randolph St.Ste. 1900
Chicago, IL 60601
312-814-5600 www.inspectorgeneral.illinois.gov

ILLINOIS OFFICE OF MENTAL HEALTH
160 N. LaSalle, 10th Fl.
Chicago, IL 60601 312-814-3784 http://www.dhs.state.il.us/page.aspx?item=29728

EQUIP FOR EQUALITY
20 N. Michigan Ave., Ste. 300
Chicago, IL 60602 312-341-0022 http://www.equipforequality.org/

CARF INTERNATIONAL
6951 East Southpoint Road Tucson,
AZ 85756-9407, USA Phone: (520)
325-1044
Toll-free: (888) 281-6531 voice/TTY
Fax: (520) 318-112 http://www.carf.org/contact-us/

The information in this Statement of Rights shall be explained using language or a method of communication that the client understands and documentation of such explanation shall be placed in my clinical record. I have read this Statement of Rights, or had it read to me and explained to me and understand its content. A copy of these rights has been provided to me.

Client Signature (12y/o & older) Date	**Language / Method of Communication**
Parent / Guardian Signature (if applicable) Date	**Service Provider Signature / Credentials Date**

GRIEVANCE PROCEDURE

Client Name: _____ **ID/#:** _____

It is the goal of Rincon Family Services to provide services to clients that are respectful and of the highest quality. Rincon Family Services is committed to provide services free from the practice of illegal discriminatory behavior and are respectful toward all persons regardless of race, ethnicity, religion, sex, age, marital status, sexual orientation, and mental or physical disability. Rincon Family Services encourages open and honest discussion between the clients and staff. Rincon Family Services expects that the majority of client concerns can be addressed satisfactorily. Rincon Family Services will address grievances and concerns brought to our attention by clients. Staff is to inform clients about the Rincon Family Services Grievance Policy during the initial contact. All staff is committed to ensure that all clients have an exceptional and dignified experience while receiving services with any Rincon Family Services program.

Procedures:

- Clients are to discuss concerns or dissatisfaction related to their services, treatment, outcomes, or experiences with their assigned Rincon Family Services worker. The Rincon Family Services worker will make every effort to address any/all-identified issues, under the monitoring and knowledge of their supervisor. Complaints may be formalized by completing the Client Complaint Form.
- If the client believes that their identified concerns have not been adequately addressed or resolved with their assigned worker, the client will then contact the worker's supervisor for a meeting to further discuss the complaint, which should resolved within three (3) business days.
- If the client feels that the issue or concerns are not resolved, the client may submit a formal grievance in writing to the Program Director, who will respond to the grievance within three (3) business days, or submit directly to compliance through any of the three methods identified below.
- If a resolution was not able to be formed, the Program Director will forward the grievance to Corporate Compliance, who will respond within three (3) business days.
- If a resolution is still not able to be formed, Corporate Compliance will forward the grievance to the President/CEO. The President/CEO's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by our governing board, in which case the governing board's decision is the final authority at the Rincon Family Service level);
- The client and the assigned worker will be informed of the final outcome in writing within three (3) business days of the decision President/CEO or two (2) additional business days for the Board.

_____

Client Signature (12 y/o & older) and Date

_____ _____

Parent / Guardian Signature (if applicable) and Date **Service Provider Signature / Credentials and Date**

To Contact Corporate Compliance Directly:

Phone: 773-609-6425 * Fax: 773-321-0201 * Email: grievances@rinconfamilyservices.org

CLIENT AGREEMENTS AND AUTHORIZATIONS

Consent for Treatment
I hereby consent to the treatment provided by Rincon Family Services and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by any legal caregivers to address my needs. I was informed of all the risks and costs involved in the treatment, including the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment. (___).

