



Scottsdale Providence

8889 E. Via Linda blvd, Scottsdale, Arizona, US, 85258

4802847440

Consent for Treatment

Authorization and Informed Consent for Treatment and Conditions of Admission

1. Consent: I voluntarily consent to this admission to the Facility and do hereby voluntarily consent to such care-encompassing procedures and treatment by the Facility that its Director, employees, and designees deem necessary in their judgment. These services may be terminated by me at any time I so desire by informing the Facility verbally or in writing. I understand that any evaluation, testing, counseling/therapy or other treatment procedure is confidential and will not be released by the Facility without my written consent.

2. Emergency Treatment and/or Hospital Transfer: I understand while at the Facility, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate due to an emergency, by attending physician, their assistants and designees, I consent to such emergency treatment and/or transfer to a hospital and indemnify the Facility and its staff, or any physician who may be in attendance, from any loss resulting from such emergency treatment and/or transfer.

3. Medical Consent: The Patient is under the care of their attending physician, or the physician assigned by the Facility and the undersigned consents to examination and laboratory procedures. Medical treatment is rendered under the order of the physician or his/her designee.

4. Drug Screen Consent: I further understand that part of the treatment offered by the Facility may require my submitting to urinalysis for drug/alcohol content, psychological testing and other such similar procedures and that the consent that I have given in this document shall include, but not limited to, the same. The results of urinalysis will be released without Patient consent. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person whom it pertains or as otherwise permitted by CFR 42, part 2.

5. Conditions of Treatment: I acknowledge and understand that no promises or guarantees have been made to me regarding the final outcome of my treatment by the Facility and I do hereby absolve the Facility from any liability in the event its treatment of my person is unsuccessful either in the short or long term.

6. Rules and Regulations: I hereby agree to comply with and abide by the policies, rules and regulations of the Facility during my treatment stay.

7. Releases of Information: The Facility may disclose all or any part of the Patient's record to any person or corporation which is or may be liable under a contract to the facility, or the Patient, or to a family member of the Patient, all or part of the facility charges. The Facility may further disclose all or said part of the Patient's record to the referring doctor, hospital, clinic, and in case of minors, may disclose aftercare forms to the Patient's school system.

8. Personal Valuables: The Facility shall not be liable for the loss or damage to any money, jewelry, eyeglasses/contact lenses, dentures, documents or other articles of value.

9. Drugs: The Patient shall neither use, nor keep, any drugs or drug paraphernalia as not permitted by or on behalf of the attending physician. All medications should be taken as prescribed by the physician during the Patient's stay at the Facility. Any such contraband found in the Patient's possession will be removed and

destroyed.

10. Injury: In consideration of the acceptance of the undersigned for voluntary care by the Facility, I do hereby waive, release and indemnify the facility, its officers, agents, employees and professional associates of all any kind of liability (legal, financial, medical, and otherwise) for any claim of loss or damages, because of any injuries, direct or indirect which may occur to me or to my family or friends, or for loss, damage or theft of any of my personal property during my enrollment, whether or not the professional associates, and whether or not such injury, loss or damage occurs on or off the premises or in or out of a vehicle, surveillance or supervision of the facility or its officers, agents, employees or professional associates.

11. SMS Communications Consent: I consent to receive up to 2 SMS text messages from Scottsdale Providence Recovery Center at the mobile phone number I provide, containing a link to leave a review of my experience. Message and data rates may apply. I understand I may opt out at any time by replying STOP to any message. My mobile information will not be shared with third parties or affiliates for marketing or promotional purposes. Full SMS terms are available at <https://scottsdaleprovidence.com/sms-consent/>.
Mobile Phone Number: _____

The undersigned certifies to understand and agree to above, receiving a copy thereof, and is the Patient, or is duly authorized by and on behalf of the Patient to execute the above and accepts its terms personally and upon the Patient's behalf.

Client Name : Scot Prov

DOB : 01/02/2000

MRN : PR1M00006