Recovery Pathways, LLC
Consent to Drug Testing Agreement

Patient Name_____ DOB_____

I understand that random Urine Drug Screens are required for all patients. I consent to be tested for controlled substances. I understand that lab fees are separate from Recovery Pathways service fees and I am financially responsible for these drug screens. I further agree that refusal to submit to testing as required may subject me to termination from the treatment program without recourse for appeal.

I hereby acknowledge that I have been advised of Recovery Pathways, LLC policy on Controlled Drugs and Substances. I hereby further acknowledge that I am aware of the following specific requirements:

Initial each item in the space provided indicating you have read and agree to the following:

_____ Recovery Pathways, LLC will not tolerate the possession, solicitation, distribution, sale, or use of any narcotic or other controlled drugs or substances.

_____ Violation of the treatment agreement will result in probation or termination from Recovery Pathways, LLC without recourse for appeal.

_____ I may be required to submit to unannounced random urine/oral/blood drug tests at any time.

_____ I may be required to submit to observed urine tests, blood work, and/or saliva tests as determined by treatment staff.

_____ My drug screens will be submitted for laboratory confirmation and I am financially responsible for any lab fees not covered by my insurance, or if I do not have insurance.

_____ Refusal to submit to drug testing in accordance with Recovery Pathways, LLC Drug Testing Policy will be regarded as the equivalent of a positive drug test and can also result in my being terminated from Recovery Pathways, LLC.

I have read and understand this agreement.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Recovery Pathways, LLC
Appointed Pharmacy Consent

I _____ do hereby:
Patient Name (Print)

- ☐ Agree to have all my prescriptions filled at one pharmacy
- ☐ Authorize Recovery Pathways, LLC to disclose my treatment for Substance Dependence to the pharmacy in order to allow my prescriptions to be filled.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for substance dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Appointed Pharmacy:

Name_____

Phone_____ Fax_____

Address _____