Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREATMENT**

I consent to care and treatment by Aspen Counseling & Consulting, LLC (“Aspen”). I also consent to treatment and care by physicians, behavioral health providers, and healthcare providers who are not employees or agents of Aspen, but are authorized by Aspen to provide treatment and care to me. I understand that my care team at Aspen may include resident physicians and students or other trainees.

I acknowledge that the specific benefits and risks of treatment; factors influencing the likelihood of success; treatment alternatives; and my right to refuse treatment services have been explained to me. I acknowledge that sufficient information and explanation concerning the nature and purpose of Aspen treatment programs, the procedures, and methods of treatment have been explained to me in order for me to make an informed judgment about my treatment. I am aware that mental health and substance use disorder treatment is not an exact science, and I acknowledge that no one has made any guarantees about the results of my treatment.

## I UNDERSTAND THAT ALL INDEPENDENT PRACTITIONERS FURNISHING SERVICES ARE NOT EMPLOYEES OR AGENTS OF ASPEN COUNSELING & CONSULTING, LLC.

## VOLUNTARY NATURE OF PROGRAM

I voluntarily consent to treatment at Aspen and that the success of my treatment rests in my willingness to cooperate with the treatment process. I acknowledge that I may leave treatment at any time. I hereby release Aspen from all responsibility for any acts or consequences, medical or otherwise, which may result from my leaving treatment without authorization.

**ASPEN RULES**

I agree to cooperate and abide by all Aspen policies. I understand that Aspen may terminate services if I fail to engage in treatment, if I do not attend scheduled appointments, or if I do not follow treatment recommendations. Aspen Counseling & Consulting LLC reserves the right to suspend services if you have more than one failed appointment or cancelled appointment with less than 24 hours’ advance notice. Aspen Counseling & Consulting LLC does **not** prescribe Medical Marijuana.

**CLIENT RIGHTS AND CONFIDENTIALITY**

I have had my client rights and responsibilities explained to me. I understand that my treatment at Aspen is subject to strict federal and state confidentiality laws. During the program, such as in group sessions, I may learn confidential information about other clients in treatment. I agree to keep all information about other clients, including their participation in services, in the strictest confidence.

# PERSONAL PROPERTY AND ASPEN PROPERTY

I understand that Aspen is not responsible for personal property that is lost, stolen, damaged, or left behind. I accept responsibility for any damage or destruction that may occur to Aspen property as a result of my behavior while I am an Aspen client.

**CONSENT TO VIDEOTAPE / AUDIOTAPE**

I understand that some Aspen facilities may employ video surveillance equipment for security monitoring purposes. I further understand that it is possible that my image will be captured by that equipment and that such images are protected by state and federal confidentiality laws. I also understand that some of my treatment sessions may be audio taped for internal performance improvement and quality assurance.

I understand that if I am under the age of 18 and leave Aspen against medical advice that my photograph may be released to law enforcement authorities.

**CONSENT FOR ELECTRONIC COMMUNICATION**

I give my consent for Aspen to communicate with me electronically via email, voicemail, or text message. I understand and acknowledge that there are risks inherent in the electronic transmission of unencrypted information over the internet or cellular networks and that such communications may be lost, delayed, intercepted, corrupted, or otherwise not delivered.  I understand I may revoke this consent in writing to the Medical Records Department at Aspen at any time.

In the case of a crisis or emergency, email and text message communication is not an appropriate method of reaching Aspen staff.

**Yes  No**

Appointment Communication Preference:  **Home Phone**  **Cell Phone**

Appointment Reminder Preference:  **Voicemail**  **Text**

**Authorization for Medical and Dental Treatment and financial responsibility**

I authorize Aspen to seek and refer to medical or dental treatment as deemed appropriate and necessary by Aspen staff. I understand Aspen utilizes third party services for laboratories, pharmacies, and other medical services and even if recommended by an Aspen physician, these services represent an additional cost that I am responsible for. If I require emergency services while receiving treatment, I will be responsible for any costs charged by third parties who provide these emergency services.

**I certify that I have read the above form, that I understand its contents, and that I have asked all questions I have about this form. I agree to be bound by the terms of this consent form.**

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Client Name (Please Print) Client ID# Client DOB

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Client Signature Date

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Parent/Guardian Signature, *if applicable* Date

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Staff Witness Signature Date