CONSENT FOR TREATMENT

I the undersigned, or a (representative, guardian) of ____
Print client's name
and the subject of the Authorization and Release, hereby authorize the above stated facility staff to administer counseling. I also authorize such additional procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I understand that my refusal for treatment is grounds for discharge.

- In consideration of treatment of substance abuse, I hereby agree to fully indemnify Dr. D. Paul Rodriguez for any judgments and expenses arising out of suits brought by me or on my behalf for any incident related to my treatment.
- The use of duplicated copies of this form is hereby authorized and shall be accepted as valid as the original.
- I hereby certify that I have read and fully understand the above Authorization for Counseling and Liability Release. I also certify that no guarantee or assurance has been made as to the results that may be obtained.
- I hereby authorize Dr. D. Paul Rodriguez to report to the appropriate agencies the reportable communicable diseases that I may have or that I have been in contact with. This is done in accordance with section 381.231 and 284.06, FS.

CONSENT FOR DRUG SCREENING

I GIVE PERMISSION FOR Dr. D. Paul Rodriguez to obtain urine and breathe samples from me as needed for drug screening and laboratory testing. This includes random urinalysis tests for suspected drug/alcohol use. Results will be used in accordance with existing Florida Statutes and Federal Guidelines.

____ ___________________
Signature of Client Date

UNDERSTANDING OF APPOINTMENT CANCELLATION
Financial Responsibility

Payment is part of the therapeutic process therefore; a 24 hour cancellation notice is expected. **No Show appointments will be billed at $25.00**. This fee is NOT insurance billable and is your responsibility.

STATEMENT OF FINANCIAL RESPONSIBILITY
Dr. D. Paul Rodriguez accepts cash, you are responsible for any deductible or co-payments claim. The services you have received from this facility may not be covered by your insurance. If services are not covered by your insurance, payment of these services will be your responsibility. **You will be asked for payment at the time services are delivered.**

In the event this account is placed with a collection agency or attorney for collection, you will be responsible for collection and/or attorney fees.

____
Client Signature/Parent/Guardian

____
Date