ASSURANCE OF FREEDOM OF CHOICE FORM

Campbell
PSYCHOLOGICAL SERVICES

This form verifies that I have been informed and understand that I have a choice of providers available to me.

I have been given freedom of choice in selecting available providers and realize that I may choose to receive treatment at any agency available through my Medical Assistance Behavioral Health Managed Care Organization (insurance). I am aware that I have a right to choose my provider and treatment options. If I wish, alternative providers will be made available to me through my insurance's Member Services Department.

PerformCare Member Services
Capital Region – (888) 722-8646
Franklin/Fulton – (866) 773-7917

Community Care Behavioral Health
Adams – (866) 738-9849
York – (866) 542-0299

I am also aware that my provider will discuss with me all treatment options and what the treatment options involve including advantages and/or disadvantages of each type of treatment.

Family members and significant others will be included in treatment, if I wish them to be.

_____ _____
Client Name Date of Birth

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date