BEHAVIORAL HEALTH SERVICES LETTER OF TERMINATION

Member Name: ***FirstName LastName*** Recipient ID: ***123456789***

I, ***FirstName Lastname***, have discussed my services with the clinician identified below and understand that the billing system reflects that I have been receiving services at another agency. After discussing my service options with the clinician, including the possibility of receiving designated services from both agencies, I have decided that I would like to discontinue receiving services from the other agency, and begin receiving services from ***AGENCY NAME*** as of ___________________ *(MM/DD/YY).*

My reason for ending services with the other agency is as follows (check all that apply):

- ☐ Inconvenient location/hours
- ☐ Concerns about the quality of services received
- ☐ Does not have a good relationship with staff
- ☐ Unaware of other agency
- ☐ Provider doesn't offer all desired services
- ☐ Moved or new provider is closer or more convenient
- ☐ Declined to respond
- ☐ Other (fill in blank) ____

I understand that by signing this form I will be ending all of the services previously received at the other agency (including any medication services).

____ _____________________
Member Signature (14 and over must sign) Date Signed

____ _____________________
Legal Guardian Signature Date Signed

____ _____________________
Name of LBHP, Credentials NPI

____ _____________________
LBHP Signature Date Signed

SAMPLE