Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[*Practice Header Here*]**

**Consumer Acknowledgement**

**24 Hour Behavioral Health Crisis Coverage**

In the event of a behavioral health crisis after business hours please call [**Practice name & phone number.]** Crisis calls will be returned within **[\_\_\_\_\_\_\_\_\_]** minutes. In the event of a medical emergency please call 911 or have someone take you to your nearest emergency room.

Should your provider not be available after business hours, you will be instructed to call [**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**; the person/agency with whom there is a written agreement to provide coverage in your provider’s absence.

I acknowledge that I have received a copy of my provider’s 24 hour/ after-hours behavioral health crisis coverage number/information. I understand that this information indicates how to access support for after-hours behavioral health crises only.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Consumer /Legally Responsible Person (Relationship) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Provider Date