Admission Agreement/Informed Consent

The Undersigned hereby applies to Alarus Healthcare, LLC as a client in their outpatient program. Alarus Healthcare, LLC wants you to be aware of your rights as a client and asks for your informed consent to receive treatment. We follow the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). This application is subject to the conditions hereinafter set forth.

1. I hereby volunteer to such outpatient treatment as deemed necessary or helpful by Alarus Healthcare.
2. The outpatient program is operated Monday through Friday 9 am to 9 pm.
3. The benefits from therapy may include, but are not limited to, working together to better meet your needs, improve communication skills, more satisfying and intimate relationships, and a better understanding of your personal goals and values.
4. The treatment process includes a series of one on one individual sessions and/or group therapy, AODA Outpatient or AODA IOP (Intensive Outpatient).
5. An appropriate family member or significant other may be expected to participate in a family conference and/or in a Family Program to be recommended by the treatment staff.
6. I will actively participate in my treatment plan and discharge planning with my counselor.
7. I understand that if I am a client in the alcohol and/or other drug program, I will be requested to submit a drug screen as part of the program requirements, and the fee for the drug screen may be my responsibility.
8. The therapist may suggest alternative treatment modes and will make referrals when appropriate or necessary.
9. I understand If I do not comply to the treatment program I may be raised to a higher level of care or terminated from the program.
10. I understand there will be a charge for missed appointments without a 24 hour notice.
11. If you forgo therapy, it is possible for your problems not to be resolved, or to become worse.
12. I have been screened, educated, and referred, if applicable, for communicable diseases.
13. If I have a grievance, I agree to fully utilize the grievance procedure provided by Alarus Healthcare acknowledge that I received a copy of my rights under HSS 94.
14. It is understood that foregoing conditions of admission govern the treatment and care of all clients admitted to Alarus Healthcare.
15. This informed consent will be in effect until such time that you are discharged from treatment, either by mutual agreement with your therapist/case manager, or through your own decision, or for 12 months, whichever comes first.
16. You have the right to withdraw this informed consent at any time in writing.

Your rights may only be denied in certain circumstances.

1. When there is danger to the life or health of the client, or potential harm to others.
2. Suspected cases of child abuse or neglect (s49.98)
3. A lawful order of the court to which you must comply.

I hereby certify that this form has been fully explained to me and that I have read and understand its contents.

Client Signature_____ Date: _____

Parent or legal guardian_____ Date: _____

Witness Signature_____ Date: _____