Authorization for Release of Personal Health Information
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting the healthcare operations of Rincon Family Services. I authorize the organization to disclose any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Rincon Family Services may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

Privacy Policy
I acknowledge having received "Notice of Privacy Practices". My rights', including the right to see and copy my record, to limit disclosure of my health information and to request an amendment to my record, are therein explained. I understand that I may revoke, in writing, any consent for release of health care information, except to the extent that Rincon Family Services already made disclosures with my prior consent. (_____)

Follow Up Interview/Outcome Management
I hereby consent to have a representative from Rincon Family Services contact me by telephone, mail or other means within 30 days after discharge in order to do a follow up interview to review my progress. (_____)

Refusal for Services
I hereby decline services offered to me at this time by Rincon Family Services. At any time I may request services. (_____)

_____ _____
Client Signature (12y/o & older) **Date**

_____ _____ _____
Parent / Guardian Signature (if applicable) **Relationship** **Date**

_____ _____
Service Provider Signature / Credentials **Date**

☐ **Client is unable to sign verbal consent given.**

Reason: _____

NOTICE OF PRIVACY PRACTICES

The agency has specific policies and procedures controlling access to records and information which is governed by the confidentiality of Alcohol and Drug Abuse Client Records regulations (42 CFR 2/1987) of the Alcohol, Drug Abuse and Mental Health Administration of the Public Health Service of the United States Department of Health and Human Services, effective August 10, 1987, which is incorporated herein by reference, and article 30 of the Act (20 ILCS 301/Art. 30), the Confidentiality of HIV/ AIDS status and testing are governed by the AIDS Confidentiality Act (410 ILSC 305) (AIDS Act), the AIDS confidentiality and Testing Code (77 IL Adm. Code 697) AIDS Code), and the Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

These policies and procedures are consistent with said regulations and statutes. The agency shall comply with said regulations and statutes.

The agency shall not release any clinical record in whole or in the part without a written release signed and dated by the client. Generally, program staff may not inform any person outside the organization that any individual attends the program, nor may any staff member disclose any information identifying an individual as alcohol or drug dependent, behavioral health consumer, or as a member of any treatment program.

Violation of these federal laws and regulations by any person is a crime. Suspected violations may be reported to appropriate authorities in accordance with these federal regulations.

These laws and regulations regarding privacy/confidentiality practices shall not prohibit:

- Disclosure of information about a crime committed by a client at the organization;
- Disclosure of information about the potential for harm to self or others;
- Disclosure of information about suspected child or elder abuse or neglect, as allowed by, required by and consistent with state and federal law;
- Disclosure of a client's own records to the client, or as consented to in writing by the client;
- Communication of information between or among personnel having a need for the information in connection with their duties either within the program or with an entity having direct administrative control over the services.
- Disclosure of medical information to medical personnel if necessary, in a medical emergency;
- Disclosure of information as authorized by an appropriate court order upon showing good cause, after appropriate procedure and notice, and with appropriate safeguards against unauthorized disclosure contained in the order as set forth in 42 CFR 2.61-2.67 (1987);
- Disclosure of information to qualified personnel who are authorized by law or who provide financial assistance for the purpose of conduction audit or evaluation activity as set forth in 42 CFR 2.53 (1987);

The section shall not prohibit any other disclosure not precluded by the regulations and statutes cited above, nor by any other applicable state law, provided that any and all of the above disclosures are done consistent with the regulations and laws in the section above are made only to the extent allowed, for the purposes allowed and appropriate safeguards as required therein are provided.

This agency participates with other behavioral health service agencies (each, a "Participating Covered entity") in the IPA Network, established by Illinois Health Practice Alliance, LLC ("Company"). Through Company, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement ("OHCA"), as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all the OHCA participants.

Client records shall remain secure in a locked room and locked file cabinet.

Except as authorized by an appropriate court order granted pursuant to state and federal regulations, no record may be used to initiate or substantiate charges against a client or to conduct an investigation of a client.

When the department of Human Services requests records for audit, evaluation, research and other authorized purpose, it will:

a. indicate the purpose for requesting information;
b. agree in writing to maintain the information in accordance with security requirements of state and federal regulations;
c. agree in writing to comply with limitations on disclosure; and
d. indicate the authorized personnel to whom such information is to be submitted

I hereby acknowledge that the staff at the agency has informed me that federal law and regulations protect the confidentiality of client treatment records and that a written summary of the law and regulations has been given to me as desired.

