**Recovery & Prevention Resources of Delaware and Morrow Counties, Inc.**

Client Name_____ Date_____

**Section I. Assistance for Clients with Sensory Impairments**

Recovery & Prevention Resources provides qualified sign language interpreters and other auxiliary aids to sensory impaired persons. Such additional services will be provided at no extra cost to clients, so they receive an equal opportunity to benefit from our services.

Are you in need of an interpreter? _____ Yes _____ No

If yes, do you wish to use an interpreter provided by this agency? _____ Yes _____ No

If you require an interpreter, but wish to utilize a friend or family member rather than an interpreter provided by this agency, indicate that person's name, address and telephone number below:

_____ _____
(Interpreter's Name) (Telephone)

_____ _____
(Address) (City, State, Zip)

Please indicate if you wish to have our staff use any of the following as methods of communicating with you:

_____ Sign language/manual communication _____ Written form

_____ Require assistance of hearing aid _____ Lip reading

_____ Communication board _____ Gestures and pantomime

_____ Telecommunication device for deaf (TDD)

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**Section II. Missed Appointment Policy**

It is the policy of Recovery & Prevention Resources to charge a $15.00 missed appointment fee to the account of any client who fails to attend, or arrives more than 15 minutes late for, a scheduled appointment. Should this occur, the $15.00 fee must be paid before scheduling a new appointment. If it is necessary to cancel an appointment, a phone call to the agency prior to your appointment time will prevent this fee being charged to your account.

My signature below confirms that the Missed Appointment Policy has been explained to me.

_____ _____
(Signature of Client) (Date)

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**Section III. Treatment Agreement**

In order to become a client at Recovery & Prevention Resources as required by the State of Ohio Program Certification Standards, each person must demonstrate informed consent to participate in treatment services. By signing below, I acknowledge that no employee of Recovery & Prevention Resources is coercing me to participate in their treatment program. I further agree to participate in the alcohol/drug treatment services provided by Recovery & Prevention Resources as these services may apply to my individual needs.

Signature of client_____ Date_____

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_____ Date_____
(Signature of Parent/Legal Guardian – if Client is a Minor)

_____ Date_____
(Signature of Witness)