PROVIDER SELECTION FORM

Consumer Name:_____ Medical Record #:_____

Medicaid Number:_____ Date of Birth: _____

I, _____, have been provided a list of service providers. My signature below confirms that I have selected my service provider freely, without influence, pressure or coercion, direct or indirect, from any staff employed by Transformative Life Center, LLC. I have selected ***Transformative Life Center, LLC.*** to be my service provider.

Consumer Signature: _____ *Date:* _____

Legal Guardian Signature (if applicable): _____ *Date:* _____

Witness Signature & Title: _____ *Date:* _____