Consent for AoD Treatment Fee Agreement Receipt of forms

Client Name: _____ **Client ID:** _____

Name of Agency Rendering Treatment / Services:

_____ provides services to individuals and/or their families who provides services to individuals and/or their families who have substance abuse / chemical dependency problems. The staff members are trained to provide appropriate treatment / services as needed in this area.

I have read and understand the information regarding consent to AoD treatment/services. I have also received a copy of and understand the following:

I will pay $ _____ for each session

☐ Yes ☐ No Program rules and expectations

☐ Yes ☐ No Client rights policy and grievance procedures

☐ Yes ☐ No A written summary of the Federal Laws and regulations pertaining to the confidentiality of client records as required by 42 CFR, Part 2.

☐ Yes ☐ No Education materials on tuberculosis, hepatitis B and C and HIV/AIDS.

I agree to treatment offered by the above mentioned agency rendering treatment/services for:

☐ Myself ☐ My Child _____

Or the person for whom I am legal guardian/custodian

_____ _____
Client Signature Date

_____ _____
Legally Responsible Person Signature Date

_____ _____
Staff Signature/Credentials Date