Consent to Treatment for Drug and Alcohol Counselling

Client Information:

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____

Treatment Provider Information:

- Provider Name: Kelly-Ann Faulkner
- Facility Name: AOD Counselling
- Phone Number: 0452 420 367

Purpose of Treatment:

This document is intended to provide you with sufficient information about the treatment process for drug and alcohol counselling. The purpose of this treatment is to assist you in addressing issues related to substance use, promoting recovery, and improving overall well-being.

Nature of Treatment:

Counselling may include individual therapy, group therapy, educational sessions, and referrals to additional treatment services if necessary.

Confidentiality:

All communications during treatment are confidential and protected under applicable laws. However, there are exceptions where disclosure may be required by law, such as instances of abuse, harm to self or others, or a court order.

Risks and Benefits:

- Potential Risks: The treatment process may involve discussing sensitive topics that may cause emotional discomfort.

- Benefits: Participants often experience improved coping mechanisms, enhanced relationships, and a reduction in substance use.

Voluntary Participation:

Your participation in this treatment is voluntary. You have the right to withdraw from treatment at any time without penalty.

Consent:

I have read and understood the information provided above. I hereby consent to participate in treatment for drug and alcohol counselling with the listed provider. I acknowledge that I have had the opportunity to ask questions and receive answers regarding the treatment.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____