Client Name:
EMR No.
DOB:

AUTHORIZATION AND INFORMED CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. I **Consent**: I voluntarily consent to this admission into **All About Recovery Inc.**

2. **Emergency Treatment and/or Hospital Transfer:** I understand while at **All About Recovery Inc**., the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate by my attending physician, their assistants and designees? I consent to such emergency treatment and/or transfer to a hospital and indemnify the **All About Recovery Inc.** and its staff, or any physician who may be in attendance, from any loss resulting from such emergency treatment and/or transfer.

3. **Medical Consent:** The Client is under the care of their attending physician, or the physician assigned by **All About Recovery Inc.** and the undersigned consents to examination and laboratory procedures. Medical treatment is rendered under the order of the physician, or his designee.

4. **Drug Screen Consent:** I further understand that part of the treatment offered by **All About Recovery Inc.** may require my submitting to urinalysis for drug/alcohol content, psychological testing and other such similar procedures and that the consent that I have given in this document shall include, but not limited to, the same. The results of urinalysis will be used for treatment planning purpose and will not be used for treatment planning purposes and will not be released without Client consent. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person whom it pertains or as otherwise permitted by CFR 42, part 2.

5. **Conditions of Treatment:** I acknowledge and understand that no promises or guarantees have been made to me regarding the final outcome of my treatment by **All About Recovery Inc.** and I do hereby absolve **All About Recovery Inc.** from any liability in the event its treatment of my person is unsuccessful either in the short or long term.

6. **Rules & Regulations:** I hereby agree to comply with and abide by the policies, rules, and regulations of **All About Recovery Inc.** in my treatment.

7. **Release of Information: All About Recovery Inc.** may disclose all or any part of the Clients record to any person or corporation which is or may be liable under a contract to **All About Recovery Inc.** , or the Client, or to a family member of Client, all or part of the facility charges. **All About Recovery Inc.** may further disclose all or said part of the Client's record to the referring doctor, hospital, clinic, and in case of minors, may disclose aftercare forms to the Client's school system.

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8. **Personal Valuables: All About Recovery Inc.** shall not be liable for the loss or damage to any

Select	Items	Comments
☐	**Credit Card**	
☐	**Debit Card**	
☐	**Dentures**	
☐	**Documents**	
☐	**Eyeglasses**	
☐	**Jewelry**	
☐	**Laptop**	
☐	**Money**	
☐	**Phones**	
☐	**Contact Lenses**	
☐	**Other articles of value**	

9. **Drugs:** The Client shall neither use, nor keep, any drugs or drug appliance/apparatus not prescribed by or on behalf of the attending physician. All medications should be dispensed/taken as directed by the physician during the Client's current stay. Any such contraband found in the Client's possession will be removed and destroyed.

10. **Client Acknowledgements:**

A. I consent for **All About Recovery Inc.**, to administer treatment.

B. I understand that no guarantee or **assurance** is being made as to the results that may be achieved.

C. I authorize the release of information from **All About Recovery Inc.'s** medical service record to any insurer, compensation carrier, or welfare agency that may be providing financial assistance for the treatment.

D. I Authorize payment directly to **All About Recovery Inc.** for any payment of benefits derived from my medical claim.

Client Name:

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E. I Understand that staff will keep all my personal information confidential, except for the following special situations as required by law or quality assurance:
   1. If I sign a release of information to another agency or person.
   2. If I indicate a desire to hurt myself or someone else, the staff has a duty to ensure people's safety; confidentiality may have to be waived to do so.
   3. If a minor client (17 years old or younger), an elderly client or disabled client indicates that they have been physically or sexually abused, neglected, or abandoned, the staff is required by law to report this.
   4. If a judge issues a court order for the release of records or information.
   5. Accrediting and funding organizations and Center staff periodically review client's charts, to ensure quality client care, provide staff supervision and perform billing functions.

F. I agree that in order for the **All About Recovery Inc.** to serve the most clients, I accept the following policy:

   Appointments may be cancelled if staff is notified at least four (4) hours before the scheduled session. If such notice is not given to cancel two consecutive scheduled sessions, the client may be discharged from treatment.

G. I certify that to the best of my knowledge, all information supplied by me is correct and that I will be responsible for all charges for treatment, based upon my ability to pay.

H. I understand that as a patient/guardian, I am protected through a grievance procedure, which is free from coercion, discrimination, and reprisal and that I have the right to file a grievance if it becomes necessary.

I. I represent and warrant that all information submitted is true and correct and that I have complete and proper authority to involve the above-referenced patient for treatment at the Center.

J. I understand that **All About Recovery Inc.** receives, originates, maintains, discloses, & uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. This information may be used to perform the following tasks: diagnose my medical/psychiatric/psychological condition, plan my treatment, communicate with other health professionals concerning my care, and document services for payment/reimbursement, and conduct routine health care operations, such as quality assurance audits.

K. I have had this entire form explained to me.

The undersigned certifies to understand and agree to above, receiving a copy thereof, and is the Client, or is duly authorized by and on behalf of the Client to execute the above and accepts its terms personally and upon the Client's behalf.

Client Signature: **Date/Time:**

Staff Present: **Date/Time:**