ADAPT

Consent to Treatment

By signing this form, you are stating that you have received the following information in simple, non-technical terms.

(1) The specific condition to be treated;
(2) The recommended course of treatment;
(3) The expected benefits of treatment;
(4) The probable health and mental health consequences of not consenting;
(5) The side effects and risks associated with the treatment;
(6) Any generally accepted alternatives and whether an alternative might be appropriate;
(7) The qualifications of the staff that will provide the treatment;
(8) The name of the primary counselor;
(9) The client grievance procedure;
(10) The Client Bill of Rights as specified in §448.701 of this title;
(11) The program rules, including rules about visits, telephone calls, mail, and gifts, as applicable;
(12) Violations that can lead to disciplinary action or discharge;
(13) Any consequences or searches used to enforce program rules;
(14) the estimated daily charges, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources and insurance benefits;
(15) ADAPT services and treatment process; and
(16) Opportunities for family to be involved in treatment.

- I understand that I am being treated for: _____
- ADAPT's staff recommends you participate in CD Treatment for a minimum of _____ weeks.
- Your Primary Counselor will be: _____ Credentials _____

By signing this form I am consenting to chemical dependency treatment. I understand the specific condition to be treated and level of care to be received; the programs services and treatment process; the expected benefits of the treatment; the probable health and mental health consequences of not consenting; side effects and risks associated with treatment and generally accepted alternatives. I have been provided with the estimated daily charge, including an explanation of any services that might be billed separately; the qualifications of the staff who will provide the treatment; the name of the Primary Counselor; expectations for client participation.

Client's Signature: _____ Date: _____

Parent/Guardian/S.O.:_____ Date: _____

Staff Signature: _____ Date: _____