Substance Abuse Treatment Interview

Please fill this form out completely before meeting with your counselor.

Name: _____ Date: _____

Cell Phone: _____ Other Phone: _____

Address: _____ City:_____ State: ____ Zip:_____

Email: _____ Driver's License Number: _____

Date of Birth: _____ Age: _____ Race: _____Gender: __ Male __ Female

Referral source: _____

In case of emergency please contact - Name: _____

Relationship: _____ Phone: _____

Education

What is your highest level of formal education?

___GED ___High School ___Associates ___Bachelors ___Masters ___Doctorate ___Other

Name and city of the last school you attended? _____

What was your degree? _____ Did you graduate? ___Yes ___No

List any Trade or Professional Certifications: _____

Military Service? __Yes __No Branch: _____ MOS:_____ Discharge date: _____

Employment

Current employer: _____ City: _____

Job title: _____ Length of employment: _____

If you have worked at the above position less than five years, please list the names of the companies you worked for in the last five years (Please continue on reverse if needed):

Name: _____ City:_____

Job title: _____ Length of employment: _____

Legal / Arrest History

List your charges at your last arrest: _____

Arrest Date: _____ Time of Arrest: _____City/County of Arrest: _____

If you were drinking at the time of the arrest, how many did you have? _____

Type of alcoholic drink? _____ Start time: _____ End time: _____

Total number of DUI arrests: _____ Total number of drug-related arrests: _____

Other prior arrests: _____ Date: _____

Substance Use

Age when you first experimented with alcohol? _____ What type of drink? _____

Who were you with? _____ Where were you? _____

Since then, how often have you consumed alcohol?

___Daily ___Weekly ___Bi-weekly ___Monthly ___Yearly ___Other: _____

How many drinks per setting? _____

What is your alcoholic beverage of choice? _____

What date did you last consume alcohol? _____

How many drinks did you have? _____ Over what period of time? _____

How many drinks does it take for you to start feeling the effects of alcohol? _____

What do you feel at that time? _____

Age when you first experimented with drugs? _____ What type of drug? _____

Who were you with? _____ Where were you? _____

Since then, how often have you used drugs?

___Daily ___Weekly ___Bi-weekly ___Monthly ___Yearly ___Other: _____

How much per setting? _____

What is your drug of choice? _____

What date did you last consume drugs? _____What did you consume? _____

How much? _____ Over what period of time? _____

How much of the drug does it take for you to start feeling the effects? _____

What do you feel at that time? _____

Please list any and all other drugs you have consumed: _____

_____

_____

Has your current drug use increased or decreased compared to your past use? _____

Have you ever had withdrawal symptoms from alcohol or drugs? ___Yes ____No

If so, what are/were they? _____

_____

Have you ever been violent while under the influence of alcohol or drugs? ___Yes ___No

If yes, please explain: _____

Has anyone ever complained about your use of alcohol or drugs? ___Yes ___No

If yes, who? _____

Recovery

What is the longest you have ever abstained from drugs? _____

How did you do it? _____

Do you want to stop drinking or using drugs? ____ Yes _____ No _____Maybe

Why? _____

Have you ever been in a substance abuse treatment program? ___Yes ___No

Name of program: _____ City/State: _____

How long was the program? _____ Dates attended: _____

Did you graduate from the program? ___ Yes ___No Date of graduation: _____

Have you ever attended DUI school? ___ Yes ___No Date completed: _____

Have you ever completed an Alcohol Awareness class? ___Yes ___No

Have you ever completed a Victim Impact Panel? ___Yes ___No

Have you completed any other educational program? ___Yes ___No

Which one? _____ Where? _____

Medical History

Please list any current or past medical conditions: _____

_____

How often do you see your doctor? ___Weekly ___Monthly ___Semi-annually ___Annually

Please list any current medications including date prescribed, prescribing doctor and dosage:

_____

_____

_____

_____

Please list any hospitalizations: _____

Have you ever had symptoms of or been diagnosed with any of the following:

___ High blood pressure ___ Diabetes ___ Cancer

___ Ulcers ___ H.I.V ___ Heart problems

___Cirrhosis of the liver ___ Seizures ___ Stroke

___ Delirium Tremens ___ A.I.D.S.

___ Other: _____

Do you take any over-the-counter medications?

