CLIENT NAME: ____

VOLUNTARY CONSENT FOR TREATMENT SERVICES

I voluntarily give consent for the following Bluewater Counseling service(s):

- ☐ Chemical Dependency Evaluation
- ☐ Individual Counseling
- ☐ Family Services
- ☐ Other ______________________
- ☐ Health Professional Evaluation
- ☐ Relapse Prevention Workshop
- ☐ Return to Work Evaluation

I have had an opportunity to read, ask questions, and understand the services provided by Bluewater Counseling. I agree to accept the services identified on this voluntary consent.

If applicable, my client rights have been explained to me. I have been informed of the cost for services.

I understand I can revoke my consent for services at any time. However, services authorized and rendered by this consent are valid. All services and fees for those services continue to be my responsibility.

24 hour cancellation notice: If I am unable to make an appointment, as scheduled, I will cancel my appointment within 24 hours prior to the appointment time. I understand I am financially responsible for all appointments I make including appointment(s) I fail to cancel. I also understand Bluewater Counseling does not accept insurance or credit cards.

____

Client Signature   Date