Attachment A
Service Agreement and Instructions

Consumer Name: _____
Case #: _____
Program/Unit # : _____
Medicaid #: _____

SERVICES AGREEMENT

Welcome to the Center for Health Care Services ("Center"). We appreciate the opportunity to partner with you during your journey toward wellness and health. The Center is committed to providing you with the best care possible and look forward to working closely with you on meeting your needs.

In order to ensure you receive the best care possible, the Center asks that you please agree to the following:

- You and your treatment team will work together to develop a recovery plan. Please follow the plan as written.
    - This may include taking your medications as prescribed by your medical providers, participating in services recommended by your treatment team, and working with care managers who may visit you in the clinic or at home to provide services.
    - If at any point you do not agree with the recovery plan, please let your care manager know what you would like to be changed.
    - If at any point you do not understand any aspect of your recovery plan, please let your care manager know so that they may be able to explain the plan or answer your questions.
- Please cancel or reschedule appointments at least 24 hours prior to the schedule appointment time.
    - If you no-show (miss your appointment or are more than **fifteen (15)** minutes late without the required advance notice) or cancel less than 24 hours prior to the schedule appointment time **two (2) consecutive times,** you will be placed on a walk-in status. You will be able to continue to be seen as a walk-in at the clinic and can schedule a new appointment once you have completed two (2) consecutive walk-in appointments.
    - You must successfully complete **two (2)** consecutive walk-in appointments in order to resume your scheduled appointment process.
- **Medication Refill requests must be made five (5) business days in advance to allow for the necessary authorizations to be granted by your insurer and for the pharmacy to fill the medication.** All medication requests will be reviewed by Center medical staff to determine appropriateness.
- Complete periodic lab monitoring which may include urine screens to ensure that your medication is working safely for you.
- Co-payments, Deductibles, Monthly Ability to Pay (MAP) and Standard fees may apply to the services you receive. Please make sure you understand what fees, if any, may pertain to you. If you have any questions, please ask and we will be happy to assist you.
- Allow your voice to be heard. Share what you need and want, but please do so in a way that is respectful. We want to do what is best for you; you are part of the team, and we need to know any concerns or questions you may have.

By signing this document, you agree to the above statements. This is an agreement between you and the Center for Health Care Services. Remember, if you do not abide by the above agreement, you may be discharged from services.

_____ _____
Signature of Consumer or Legally Authorized Representative Date

_____ _____ _____
Signature/Title of Staff Server ID# Date