BellVue Health PLLC

984-250-6460 | admin@bellvuehealth.com

CLIENT & REFERRAL FORMS

Consent for Services

Client full name

Date of birth

Service(s) being authorized

Authorized representative name / relationship (if applicable)

Understanding services

I voluntarily consent to the BellVue Health PLLC service(s) identified above. Staff have explained the purpose, expected benefits, possible risks or discomforts, available alternatives, and how services will be delivered. I have had an opportunity to ask questions and participate in planning my care.

I understand that outcomes cannot be guaranteed. I may ask questions, request changes, decline a particular intervention, or withdraw this consent. Staff will explain any effect on my care and help discuss appropriate alternatives or transition needs.

Privacy, rights, and participation

BellVue will protect my information and may use or disclose it as permitted or required by law. Limits may include required abuse or neglect reporting, emergencies, and legally required disclosures. This form does not authorize a separate release of records, telehealth, medication treatment, or services outside those listed above.

Notice of Privacy Practices (choose one)

☐ Received ☐ Offered; copy requested ☐ Previously received

Client rights and complaint process (choose one)

☐ Received and explained ☐ Need further explanation before signing

Questions, preferences, accommodations, or limits on consent

Client / authorized representative signature

Date (MM/DD/YYYY)

Representative authority (if applicable)

Staff name / credentials

Staff: Resolve outstanding questions and confirm legal authority before services begin. Give the client or representative a signed copy.