Hope Therapeutic Services Consents

1. Consent for Professional Home-Based Treatment:

   I authorize _____(print name of client) to participate in the Professional Home Based program with HTS. I understand that this includes professional diagnostic assessment, counseling, and skills training services with professionals and practitioners from HTS.

   _____ _____
   Client/Legal Guardian Signature Date

2. Assignment and Release

   I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

   _____ _____
   Client/Legal Guardian Signature Date

3. Transportation Authorization

   I give permission to HTS to provide transportation to our family as needed. I understand this transportation is for Home-Based services only and is valid for the duration period of service with this agency. I understand that HTS staff carry appropriate vehicle insurance, however, I release HTS and their staff from liability.

   _____ _____
   Client Name (Print) Date of Birth

   _____ _____
   Client/Legal Guardian Signature Date

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