

## INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_, am being admitted to Retrospective Solutions for \_\_\_\_\_.  
As a condition of treatment, I acknowledge the following items and agree to them.

1. The program's treatment process is designed to assist me in an ongoing recovery effort for my diagnosis of **(list diagnosis)** \_\_\_\_\_.
2. Retrospective Solutions provides Psychotherapy, SA Counseling, Basic Parenting, and Advanced parenting services and Anger Management. The program that is recommended for me is **(circle one): Advanced Parenting, Substance Abuse Counseling, Substance Abuse Psychosocial Assessment, Anger Management** and, I am required to attend all individual, group and family counseling, education about the disease concept of chemical dependency and the various effects of specific drugs through the use of counseling, written assignments and education while enrolled in this level of care. **Please be advised you are only allowed to miss 3 group sessions, if you accrue more than 3 absences you will be unsuccessfully discharged from the program in which you are enrolled in.**
3. The benefits of treatment that I may expect are learning ways to re-create a lifestyle that allows me to achieve personal, social and spiritual growth without reliance upon mind altering chemicals. This program is designed to involve family members in my treatment experience; therefore, I agree to invite family members to all appropriate meetings and events that take place at Retrospective Solutions.
4. The consequences of not entering treatment of any kind for my current condition may be dire. Chemical dependency/Mental Health barriers are a progressive illness that has the tendency to get worse. If left untreated, eventual outcomes may result in increased health risks, legal problems, or other major life crises.
5. As I am in treatment, I may experience unique side effects and risks associated with the consequence of using illegal drugs and/or alcohol. These side effects can be diminished as I remain in treatment and continue my recovery efforts. No specific outcomes can be guaranteed.
6. I have the right to refuse medications at any time unless a physician orders medication to prevent harm to myself or others.
7. I may choose to participate in an alternative level of care, which may include a less restrictive or self help program such as Alcoholics Anonymous, Narcotics Anonymous, and Rational Recovery; a more individualized approach with psychotherapy or "just say no." You may have tried alternative treatments or programs and found them to have not worked for you. You are free to leave Retrospective Solutions or seek some other level of care within the Retrospective Solutions programs, at any time, if you find this level not working for you. Of course, dependent upon your assessment and counselor recommendation, a lower level of care may not be possible until your current treatment episode is completed. Reassessments may be requested at any time.
8. The staff members who will provide the services are Master Level Counselors, Licensed Chemical Dependence Counselors or Counselor Interns, under the supervision of a licensed counselor. Some educational presentations may be given by unlicensed (certified) persons or persons who are recovering from drug and/or alcohol abuse.
9. The name of your primary counselor will be \_\_\_\_\_, and you have the right to request another Retrospective Solutions counselor at any time.
10. As a client of Retrospective Solutions you will receive Retrospective Solutions Client Grievance Procedures that outline your rights to file a grievance and whom to contact if filing a grievance.
11. Confidentiality and Client Rights (§448.701): I acknowledge that all Client Rights listed on the Notice of Privacy and Confidentiality have been communicated to me by Retrospective Solutions staff and I have received a signed copy of such rights. All information disclosed within these sessions is strictly confidential and may not be revealed to anyone outside the facility staff without the written permission of the client or the client's family. The only exceptions are when disclosure is required or permitted by law.

Those situations typically involve substantial risk of physical harm to oneself or to others, or suspected abuse of children or the elderly. In the event of audits and evaluations due to licensing and accreditation processes, all auditors will be required to sign a Confidentiality Pledge for Drug Records. An accounting log will be in place



12. As a client of RETROSPECTIVE SOLUTIONS, I agree to follow all RETROSPECTIVE SOLUTIONS program ground rules as listed in the Client Handbook:

**A.** Conditions of treatment require *abstinence from all drug and alcohol use for the entire treatment program*. If I am unable to make this commitment, I will discuss other treatment options with the program staff.

**B.** I will discuss any drug or alcohol use with the staff and group while in treatment.

**C.** Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients.

**D.** I understand that any incident of fighting, carrying weapons, or threatening behavior towards staff or other clients will result in termination of services.

**E.** I agree not to become involved romantically or sexually with other clients or staff.

**F.** I understand that it is not advisable to be involved in any business transactions with other clients.

**G.** I understand that there are rules and specific times for making phone calls, having visitors, receiving mail and giving/accepting gifts to and from Retrospective Solutions staff.

13. I accept these program rules and realize that if these rules are violated I may be terminated from the program or placed on probationary status for a specified length of time.

14. I understand that to enforce program rules Retrospective Solutions has the authority to search my possessions. If any violation in Retrospective Solutions program rules occurs, I understand that this is grounds for termination from program.

15. I am responsible for payment of services received at Retrospective Solutions. If I have insurance Retrospective Solutions will submit claims to my insurance provider for reimbursement. However, all co-payments are detailed on the Assignment of Benefit form, which I understand and have signed, and are due at admission of treatment. In cases where my insurance company reimburses at a lower rate than stated on the AOB form, I am responsible for the outstanding balance to Retrospective Solutions.

16. As stated in #2 of this Informed Consent, Retrospective Solutions providing me with the recommended treatment service, based on the 12-Step and evidence based clinical protocols, consisting of individual and group sessions, education, family involvement. I understand that the treatment process combines clinical and medical elements, which were developed to engage and motivate me through my entire treatment episode.

17. As a client at Retrospective Solutions, I realize that my family may become involved in my treatment with my written authorization, at the scheduled meetings times, and provided family groups and sessions.

I have had the above information explained to me in a clear manner and give voluntary consent to treatment at Retrospective Solutions. In signing this authorization, I certify that I am not subject to any medication, illness or other impairment that might affect my ability to comprehend or understand this consent. I have received a copy of this consent, the Grievance Procedure, Notice of Privacy & Confidentiality (Client Rights), and Assignment of Benefit.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Custodial Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
RETROSPECTIVE SOLUTIONS Staff Signature

\_\_\_\_\_  
Date

