KIOWA ALCOHOL-DRUG ADDICTIONS & PREVENTION/BHS

208 Hardee St.W
Anadarko, Ok 73005
Phone 580-919-1576 or 405-648-0943

INFORMED CONSENT TO TREAT

Client Name _____ Date of Birth_____

I understand that I am eligible to receive a range of services from KADAP/BHS, the type and extent of services will be determined following an initial assessment and a thorough discussion with program staff.

The goal of the assessment process, is to determine the best course of treatment for me, however, Outpatient services are provided over a 12 week period.

By my signature below, I voluntarily request and consent to Substance Use Disorder (SUD) and or Behavioral Health assessment, care, treatment, services or referral and authorize KADAP to provide such care, treatment, services or referral, as are considered necessary and advisable. I understand and acknowledge that no on has made guarantees or promises as to the results that I may receive.

By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained therein. I further acknowledge that I have been given ample opportunity to ask questions and seek clarification on anything that may be unclear to me.

I, _____, give KADAP/BHS consent to treat me.

Staff Signature: _____ Date: _____