I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am presenting myself to John J. Brogan Bereavement Center for counseling services. Clients are rendered services in this program without distinction due to race, faith, national origin, handicapping condition, age, or sexual orientation. This program complies fully with: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

**“HIPAA” (Health Insurance Portability and Accountability Act) and “CLIENT BILL OF RIGHTS”:**

**☑** I have been informed of my rights and have received the “Notice of Privacy Practices” pamphlet and a copy of the “Client Bill of Rights” notice (BER720).

**CONSENT FOR SERVICES:** I hereby voluntarily consent to and authorize such care, which may include (but not necessarily limited to) individual, family, group counseling, and education by authorized agents and employees of the facility or their designees as may in their professional judgment be necessary and beneficial. I acknowledge that no guarantees have been made to me as to the effect of such assessments or services provided, and that these services apply as stated in my Plan of Care.

**SCOPE OF SERVICES:** I understand that counseling services provided by John J. Brogan Bereavement Center must be primarily related to my grieving process and are time limited. Intervention and frequency will be determined by presenting need, for a duration of time not to exceed 13 months, or as clinically indicated.

**CONFIDENTIALITY:** I understand that John J. Brogan Bereavement Center clinicians maintain confidentiality of client information in accordance with the legal and ethical requirements of their profession. I accept that my information may be released or reported under certain circumstances that are required by law (see “Notice of Privacy Practices”).

**FEES FOR SERVICES:** I understand that all bereavement counseling services rendered at John J. Brogan Bereavement Center are free of charge for hospice family members. A fee for service is required for non-hospice family members on a sliding scale. I understand this fee will be determined at the initial assessment and will be paid at the time services are rendered.

**RESPONSIBILITY FOR PERSONAL VALUABLES:** I hereby release John J. Brogan Bereavement Center from any liability resulting from loss by theft or negligence of mine or that of any employee. I understand that I am fully responsible for all of my personal articles while at the John J. Brogan Bereavement Center.

The undersigned certifies that he/she has read the above paragraphs and is the client, or is duly authorized by the client as the client's general agent, to execute the above and accept its terms.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Client's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Copy given to client or parent/guardian Client's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Original in chart Client's Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name, Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Client is a minor Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client unable to sign due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BER712** Rev 5/14

 Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_