Client Signature (12 y/o & older) **Date**

Parent / Guardian Signature (if applicable) **Date**

Witness / Service Provider Signature **Date**

RINCON
FAMILY SERVICES

DOCUMENTATION OF CONSUMER CHOICE TO RECEIVE DHS-FUNDED SERVICES
(MEDICAID AND MEDICAID MCO CLIENTS ONLY)

The department of Human Services (DHS) may pay for part or all of the cost of your mental health services. If DHS is to pay for these services, the provider must report certain personal information to the Department. If you do not want the provider to report this information, you may decline to be a recipient of DHS funding. If you do not decline, the provider will report all of the following information to the Department of Human Services

- ☐ Your full name (first, last, and middle initial)
- ☐ Your social security number
- ☐ Your birth date
- ☐ Your gender (male or female)
- ☐ Your county of residence
- ☐ Your household income and size
- ☐ All mental Health services for which the provider expects payments

Client name (please print) _____

To **ACCEPT** being consider as a DHS consumer

_____ I choose to have the provider bill DHS for my services, and I understand the provider will report the information above to the Illinois Department of Human Services.

_____ _____

Signature of Client or Parent or Guardian Date

To **DECLINE** being considered as DHS Consumer

_____I DO NOT choose to have the provider bill DHS for my services, and I understand the provider will NOT report the information above to the Illinois Department of Human Services.

_____ _____

Signature of Client or Parent or Guardian Date

Explanation by the provider why client choice was not documented

_____

_____

CLIENT FINANCIAL AGREEMENT

Client Name: _____ ID/DOB #:_____

Rincon Family Services works with its clients to provide affordable, quality care, and our standard expectations on payment for services are outlined below. No client will be turned away based solely on ability to pay.

In-Network Insurance

If Rincon Family Services is in-network with your insurance company; your insurance company has already determined your co-payment/deductible responsibility, **which is due at the time of each service.** If your insurance determines that you are responsible for any other cost, you will be invoiced the full amount.

Out-of-Network Insurance or No Insurance

If we are out-of-network with your insurance carrier, please note that your insurance company may or may not pay for out-of-network services. For any services your insurance determines are not covered, but are your responsibility, you will be invoiced the full amount. If insurance payments are received, all preceding payments will be applied to any out-standing balances and refunds will be determined at the end of service.

Medicaid Insurance

If you have insurance either provided directly from the Department of Human Services or through a managed care organization (MCO), please be aware of disruptions in insurance or changes in the company managing your insurance as that might alter how Rincon Family Services can continue providing you with services. While we will work with you to continue services, the costs associated with your services become your responsibility.

Minor Children

The parent/legal guardian(s) who bring the child to the appointment are responsible for payment and the account.

Billing for Services

The billing is based on time spent either directly or indirectly with your care. When you set up an appointment with a clinician, you are reserving that time, and in the process guaranteeing that you will be present during that time. Returned Checks: Clients are responsible for any bank fees from returned checks. **A bank service fee of $25.00 per returned check will be charged**.

Missed Appointments

A cancellation less than 24 hours in advance is treated the same as a missed appointment; this is because we are unlikely to be able to fill that slot with another appointment. **The Missed appointment fee is $25.** Any client who does not show or late cancels for **3 consecutive sessions, may be closed, put on the waitlist or be referred out.**

Requesting Copies

Please be aware that completing an assessment takes longer than the time spent with the client. Each assessment is reviewed with a clinical supervisor to ensure medical necessity and confirm a diagnosis, as applicable. Requests for assessments take at least a week, and a copy of your assessment, or any other medical record costs $30 for the first 25 pages, and $.025 each page after, per request. If mailing records, appropriate charges are added for postage. When requesting copies for an outside person or organization, a signed release from the client must be present, indicating their confirmation and consent that their information be sent out. Rincon Family Services will not release records without this signed consent, or if there is any unpaid balance.

Failure to Pay

Rincon Family Services will expect payment at the time of appointment; if you cannot pay and build an outstanding balance, reception will continue to invoice you. Please be aware Rincon Family Services reserves the right to alter the agreement of service provision if there is failure to provide payment over time. If you discontinue services, requesting copies of your records will be attained once balance is paid in full.

Fee Assessment

Rincon Family Services is committed to serving clients, regardless of their ability to pay. All clients with any cash-payment option will have a maximum out-of pocket expense per hour, based on their **documented** household income and size, per the federal poverty level.

RINCON FAMILY SERVICES

CLIENT FINANCIAL AGREEMENT CONTINUED

Client Name: _____ ID/DOB #:_____

Please initial each line:

_____I have read and understand the terms of this financial agreement.

_____I understand that I must notify the receptionist with any changes in my insurance or insurance coverage.

_____I authorize the release of information necessary to process insurance claim.

METHOD OF REIMBURSEMENT (Mark all that apply)

_____ Medicaid ____ Private Insurance _____ Self-Pay _____ Fee Scale (per income documentation)

PRIMARY INSURANCE (____ Check if Client does not have Primary Insurance)

Insurance Provider		Insurance Phone #	
Employer Name		Employee Name	
Group/Policy #		Recipient ID #	
Co-Payment		Effective Dates	

SECONDARY INSURANCE (____ Check if Client does not have Secondary Insurance)

Insurance Provider		Insurance Phone #	
Employer Name		Employee Name	
Group/Policy #		Recipient ID #	
Co-Payment		Effective Dates	

_____ _____

Client Signature (12 y/o +) Date

_____ _____

Guardian Signature (client under 18y/o) Date

_____ _____

Staff Signature with Credentials Date

RINCON FAMILY SERVICES

ADVANCED DIRECTIVES

Client Name:_____ **ID/DOB:**_____

I, _____, have been informed of my right to document my Advanced Directives.

An Advanced Directive is a document of written instruction that allows a person to specify what actions should be taken for their health, in the case that they are no longer able to make decisions due to illness or incapacity.

I have been informed that if I choose to document my Advanced Directives, they are only guidelines and I am still encouraged to consult with an attorney to validate my Advanced Directives. It has been explained that I can make changes to my Advanced Directives at any time, even if that is to choose to have them no longer followed.

I ☐ do ☐ do not choose to document my Advanced Directives with Rincon Family Services.

The following are the Advanced Directives that I choose to document with Rincon Family Services. Advanced Directives can include, but are not limited to, Do-not-resuscitate (DNR) preferences, hospital preferences, medication preferences, the name of a health care power of attorney and more.

_____

_____

_____

_____

_____ _____

Client Signature (12 y/o & older) **Date**

_____ _____

Parent / Guardian Signature (if applicable) **Date**

_____ _____

Service Provider Signature / Credentials **Date**

RINCON FAMILY SERVICES

CLIENT ORIENTATION CHECKLIST

Client Name:_____ **RIN/ID#**_____
Program: _____ **Location:** _____

The client will be given an orientation at admission. Please date and initial each orientation topic as it is discussed with client. Both client and staff member should sign below once orientation is completed.

Orientation Checklist	Client Initials	Date
Consent for treatment		
Client rights and responsibilities		
Code of ethics and standards of professional conduct		
Confidentiality policy and release of information		
Assessment process and client participation in the development of individual service plan; goal achievement; and course of treatment		
Expectations for legally required appointment, sanctions, or court notifications.		
Requirements for reporting and or follow-up for the mandated client, regardless of his or her discharge outcome		
Financial obligations, fees, and financial arrangements		
Opportunities for input from client regarding quality of care, achievement of outcomes and satisfaction		
Grievance procedures for complaint(s)and appeal procedure		
Explanation of program's services and activities including expectations, sanctions, interventions, incentives, transition criteria and procedures, discharge criteria and post discharge follow-up		
Program rules and behavioral expectations of the client		
Restrictions that the program may place on a client and the means by which the client may regain the rights or privileges that have been restricted		
Information regarding hours of operation and access to after-hours services		
Policy on non-violent Practices		
Policy on smoking and use of tobacco products		
Policy on illicit/licit drugs; prescribed medication; and/or weapons brought into the program		
Tour of the facility: location of emergency procedures, emergency exits, evacuation meeting sites, fire extinguishers and first aid kits		
Education on Advance Directives		
Treatment Team and Service Coordination		

