Consent for
Alcohol or Drug
Assessment and Treatment

Name: _____

DOB: _____

Record #: _____

I understand that as a patient of BrightView Health, LLC ("BrightView") I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months.

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in an alcohol or drug assessment and/or treatment by staff from BrightView. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
   e. Probable consequences of not receiving treatment

   Treatment will be conducted within the boundaries of Ohio substance abuse treatment laws. I understand that a range of mental health professionals, some of whom are in training, provides BrightView services. All professionals-in-training are supervised by licensed staff.

2. **Benefits and Risks to Assessment/Treatment:** Assessment and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this assessment include diagnosis, assessment of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects.

3. **Research:** As part of ongoing client satisfaction surveys and future research some information from your file may be submitted to third parties or utilized by BrightView. Your identifying information will not be shared, however, general information (age, race, and sex) may be shared.

4. **Charges:** Fees are based on the length or type of the assessment or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. **Confidentiality:** Information from my assessment and/or treatment is contained in a confidential medical record at BrightView. I understand that BrightView will obtain my photograph for the purpose of providing me with a BrightView identification card. This same photograph will be stored electronic health records as a primary form of my identification. The purpose of these photos is to be in compliance with BrightView's policy and procedures of using two forms of identification to recognize each client.

   I understand surveillance cameras are located throughout BrightView for routine observation. I further understand surveillance cameras that do not record are located in the patient restrooms for the purpose of monitoring my compliance when providing a urine drug screen.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician.

7. **General Laboratory Testing and Reporting:** Laboratory testing, including, but not limited to blood work, may be requested. This testing may be to identify diagnosis of HIV, Hepatitis B or C, or other bloodborne disease. Positive results from this lab work must be reported to the appropriate authorities. I authorize BrightView to disclose any reportable infectious disease and information regarding that infectious disease to my local and state health department for purposes of coordinating care. Only the minimum amount of protected health information needed to accomplish the intended purpose of the use is permitted for these disclosures. I understand that my alcohol and/or drug abuse treatment records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will remain valid 90 days after discharge.

8. **Toxicology Testing:** I understand that upon admission and throughout my course of treatment, I will be required to submit to a variety of toxicology tests to include urine drug testing, alcohol testing, pregnancy testing (if applicable), and blood/lab work testing. The treatment team and provider will determine the frequency of these tests. I give my consent to undergo all tests described above as they apply to me. I further give my consent to allow BrightView to send my urine specimen to the laboratory for analysis.

9. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

10. **Informed Consent for Medication Assisted Treatment:** In accordance with evidence-based practices, BrightView, upon assessment and evaluation and at the recommendation of a physician may prescribe various medications to patients in recovery. These medications are used in conjunction with group counseling, individual counseling, and family counseling. Any medication I receive may have an adverse reaction and/or possible side effects.

    The goal of medication assisted treatment is to stabilize functioning. I realize that for some patients' treatment may continue for relatively long periods of time, but that periodic consideration shall be given concerning my complete withdrawal from the use of all drugs.

    Treatment with Buprenorphine (if applicable):

    Buprenorphine is an FDA approved medication for the treatment of opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications. The appropriate treatment plan for you will be determined by your primary counselor and a physician.

    Use of buprenorphine will maintain your physical dependence. If you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine as it could eventually cause physical dependence. The medication you will be taking will likely contain both buprenorphine and an opiate blocker (naloxone). If the medication is abused by snorting or injection, the naloxone will cause severe withdrawal but when taken as directed, the naloxone has no effect.

    If you are dependent on opioids **you should be in as much withdrawal as possible when you take the first dose of buprenorphine/naloxone**. **If you are not in withdrawal, buprenorphine/naloxone can cause severe opiate withdrawal.** We recommend that you arrange not to drive after your first dose, because some patients may

experience drowsiness during the early phases of treatment. It may take several days to feel completely comfortable with the transition to buprenorphine/naloxone.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths. Although sublingual buprenorphine has not been shown to be liver-damaging, your doctor will monitor your liver tests while you are taking buprenorphine. (This is a blood test.) Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with the physician first.

I understand that buprenorphine products and other medication assisted treatment medications may interact with other prescription medications, vitamins and nutritional supplements. Potential interactions include increasing or decreasing the level of buprenorphine products in my body or, in extremely rare instances, possibly causing an abnormal heart rhythm that has the potential to be lethal. I agree that it is my responsibility to provide documentation of all medication, vitamins and nutritional supplements I am taking on at least a monthly basis.

I understand that I may withdraw from this treatment and discontinue when indicated the use of the medication at any time, and I shall be afforded medical withdrawal under medical supervision. The medically supervised withdrawal could be either a short-term withdrawal or long-term withdrawal. This will be at the discretion of the Medical Director/Provider. I understand that once I complete a medically supervised withdrawal, I may be offered an aftercare program which will include counseling only.

I have read and understand these details about medication assisted treatment, including risks and benefits. I understand there are alternatives and wish to be treated with buprenorphine if that is medication that the physician deems medically appropriate.

11. <u>Opiate Treatment Program (OTP) (if applicable)</u>

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a substance use disorder treatment program, since the use of other medications in conjunction with medication assisted treatment prescribed by the treatment program may cause me harm. In addition, I agree that I am not currently enrolled in another OTP at this time.

I understand State and Federal law prohibits dual enrollment in opiate treatment programs. I therefore give my consent to allow BrightView to disclose my enrollment status, via fax or verbal confirmation, to all opiate treatment programs in accordance with state and federal law guidelines. I further give my consent to allow BrightView to disclose my enrollment status, via fax, electronic transfer or verbal confirmation, to a statewide Central Registry in accordance with State and Federal law as well as any other OTP within a 150-mile radius.

I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from alcohol and drug treatment. With full knowledge of the potential benefits and possible risks involved, I consent to assessment and treatment.

_____

Printed Name of Client

_____ _____

Signature of Client **Date**

_____ _____

Witness **Date**