Informed Consent for Behavioral Health, Screening, Diagnosis, and Medical Treatment

Name: _____

Date of Birth: _____

This document provides a general review of Blooming Cactus Wellness LLC's screening, evaluation, diagnosis, and treatment procedures and protocols. You have the right to refuse, any or all of those procedures, even after you have previously agreed to any or all of these services. Our only obligation is to offer them to you when we think they may be helpful, in an effort to provide assistance during a difficult time in your life. In order to promote respect for individual autonomy and encourage active participation, each of our clients have the right to informed consent for any and all evaluations and treatment. All patients with unimpaired capacity have the right to consent to, or to refuse evaluation and/or treatment, absent an emergency. Because we comply with all State, County, Municipal, and Federal laws, the confidentiality of these services are limited. Further, we are required to report any allegations of abuse, neglect, or exploitation to the proper authorities for investigation; and we must respond to threats of harm to self, or others to ensure safety. Our staff is bound to the confidentiality requirements of Title 42 CFR, Part 2 of the Federal Regulations.

- The procedures to treat my condition have been explained to me and I understand it will involve my taking medications at the schedule determined by the Blooming Wellness Director's Program Medical Director.
- It has been explained to me that medications used in medical practice can produce adverse results. The alternative method of treatment, the possible risks involved, and the possibilities of complications have been explained to me.
- The goal of detoxification is total rehabilitation of the patient. Withdrawal from the use of all drugs is an appropriate treatment goal.
- I acknowledge that I am entering treatment on a voluntary basis, and that I have been informed of Blooming Cactus Wellness methods of treatment and procedures.
- I hereby request medical treatment from Blooming Cactus Wellness LLC, and I therefore consent to any and all examinations, laboratory procedures, medical treatment, onsite toxicological testing and services rendered to me.
- I am aware that Blooming Cactus Wellness LLC utilizes specially trained licensed nurses and other non-physician personnel to provide adjunct services under the direction of licensed physicians.

- I hereby authorize and consent to Blooming Cactus Wellness LLC to contact my personal physician for consultation regarding any past or existing medical or psychiatric conditions, and to disclose to my personal physician that I am enrolled in Blooming Cactus Wellness LLC's detoxification program.
- I acknowledge that I have read all of the forgoing and have been offered a copy of this authorization and consent if I choose to request a copy.
- I hereby freely give my authorization and consent for behavioral health screening, evaluation, diagnosis, and treatment.

_____

Print Name

_____ _____

Client Signature **Date**

_____ _____

Parent/ Guardian Signature **Date**