CONSENT TO TREATMENT

Patient Name:_____

I specifically agree and understand that patients in the Meier Clinics Catalyst(DP) or the Intensive Outpatient Program (IOP) must obey all the rules and regulations of the Program.

A. I agree to notify the staff if I choose to request a discharge from the program.

B. If a patient who is admitted on a voluntary basis becomes a danger to self or others and requests to be discharged, the attending physician has the prerogative to proceed with an application to involuntarily hospitalize that patient.

C. The patient will leave the Program at the request of his/her physician if the condition of the patient requires different care or treatment than that afforded by the Program, or if in the judgment of the physician, it will contribute to the most effective use of the Program.

D. It is customary, with the exception of emergency or extraordinary circumstances, that no substantial medical procedures are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional.

E. Each patient has the right to consent, or to refuse to consent, to any proposed procedure or therapeutic course, including psychotropic medication.

F. No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

Patient's Initials _____ Witness's Initials _____

CONFIDENTIALITY STATEMENT

In connection with my activities as a patient at Meier Clinics®, I agree to hold confidential all information I may have access to about current and/or former patients and will not divulge any information to unauthorized persons. Members of the treatment staff at Meier Clinics, however, are authorized to receive such information, particularly if it involves another patient's intent to harm him/herself or others, or any patient's involvement in prohibited activities or suspected child abuse. I further agree to inform my family, friends and visitors of their responsibility in maintaining confidentiality.

Patient's Initials _____ Witness's Initials _____

CONSENT FOR BREATHALYZER / DRUG TESTING

FOR SUBSTANCE ABUSE CLIENTS ONLY. I hereby consent to a breathalyzer test as a part of my pre-admission screening. If admitted, I agree to random repeat breathalyzer tests and/or other drug tests during the Program as may be required by the Meier Clinics staff.

Patient's Initials _____ Witness's Initials _____

CONSENT FOR PHONE CALLS AND VISITS

Under the Illinois Mental and Developmental Disabilities Code and Confidentiality Act the fact of admission shall be confidential. This means Meier Clinics may not relay any information, including that you are a patient here, without your consent.

A. COMMUNICATION WITH FAMILY/SIGNIFICANT OTHERS

Meier Clinics believes it is helpful to involve family members/significant others in the patient's treatment. To insure coordinated treatment, please list those we may contact regarding your background information and to whom we may provide progress updates. The results will also be communicated during your participation in the program.

Name	Relationship	Phone # with Area Code

B. CONSENT TO CONTACT PROFESSIONALS

It is helpful for Meier Clinics staff to be able to contact your outpatient therapists, psychiatrists, primary care physicians, pastors, or other professionasl. This helps insure coordinated treatment through verbal communication of previous treatment information which is in your best interest. You have the right to refuse consent or to limit consent.

Name	Profession	Phone # with Area Code
	Outpatient Therapist	
	Psychiatrist	
	Primary Care Physician	
	Pastor	

C. EMERGENCY CONTACT

In the event of an emergency, please let us know who you would like us to contact.

Primary Contact Name: _____ Relationship: _____

Address: _____ Phone: (_____)_____

Secondary Contact Name:_____ Relationship: _____

Address: _____ Phone: (_____)_____

Patient's Initials _____ Witness's Initials _____

ALL SECTIONS I HAVE INITIALED HAVE BEEN FULLY EXPLAINED TO ME. I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO ABIDE BY THESE DURING MY TREATMENT IN THE MEIER CLINICS PROGRAM.

_____ _____

Patient's Signature Date

_____ _____

Witness' Signature Date