NORTH DAKOTA GLOBAL CLIENT CONSENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FIELD SERVICES
SFN 1187 (1-2023)

Clear Fields

Client Name (Last, First, Middle Initial)	Patient ID	Date of Birth

REQUEST AND CONSENT FOR SERVICES

I am requesting services from the Department of Health and Human Services. I understand the Department of Health and Human Services will assess my treatment needs, the services necessary to address my treatment needs, and the availability of such services. Treatment recommendations and treatment options will be discussed with me. Further evaluations may be advisable now or during the course of my treatment. The purpose of these evaluations will be explained to me and are subject to my verbal agreement and consent, unless my written consent is specifically required. I have the right to accept or refuse the proposed treatment.

If I am denied services, I will be notified in writing of the reasons for the denial. At my request, the Department of Health and Human Services may be able to assist me in referral to other possible resources.

The disclosure of my social security number is voluntary and withholding this information will in no way affect my eligibility for services. If I choose to provide my social security number, it will be used only for identifying information.

By signing below, I consent to participate in the assessment of my treatment needs and further evaluations advisable now or during the course of my treatment. I understand that this consent for services is effective for the duration of my treatment.

Client or Legal Representative Signature	Date

ASSIGNMENT OF BENEFITS

I authorize the Department of Health and Human Services to secure payment from any third party payer such as insurance companies or government entities. I understand that my third party payers may or may not cover these charges.

I authorize payment of any insurance or government benefits to the Department of Health and Human Services.

This assignment is voluntary and in effect from the case opening and remain in effect until all claims from this opening have been settled. A copy of this assignment is as effective as the original.

Client or Legal Representative Signature	Date

CONSENT FOR CLIENT PHOTO IDENTIFICATION

The Department of Health and Human Services utilizes an Electronic Health Record, which includes a client photograph. Client photographs are for the purpose of accurate client identification. Client photographs are protected by state and federal laws and regulations governing privacy and confidentiality of health information. By signing below, I agree to have my photo taken for identification and treatment purposes and included in my Electronic Health Record.	
Client or Legal Representative Signature	Date

ACKNOWLEDGEMENT OF CLIENT HANDBOOK

By signing below, I acknowledge that I have received a copy of the Client Handbook including the following: Overview of Mission/Values, Notice of Privacy Practices, Patient Right and Responsibilities, Grievance Procedures, Confidentiality of Substance Use Disorder and Patient Identifying Information, Civil Rights, Safety and Security, Assignment of Benefits and Financial Responsibility.	
Client or Legal Representative Signature	Date