rosecrance

ROSECRANCE AND AFFILIATES
CONSENT FOR TREATMENT

Client Name: _____ Client ID: _____ Client DOB: _____

CONSENT TO TREATMENT

I consent to care and treatment by Rosecrance, Inc., its affiliates, and its employees. I also consent to treatment and care by physicians, behavioral health providers, and healthcare providers who are not employees or agents of Rosecrance, but are authorized by Rosecrance to provide treatment and care to me ("Rosecrance Providers"). I understand that my care team at Rosecrance may include resident physicians and students or other trainees.

I understand that my treatment and care will include mental health or substance use disorder treatment, including but not limited to group, individual, and family counseling; family program; educational lectures; recreational and art activities; and AA/NA/CA meetings. I understand that Rosecrance is an integrated behavioral health system with multiple treatment programs. By signing this form, I understand I am consenting to treatment in any program recommended by my Rosecrance providers.

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 Rosecrance 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.

INDEPENDENT PHYSICIANS

I have been informed and understand that most physicians providing services at Rosecrance are not employees, agents or apparent agents of Rosecrance, but instead are independent medical practitioners who are responsible for their own judgment or conduct. These independent medical practitioners are not employees of Rosecrance and Rosecrance is not responsible for their actions. A list of physicians who are independent medical practitioners will be provided upon request.

VOLUNTARY NATURE OF PROGRAM

I voluntarily consent to treatment at Rosecrance 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 Rosecrance from all responsibility for any acts or consequences, medical or otherwise, which may result from my leaving treatment without authorization.

ROSECRANCE RULES

Upon admission, I received a Treatment Guide. I agree to cooperate and abide by all Rosecrance Rules contained in the Treatment Guide. I understand that Rosecrance may terminate services if I fail to engage in services, if I do not attend scheduled appointments, if I do not follow treatment recommendations, or if I fail to comply with all rules in the Treatment Guide. I understand that, upon admission to Rosecrance residential services and from time-to-time thereafter, my person and property will be searched for contraband. While in treatment, all alcohol, drugs, medications without appropriate prescription, or drug paraphernalia in my possession and/or brought onto Rosecrance property will be destroyed.

CLIENT RIGHTS AND CONFIDENTIALITY

I have had my client rights and responsibilities explained to me. I have been given a copy of and clearly understand the statement that describes the rights I have in treatment. I understand that my treatment at Rosecrance 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 the program, in the strictest confidence.

PERSONAL PROPERTY AND ROSECRANCE PROPERTY

I understand that Rosecrance 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 Rosecrance property as a result of my behavior while I am a Rosecrance client.

RELEASE OF LIABILITY

I understand that part of my treatment may involve activities including but not limited to: 1) use of fitness/gym equipment, 2) participation in sports and recreational activities, 3) participation in experiential therapies, and 4) transportation by Rosecrance ("Activities"). These Activities involve the risk of accident, personal injury, and property damage. I understand that I can refuse to participate in these Activities. I agree for myself, my heirs, assigns, or representatives to waive, release, and forever discharge Rosecrance, its affiliates, and its employees from and against any and all claims, liabilities, and causes of action, whether foreseeable or unforeseeable should any accident occur involving personal injury or property damage during my participation in treatment.

CONSENT TO VIDEOTAPE / AUDIOTAPE

I understand that some Rosecrance 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 Rosecrance against medical advice that my photograph may be released to law enforcement authorities.

CONSENT FOR ELECTRONIC COMMUNICATION

I give my consent for Rosecrance 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 Rosecrance at any time. In the case of a crisis or emergency, email and text message communication is not an appropriate method of reaching Rosecrance 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 Rosecrance to seek and refer to medical or dental treatment as deemed appropriate and necessary by Rosecrance staff. I understand Rosecrance utilizes third party services for laboratories, pharmacies, and other medical services and 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. Rosecrance is not responsible for the actions and decisions of third party providers.

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.

Client Name (Please Print)	Client ID#	Client DOB

Client Signature	Date

Parent/Guardian Signature, *if applicable*	Date

Staff Witness Signature	Date