_____
Client Signature (12 y/o & older) and Date

_____
Parent / Guardian Signature (if applicable) and Date

_____
Service Provider Signature / Credentials and Date

CONSENT TO BE RECORDED

Name:_____ **ID/DOB:**_____

Video and audio recordings are sometimes used as aids in the therapy process, or for the review of a particular therapy, interview, or testing session. Any such recordings will be viewed with discretion and will only be viewed by for professional purposes of clinical supervision, training and professional development. All materials are kept in a safe secure location, in accordance with HIPPA and all relevant state laws and governing bodies.

I, the client (or his or her parent or guardian)_____, consent to the recording of my therapy sessions for the purposes described above. This recording may be done by video and/or audio taping, or by any other means. The purpose and value of recording have been fully explained to me, and I freely and willingly consent to this recording.

This consent is being given in regard to the professional services being provided by the therapist(s) named below. I agree that there is to be no financial reward for the use of the recordings. I understand that I will not be punished in any way if I do not wish a particular session to be recorded. I understand that I may ask for the recording to be turned off at any time during my sessions. I also understand that within 5 days following a session, I may choose to request a viewing of the recording with the therapist.

I understand that I am fully responsible for my own participation in any and all exercises and activities suggested by the therapist(s). I agree not to hold the therapist or the agency legally responsible for the effect of these exercises on me, either during the therapy session or later.

I give the therapist(s) named below my permission to use the recordings of me for professional purposes. I understand that my therapist(s) and Rincon Family Services are bound by state laws and by professional rules about clients' privacy.

_____ _____

Client Signature (12 y/o & older) **Date**

_____ _____

Parent / Guardian Signature (if applicable) **Date**

I, the therapist(s), have discussed the issues above with the client (and/or parent or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Service Provider Signature / Credentials **Date**

_____ _____

Service Provider Signature / Credentials **Date**

RINCON
FAMILY SERVICES

COMMUNICATION AUTHORIZATION

During your course of treatment at Rincon Family Services (RFS), communication with you may be conducted by phone, text messaging and/or e-mail correspondence. However, each of these modes of communication may have security risks. To ensure that you have the choice and knowledge to make an informed decision of how we communicate with you, please read and confirm your choice(s) about communication methods below.

Telephone Correspondence: The name and number of RFS may appear on the Caller ID feature of telephones. That means that others in your home who pick up the phone may see that communication is occurring between you and RFS.

Text Messaging and Email Correspondence: Electronic methods of communication are effective and convenient and, as a result, could make communication with you during your course of treatment the best option. Be informed, however, that this form of communication is not secure and may not always be the most confidential means of communication. If you choose to use these methods to communicate with RFS, a third party may be able to intercept and /or eavesdrop on those messages. Examples of those third parties could include, but not be limited to:

- Other people in your home who can access your phone, computer or other devices that you use to read and write messages;
- Your employer, if you use your work email to communicate with Rincon Family Services;
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

Remember this is not a substitute for treatment and will be used only to address nonclinical issues such as appointment reminders, billing issues or other administrative matters. Our clinical staff does not always monitor emails or texts and are not available 24 hours a day 7 days a week. In the event you need to discuss a clinical issue, call us during regular business hours. If you are experiencing a crisis during off hours, please call 911.

By initialing each line, I consent to receive communication from Rincon Family Services through:

_____ Text Message: Number: (____) _____ - _____ Cell Phone Carrier: _____

_____ Voicemail/Message Number: (____) _____ - _____

_____ Email: _____

If I have not initialed any of the lines above, I understand that I will still be contacted by Rincon Family Services via the phone number I provided for general contact information, but no message will be left.

Client Signature (12 y/o & older) _____ **Date** _____

Parent / Guardian Signature (if applicable) _____ **Date** _____

Service Provider Signature / Credentials _____ **Date** _____