HEALTHWAYS SERVICES
Center for Community Outreach and Development

Consent of Services

Client Name:_____

Client Social Security Number:_____

I, _____, give consent for _____CAL Investments, Inc. DBA: Healthways Services_____to provide treatment/services. I understand that these services include an evaluation and assessment to help determine my treatment or service needs. I also understand that it is important for me to provide detailed and accurate information in response to my evaluation.

After my evaluation and before signing my Individual Service Plan, I will receive a detailed explanation in a language or method understood by me of the proposed treatment program. This explanation will cover the types of services that the Center has determined would be most beneficial. In addition, I will receive an explanation of alternative treatment/services to my proposed treatment program. If there are any changes to my treatment/service program, they will be explained to me and my consent for these changes will be obtained prior to the changes taking place.

I understand that my records may be exchanged as necessary with other components of the Department of Mental Health/Mental Retardation Services Delivery System in your state, which includes State Hospitals, social Security Administration, State Schools, Community Centers, and other designated service providers.

I authorize CAL Investments, Inc. DBA: Healthways Services to disclose any and all records, medical and otherwise (including alcohol/drug treatment and HIV status, If applicable), for the purpose of obtaining financial information to establish and collect charges for services provided; to determine benefit eligibility; and to file/pursue insurance claims for services provided by CAL Investments, Inc DBA: Healthways Services. The assignment of benefits shall expire upon disposition of all pending insurance claims. I may withdraw the consent for services by submitting my withdrawal in writing anytime. Center staff are available to assist me in the withdrawal of consent if needed. This consent will be automatically renewed annually; unless otherwise revised, case closure or terminated in writing by a Healthways Services representative.

_____ _____
(signature of Consumer and/or Representative) Date

_____ _____
(Signature of Guardian and/or Representative) Date

_____
(Relationship of Legal Representative (as applicable)

Legal Status: ( ) Adult ( ) Minor ( ) Guardianship

_____ _____
(Staff Signature) Date