



## Consent for Follow-up Contact / Referral – Outpatient

Meier Clinics® is committed to evaluating the effectiveness of our treatment program. We make every attempt to contact each Client by a mailing or by telephone some time within the year following treatment to determine whether our program had a positive and lasting impact. Information collected helps us evaluate and improve the quality of our services. All information provided is kept confidential.

We are requesting your assistance by agreeing to participate in our follow-up program. Your voluntary participation would include a follow-up contact by one of our staff members by mail and/or by telephone. This contact would take no more than 10-15 minutes. To ensure that we remain in touch, please provide the names and phone numbers of two relatives/friends who are aware of your treatment and would know how to reach you if we are unable to locate you.

**I agree to be contacted by a Meier Clinics® employee for follow-up. I am fully informed of the purpose of this and that my identity will be kept confidential. I understand that I have the option to rescind this consent at any time and it will become null and void.**

### PLEASE COMPLETE THIS SECTION IF YOU AGREE TO BE CONTACTED

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Gender: Female  Male

Age: Below 13  13-18  19-30  31-45  46-60  Over 60

Ethnicity: Caucasian  Hispanic  African American  Asian  Other: \_\_\_\_\_

Client's Signature: \_\_\_\_\_

1. Relative/Friend Name and Phone #: \_\_\_\_\_

2. Relative/Friend Name and Phone #: \_\_\_\_\_

### PLEASE COMPLETE THIS SECTION IF YOU PREFER NOT TO BE CONTACTED

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Signature: \_\_\_\_\_

## Referral Thank You

Thank you for choosing Meier Clinics® for your counseling needs. We would also like to thank whoever may have referred you to our clinic. **Your name will not be included in our thank you note unless you indicate otherwise.**

Name of Referral Person: \_\_\_\_\_

Church/Organization: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

You have permission to mention me by name in the thank you note.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Meier Clinics® Witness: \_\_\_\_\_

Copy given to MC Staff by/date: \_\_\_\_\_