Acknowledgement of Receipt & Consent to Treatments

Patient First Name:	Patient Last Name:	Patient DOB:

It is the policy of the LAMOUR CLINIC to provide all patients, or their parents, guardians, or personal representatives, a copy of our current notice of privacy practices prior. This signed acknowledgment is to be filed in the medical record.

I have received the following documents:

1. **Acknowledgement of Receipt of Notice of Privacy Practices**
2. **Acknowledgement of Receipt of Complaint Information**
3. **Acknowledgement of Receipt of Patients' Rights**
4. **Acknowledgement of Receipt of Off Hours Emergency Policy**
5. **Acknowledgement of Receipt of Client Policy Manual**
6. **Acknowledgement of Receipt of HIV/AIDS Education**
7. **Acknowledgement of Consent to Treatment**

I consent to evaluation, treatment and/or to participate in program services by LAMOUR CLINIC. My consent is valid for one year from my signatures date on this form. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

****Must be signed by adult in custody if patient is under 18****

Printed Patients Name:
Patients Signature: Date Signed:

Printed Parent/Guardian/Adult in Custody:
Parent/Guardian/Adult in Custody Signature: Date Signed: Relationship to patient: