



Patient Discharge Reconsideration Request Form

Patient Full Name: _____

Patient Date of Birth: _____

Patient Current Phone Number: _____

Patient Email Address (If applicable): _____

Date of Original Discharge: _____

Reason for Reconsideration:

Patient Signature: _____

Date: _____

Office Use Only

Received by: _____

Date: _____

Patient MRN: _____



Behavioral Reinstatement Agreement

Conditions of Reinstatement (Check all that apply):

- ☐ Respectful communication required at all times
- ☐ Compliance with appointment attendance policy
- ☐ Compliance with treatment plan
- ☐ Adherence to financial and sliding fee policy
- ☐ No disruptive, threatening, or aggressive behavior

Monitoring Period:

- ☐ 90 Days
- ☐ 6 Months
- ☐ 12 Months

Patient Signature:

UFHC Signature:

Date:
