Consent to Services Agreement

MEMBER/PATIENT NAME: _____ **Date:** ____ / _____ / _____

WHAT ARE THE SERVICES AVAILABLE TO ME? Wayspring, through your health plan, offers to help guide you in your health journey. Services available to you may include:

- connection to foundational health services (e.g., health plan case management, primary care provider)
- transition services
- peer recovery support
- access to a recovery referral community
- other community-based resources

CONSENT TO SERVICES:

- I voluntarily agree to receive services provided by Wayspring and its team members.
- I understand Wayspring is providing the services at no cost to me through my health plan.
- I received a copy of Wayspring's Notice of Privacy Practices for Wayspring's Solutions.
- I understand that Wayspring may need to receive medical information about my diagnostic procedures, examinations, and treatment from my healthcare providers.
- I consent to the use and release of my medical information when needed for treatment, payment, and healthcare operations, as permitted by HIPAA and state law.
- I understand photographs, digital, and/or other images may be recorded for treatment purposes.
- I understand that no promises, warranties or guarantees have been made to me about the services offered.

I understand that this Consent to Services is active while services are provided to me by Wayspring unless I tell Wayspring in writing that I no longer want to be a part of the program. Wayspring may recommend resources or healthcare providers to you for services. Wayspring believes these resources are high quality, but at all times the choice whether to engage in these services is yours. I understand that participation in in-person activities includes possible exposure to, and illness from, infectious diseases including influenza and COVID-19. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, and assume full responsibility for my participation.

WHAT TYPE OF MEDICAL INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at your medical providers. This includes information concerning mental illness, use of alcohol, drugs, communicable diseases (such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS")), laboratory test results, medical history, treatment progress, or any other such related information.

For further information or questions on this consent form, please contact us at 1-888-417-4304.

My signature below shows that I understand and agree with the above information and give consent for Wayspring's Services.

_____ _____

Date Signature of Consenter or Legal Representative

_____

Signer's Printed Name

If signed by a Legal Representative, description of Legal Representative's relationship to Consenter:

_____.

MEMBER/PATIENT NAME: _____ **Date:** ____ / _____ / _____

We want to be able to reach you when you are receiving Wayspring's services. May we contact you by:

Phone?	May we leave a voicemail for you?	If yes, may we leave a message with protected health information (PHI)?
☐ **YES**	☐ **YES**	☐ **YES**
☐ **NO**	☐ **NO**	☐ **NO**

Email?	If yes, we may leave a message with protected health information (PHI)?
☐ **YES**	☐ **YES**
☐ **NO**	☐ **NO**

Text?	If yes, we may leave a message with protected health information (PHI)?
☐ **YES**	☐ **YES**
☐ **NO**	☐ **NO**

Please provide emergency contact(s) below:

Name: _____

Phone Number: _____

Relationship: _____

Name: _____

Phone Number: _____

Relationship: _____

My signature below shows that I understand the above contact methods and give consent for contacting me.

_____ _____

Date Signature of Consenter or Legal Representative

_____

Signer's Printed Name

If signed by a Legal Representative, description of Legal Representative's relationship to Consenter:

_____.