___Tylenol ___Advil/Motrin ___Aleve ___Other: _____

How many milligrams? _____ How often? _____

Mental Health History

Have you ever had any of the following:

___Insomnia ___Stress ___Suicidal thoughts

___Anxiety ___Anger ___ADHD

___Depression ___Loss of Appetite ___Loss of memory

___Mood Swings ___Increased Appetite ___Irritability

___Nervousness ___Frustration ___Homicidal thoughts

___Headaches ___Sadness ___Compulsive behaviors

___ Other: _____

Have you ever attempted suicide? ___Yes ___No

If so, were you under the influence of alcohol or drugs at that time? _____

Have you ever been in mental health or psychological counseling? ___ Yes ___No

If so, where and when? _____

_____

Family History

Place of birth: _____ How long have you lived in Georgia? _____

Who do you live with? _____

Marital Status: ____Single ____Married ____Separated ____Divorced ____Widowed

Name and age of spouse: _____ How long married? _____

How many children do you have? _____ Please write their names and ages: _____

Any siblings? ___Yes ___No If yes, how many? _____Males _____Females

What is your birth order? (First second, third, youngest, oldest, etc) _____

Do any of your siblings have a problem with alcohol or drugs? ___Yes ___No

Do you parents have a problem with alcohol or drugs? ___Yes ___No

Do your maternal grandparents have a problem with alcohol or drugs? ___Yes ___No

Do you paternal grandparents have a problem with alcohol or drugs? ___Yes ___No

Do have any other relative who has a problem with alcohol or drugs? ___Yes ___No

If yes, who? _____

Do you have any relative who has been in counseling for substance abuse? ___Yes ___No

If yes, who? _____

Spiritual

I consider myself: ___Christian ___Jewish ___Buddist ___Hindu ___Muslim ___Atheist
___Unknown ___Other: _____

Are you happy with your spiritual journey? ___Yes ___No

If no, why? _____

I am visiting a Christian counseling center because:

___1) I hope to get counseling from a Christian perspective.

___2) I want to talk about spirituality, but not Christian.

___3) I am open to hearing a Christian perspective on my issues.

___4) I was referred here by a friend and hope to get a good result.

___5) This is a Christian counseling center? What does that mean?

Any comments?

_____

_____

_____

Informed Consent and Contract for SA Evaluation or Treatment

Thank you for choosing Eagle's Landing Christian Counseling Center as your evaluation and treatment provider. We are committed to the success of your treatment. We are a non-profit organization. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning your substance abuse evaluation or treatment/education.

1. GENERAL FINANCIAL POLICIES:

- Payments are due at the time of service. Please pay the receptionist or service provider **before** your meeting. For substance abuse evaluation and treatment, we accept payment by cash, debit, Visa, Discover, and MasterCard. We do NOT accept checks.
- Fee Schedule: Substance Abuse Assessment w/Written Report for Court- $95
  "ASAM Level .5 or 1" Substance Abuse Treatment: $40 per 3 hr group.
  An evaluation with an evaluator other than the treatment provider whose class you will be attending is required before attending the treatment group. Evaluations from outside ELCCC must be provided prior to your attending the treatment group.

2. MINORS RECEIVING TREATMENT:

- The parent/guardian(s) is responsible for payment at the time of service. We will not bill absent parents or others for a minor's session.
- No minor can be treated without signed consent of a parent or guardian.
- Unaccompanied minors will be denied services (except in the case of an emergency). Parent/guardian must be in the office while minor is being treated.
- Parents are expected to be involved with treatment of a minor. If a parent or guardian is unwilling or unable to participate, parent must consult with provider before minor begins treatment. (Note: Additional fees may apply)

3. HIV/AIDS CONFIDENTIALITY STATEMENT

- ELCCC does NOT perform HIV/AIDS testing.
- ELCCC does everything within its reasonable power to follow the Georgia Laws regarding the disclosure or non-disclosure of HIV/AIDS. This includes:
- If a client discloses their HIV/AIDS status to ELCCC personnel, ELCCC personnel or contractors will not, pursuant to Georgia legal code, knowingly or intentionally disclose that information to another person or legal entity, nor can they be compelled by subpoena, court order, or other judicial process to disclose that information.
- However, HIV/AIDS confidential information may be disclosed to the person identified by that information or, if that person is a minor or incompetent person, to that person´s parent or legal guardian.
- In addition, HIV/AIDS confidential information may be disclosed to any person or legal entity designated to receive that information when that designation is made in writing by the person identified by that information or, if that person is a minor or incompetent person, by that person´s parent or legal guardian.
- AIDS confidential information may be disclosed to any agency or department of the federal government, this state, or any political subdivision of this state if that information is authorized or required by law to be reported to that agency or department.
- In addition, if any ELCCC employee, contractor, or staff member reasonably believes that another employee, contractor, or staff member, the spouse or sexual partner or any child of the client, spouse, or sexual partner is a person at risk of being infected with HIV by that client, the employee, contractor, or staff member may disclose to that employee, contractor, or staff member, spouse, sexual partner, or child that the client has been

determined to be infected with HIV, after first attempting to notify the client that such disclosure is going to be made.

