TREATMENT AGREEMENT & CONSENT

Adult client or guardian of minor client should sign

Client Name: _____ **Date of Birth:** _____

CLIENT RIGHTS: I read and understood the *Client Rights Orientation* page, including what to expect in the assessment, treatment planning, treatment & discharge process; client rights & responsibilities; agency rights & responsibilities; grievance process; and treatment philosophy

HEALTH & SAFETY: I read and understood the *Health & Safety Orientation* page, including wellness education; Adapt's policies on substance use, weapons, abuse reporting, emergency procedures; Adapt's responsibility to respond to client risk of danger to self/others, and after-hours crisis/emergency phone numbers.

LIMITS TO CONFIDENTIALITY: I understand that information about the above-named client will not be shared with anyone without my consent, except under the following conditions:

- Adapt is required to report suspicion of child/elder/disabled adults abuse & neglect.
- Adapt is required to release information for the purpose of abuse/neglect investigations.
- Adapt is allowed to warn potential victims if we believe that their lives are in danger.
- Adapt is required to release a copy of records and/or testimony if subpoenaed in court.
- Adapt is obligated to report Medicaid/insurance fraud to state authorities and the insurance plan.

INVESTIGATIONS: In the event that Adapt or any of its staff are under investigation for fraud or other wrongdoing, I authorize Adapt to fully cooperate with legal and regulatory entities (Agency For Healthcare Administration, Department of Health, Behavior Analysis Certification Board, law enforcement), including sharing protected client information related to the provision of services.

COMMUNICATION SECURITY: I understand that Adapt staff are required to use encryption when emailing client information, in order to protect its privacy. I understand that cellular phone communication is not secure, however I authorize Adapt staff to use cellular phones to communicate about the above-named client with me and others that I have approved.

STATEMENT OF AUTHORITY TO CONSENT: I certify that I have the legal authority to consent to behavioral health treatment, release of information, and all legal issues involving the above-named client. **I further certify that there is no court order that requires consent from any other parent/guardian, in addition to my own.** If my status as legal guardian changes, I will immediately notify Adapt Behavioral Services of the name, address, and telephone number of the new guardian.

CONSENT FOR TREATMENT & COORDINATION OF CARE: I consent for the above-named client to [participate in assessment and treatment through Adapt Behavioral Services, including sharing relevant confidential information to coordinate care with others included in services (e.g., client's family members, school personnel, other service providers).

I understand that I may revoke consent for the above at any time, however, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED

Client/Guardian Signature: _____ **Date:** _____

Guardian Name (printed): _____ **Relationship:** _____
(required if client is a minor)