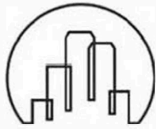

River City Counseling Group

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River City Comprehensive Counseling Services • River City Integrative Counseling • River City Residential Services

Patient Name: _______________ Record #: ________________

Drug Testing Informed Consent Form

At River City Counseling Group, we endorse the American Society of Addiction Medicine belief that addiction is a chronic relapsing disease of brain reward, motivation, and memory that is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. The inherent psychological defenses and dysfunctional thinking patterns caused by substance use disorders often influence individuals to misreport information.

The River City Substance Abuse Treatment Programs include random drug testing as a foundational component to maintain the integrity of our clinical therapeutic environment. At River City, our primary screening method is CLIA-waived urine analysis Point-of-Care tests utilized to monitor the accuracy of participant's self-reports. At River City, we believe that change is possible but first requires self-honesty, acceptance, and engagement in the therapeutic treatment process. These test results are confidential and protected by federal statute 42 CFR Part II. To confirm accuracy of results, River City is contracted with DIAX Labs and/or Lab Corp. to send specimens for definitive confirmation testing.

I, ____, understand that drug screening is a foundational component of the Substance Abuse Intensive Outpatient Treatment Program and that screens are given on a random basis approximately 1-2 times per month with potential increase/decrease in frequency based upon consistent positive/negative results. I understand the intent of River City in maintaining accountability to my self-reports of substance use and the importance of providing honest and accurate reports.

☐ **I intend to comply and participate in all Drug Testing associated with the SA IOP.**

☐ **I DO NOT intend to comply and participate in all Drug Testing associated with the SA IOP but understand that this document will be presented again within 14 days and I could be potentially discharged with a referral to a more suitable treatment service if I am unwilling to reconsider.**

My signature below indicates my understanding and informed consent to all the information above.

____

Client Printed Name **Signature** **Date**

____

LG/AR Printed Name **Signature** **Date**

____