ALTERNATIVE PATHS, INC.
CONSENT FOR PARTICIPATION IN TREATMENT

I, _____ AGREE TO PARTICIPATE IN MENTAL HEALTH and/or
(CLIENT NAME) ALCOHOL and OTHER DRUGS (AoD) TREATMENT
OFFERED BY ALTERNATIVE PATHS, INC.

Alternative Paths, Inc. (the Agency) offers the following outpatient services which may be appropriate to your treatment needs: Diagnostic Assessment, Pharmacological Management, Individual/ Group Counseling, Community Psychiatric Support Treatment, Case Management, and Crisis Intervention. I have been informed of the purpose and benefits of the services/ treatment, and any appropriate alternatives to these services. This information was explained to my satisfaction, provided in a timely manner to facilitate my decision making, and informed consent or refusal. I understand that all treatments can have side effects and risks; these have been explained to me prior to engaging in any specific service. I also understand that no guarantees can be given as to the outcome of treatment.

Alternative Paths will provide Drug Testing in addition to other treatment services for persons participating in the agency's outpatient and intensive outpatient substance abuse treatment programs. An individual participating in these programs may be subject to random drug testing at various times throughout the course of treatment, beginning when an individual requests or is referred to a substance abuse assessment. Other times in which drug tests may be requested are: at the time of disclosure of substance use, for MAT (Medication Assisted Treatment) eligibility, at the request of medical staff, suspicion of AoD use by AP staff, or by court/probation request. In order for a client to be considered a successful discharge from AoD services the client must have 30 days sobriety through documented negative drug tests. Any refusal of a drug test will be treated similarly to a positive screening and may result in termination from program with a referral for an increase in LOC (level of care).

I understand that prior to being scheduled for an initial psychiatric evaluation, the individualized service plan (ISP) will be completed by a licensed professional, such as agency nurse. Agency nurse will complete two phone call attempts in order to schedule the ISP.

I understand that the Agency's treatment providers shall engage with me in a mutual dialogue and collaborative process in planning for my individualized treatment including, expression of my choice regarding the composition of the service delivery/treatment team, within the Agency's ability to provide services as clinically and ethically appropriate. This shall include, but not be limited to, on-going discussion on the purpose, effectiveness, side-effects and any changes of medications as is applicable to my treatment. Family and other persons I identify as sources of support are invited to participate in my treatment with my consent or legal right. I understand that the Agency cannot be held liable for the services offered if I do not follow the mutually agreed upon treatment or discharge plans, or if I do not keep the appointments made with the professionals at the agency, or if I choose to withdraw consent for treatment, or choose to refuse treatment.

I understand that in order to protect the privacy and confidentiality of all individuals served at Alternative Paths, photographic, video and audio recording during the provision of services or in any office location of Alternative Paths is strictly prohibited. Violations may result in termination of services with a referral to another provider.

I understand that information shared with agency personnel will be confidential and consistent with federal, state, and accrediting standards. Agency records are subject to review by the Mental Health Board, 3rd party payors, and accrediting sources for auditing. I understand that any other information about my treatment will not be released without my permission.

Efforts to develop alternative approaches collaboratively with the client are as follows:

_____

_____

_____ _____ _____ _____
Client Signature Date Witness Signature Date

_____ _____
Guardian Signature (If applicable) Date

REVOCATION OF CONSENT FOR PARTICIPATION IN TREATMENT

I, _____, am revoking consent to treatment for the services agreed upon above. All terms of the previous agreement will be null and void.

Efforts to ensure that the client understands the implication and potential consequences of refusing or withdrawing consent for treatment are as follows:

_____
_____
_____
_____

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date

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