4. ADDITIONAL AGREEMENTS BETWEEN ELCCC AND CLIENT NAMED BELOW:

- I agree to conduct myself in an appropriate manner. In understand that minor children must be attended at all times. Illegal conduct onsite will be reported the appropriate authorities.
- **Confidentiality**: I understand that no information about me or my issues will be disclosed to anyone outside of the Counseling center unless exceptions are noted in this contract. However, for the purposes of supervision, billing, and training, some information will be shared with other staff and contracted employees. I will maintain the confidentiality of anyone I see in the counseling office or in my group.
- **Limits of confidentiality**: I understand that reasonable suspicion of physical abuse, sexual abuse or neglect, of children (under 18 years of age) or endangerment through the witnessing of domestic violence must be reported by law. I understand that reasonable suspicion of physical abuse, sexual abuse, or neglect of the elderly (65 years and older) or disabled must be reported by law. I understand that intent to do harm to another person will be reported to that person and the police. ELCCC does not guarantee that other counseling clients or family members will maintain confidentially.
- **Court Evaluations**: I understand that court evaluations may last from 1 hour to 2 hours all together and I must stay to complete the entire process or a written evaluation cannot be provided. I understand that after completing my court evaluation I will receive a Proof of Attendance certificate which may be used for court, but a complete written six-dimension evaluation may not be available for 4-7 days after the evaluation has been completed.
- If I have a psychological emergency related to my treatment, I understand that I may contact my provider on his/her after-hours number found on their business card.
- For more urgent psychiatric care I may call Crescent Pines Hospital at (770) 474-8888.

I hereby attest to the fact that I have thoroughly read all enclosed information and I have completed the questionnaire fully to the best of my knowledge. I do hereby voluntarily request the services of Eagle's Landing Christian Counseling Center, in accordance with the terms stated herein. Specifically, I request that the provider named below provide professional services to myself, (print name)
_____, and I agree to pay ELCCC's fee of:
_____ $ 95 for Substance Abuse Evaluation
_____$ 40 per 90 minute ASAM Level I Treatment Group session
_____$ 25 book fee (one time)

I may request a copy of this signed agreement at no additional charge.

_____ _____
Signature of Client (or person acting for client) Date

I, the provider, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give information and willing consent.

Provider Name: _____ Provider Signature:
_____

_____ Client's copy _____ Provider's copy

Client Rights and Responsibilities

Clients have the right to:

1. Be treated with dignity and respect.
2. Fair treatment; regardless of their race, religion, ethnicity, age, disability, gender, sexual orientation, or source of payment.
3. Their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
4. Easily access timely care in a timely fashion.
5. Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
6. Share in developing their plan of care.
7. Information in a language they can understand.
8. A clear explanation of their condition and treatment options.
9. Information about their benefit plan, its practitioners, services and role in the treatment process.
10. Information about clinical guidelines used in providing and managing their care.
11. Ask their provider about work history and training.
12. Know about advocacy and community groups and prevention services.
13. Freely file a complaint or appeal and to learn how to do so.
14. Know of their rights and responsibilities in the treatment process.
15. Receive services that will not jeopardize their employment.
16. Request certain preferences in a provider.
17. Have provider decisions about their care made without regard to financial incentives.

Clients have the responsibility to:

1. Treat those giving them care with dignity and respect.
2. Give providers information that they need. This is so providers can give the best possible care.
3. Ask questions about their care. This is to help them understand their care.
4. Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
5. Tell the provider and primary care physician about medication changes, including medications given to them by others.
6. Keep their appointments. Members should call their provider as soon as they know they need to cancel visits.
7. Let their provider know about problems with paying fees.
8. Report abuse and fraud.
9. Openly report concerns about the quality of care they receive.

MY SIGNATURE BELOW SHOWS THAT I HAVE BEEN INFORMED OF MY RIGHTS AND RESPONSIBILITIES, AND THAT I UNDERSTAND THIS INFORMATION.

_____ _____

Client Signature Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

Client Name: _____ DOB: _____

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Eagle's Landing Christian Center, hereinafter referred to as "ELCCC" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ELCCC may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and ELCCC.

I understand that I do not have to use my health insurance, but that by doing so I will be given a mental health diagnosis and this diagnosis will be revealed to the insurance company. In addition, they will have access to my complete medical record. If I chose not to use my health insurance, they will not have access to my medical record nor will they receive any information on my diagnosis.

My "protected health information" means health information, including my demographic information, collected from me and created or received by ELCCC, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 1944 Brannan Rd. McDonough, GA 30233. As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

I have the right to revoke this consent, at any time, in writing, except to the extent that ELCCC or the practice has taken action in reliance on this consent.

_____ _____

Printed Name of Client Date

_____

Signature of Client or Personal Representative:

_____ _____

Description of Personal Representative's Authority Date