CLIENT'S BILL OF RIGHTS

*Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.

*Each client has the right to be free from neglect, exploitation; and verbal, mental, physical and sexual abuse.

*Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.

*Each client has the right to exercise personal privacy by with holding consent or family's or significant other's participation and to be informed of the possible consequences of that action.

*Each client has the right to be informed of the nature and purpose of any services rendered and the name and title of personnel providing that service.

*There are circumstances that would allow for exceptions to obtaining informed consent such as: situations involving threat of harm to self or others, child or elder abuse. Under these circumstances information about the individual served must be disclosed or reported.

*Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.

*It is the right of each client to receive individualized treatment which includes:

- *Adequate and humane services regardless of the source of financial support.
- *Services provided in the least restrictive environment possible.
- *An individualized treatment plan which is reviewed periodically and as needed.
- *To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.

*If at anytime during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency:

They have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.

*The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.

*The client will be informed of his/her rights in a language they can understand.

*Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.

*Each client has the right to make decisions regarding the with holding or resuscitative measures with these decisions respected per agency policy.

***Recipients have rights protected by state and federal law and promulgated rules. For Information contact:**
Office Manager
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047

The above Bill of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

_____

Client/Guardian Signature Date

Communicable Disease Risk Assessment

Instructions to interviewer: The intent of this interview is to help you and your client determine if your client is at risk for a significant communicable disease. The questions cited below focus on important risk factors and symptoms related to HIV infection, Hepatitis B, Tuberculosis, and Sexually Transmitted Diseases. If your client responds "yes" to any of these questions, immediately refer him/her for medical evaluation and follow up on the results. If your client responds "no" to every question, recommend a medical evaluation and the recommended screenings as outlined on the previous pages, although this can be accomplished sometime later during the course of substance abuse treatment. Medical evaluations may be obtained through local health departments and through private medical providers.

PART 1

Individuals who report a history of substance abuse are at a greater risk for developing certain serious communicable diseases. Please answer the follow questions to determine if you may need further health screening.

	Yes	No
A. The following questions relate to HIV (the virus that causes AIDS), Hepatitis and Sexually Transmitted Diseases (STD's): 1. Have you ever had unprotected sex or engaged in sexual behaviors (oral, anal, or genital) with a person whose HIV, Hepatitis or Sexually Transmitted Disease (STD) status is unknown to you? (For example, sex while drunk or high with a person you do not know very well.)		
2. Have you ever engaged in sexual behavior with anyone who has: Injected drugs?		
Traded sex for drugs?		
Many sexual partners?		
HIV / AIDS?		
Hepatitis?		
STD's?		
3. Have you ever shared needles or injecting "works" with other individuals?		
4. Have you experienced other forms of blood-to-blood or body fluid contact (for example, blood transfusions, hemophilia treatments, employment in medical field), and have concerns about your risk for HIV, Hepatitis, or STD's?		
B. Individuals who abuse substances are also at risk for contracting Tuberculosis (TB). Please answer the following questions to determine if you may need health screening for TB: 1. Have you recently lived in a substance abuse treatment facility, homeless shelter, drug house, jail, mental hospital or in other close quarters with people you did not know well?		
2. Have you recently had close contact with someone diagnosed with or being treated for TB?		

3. Have you had a nagging cough for more than three weeks along with any of the following symptoms: a. Weight loss?		
b. Fever for 3 days or longer?		
c. Night sweats?		
d. Coughing up blood?		

I understand that if I answered "Yes" to any of the above questions, I may be at risk for HIV, Hepatitis, STD's, or TB. I have been given information on how HIV, Hepatitis, STD's and TB are transmitted and how substance abuse can put me at risk for contracting these diseases. I have been told about ways to decrease the risk for getting these diseases or giving them to others.

Client Signature: _____ Date: _____

PART 2 To be completed by CDR or Treatment Program.

1. This individual is a high risk candidate for (check all that apply):

   ____ HIV ____ STD's ____ Hepatitis ____ TB

2. If at risk, a referral ***must*** be indicated (check all that apply):

   ____ Health Department ____ Private Physician (name): _____

   ____ Wellness Network ____ Other (specify): _____

CDR or Treatment Staff Signature: _____ Date: _____

PART 3 To be completed by the program only when risk assessment has been forwarded by the CDR.

Name of Treatment Agency: _____

I have reviewed and updated where necessary this Communicable Disease Risk Assessment with the client, and have dated and initialed any additions or deletions to this information. I have reviewed with this client all referrals based on the results of this Risk Assessment.

Treatment Staff Signature: _____ Date of review: _____

Group Expectations

1. If you are more than 5 minutes late, you will not be allowed in.
2. Must make up any missed groups in the next series or you will have to start the entire series over.
3. A release of information must be signed so that information can be released to your P.O. or court.
4. Any missed groups your P.O. will be informed.
5. If you do not call 24 hours ahead of time for group to cancel or do not show up for group you will be charged a fee.
6. You must pay at least $45 before each group or you will not be allowed in.
7. Final reports will not be released unless all payments are made in full.
8. No eating or smoking while in group
9. Attending group under the influence will NOT be tolerated. Anyone suspected of being "under the influence" will be escorted immediately to Prompt Care for a screening. (at your own expense) Pending results of screening, if negative you may join group again immediately, positive screenings will be discharged from group and probation officer will be notified.
10. One person has the floor at a time.
11. No criticizing others.
12. Participate and appropriate behavior during group is required.
13. Be supportive.
14. Be open and honest.
15. Offer feedback.
16. Respect others.
17. NO profanity
18. Everything remains confidential with the exception of suicide, homicide or abuse.

I have read and understand the above rules and expectations for substance abuse group sessions.

Student Signature/Date

Staff Signature/Date

PERSONAL HISTORY FORM

□ MENTAL HEALTH □ SUBSTANCE ABUSE □ BOTH CLIENT ID # _____

FORM COMPLETED BY (If someone other than client)_____

A) What brought you into treatment: _____

_____

B) What are your expectations for treatment_____

_____

C) Prior treatment experiences (Dates and Location_____

_____

D) Name of Primary Care Physician_____Phone_____

E) **Current Living Arrangements*:***

1. □ House □ Group Living □ Apartment □ Other (Specify)_____
2. □ Alone □ With Family □ Unrelated Significant Other

I. **CLIENT INFORMATION (past and present)**

1) **Treatment Experiences**

	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2) **Presenting Problem** (Check all boxes that apply)

□ Medical/Organic condition
□ Depression
□ Mania
□ Chemical Abuse/Dependency
□ Delusions/Hallucinations
□ Family Issues
□ Relationship Issues
□ Other (please elaborate)
□ Anxiety
□ Aggressive Behavior
□ Suicidal Ideation's
□ Self-destructive Behavior
□ Anger
□ Life Decision
□ Uncertain

3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	□	□	Physical Activity Level	□	□
Eating Patterns	□	□	General Disposition	□	□
Behavior	□	□	Weight	□	□
Energy	□	□	Increased tension	□	□

If yes to any of the above, please describe

Are you in physical pain □ yes □ no if yes where/what kind

_____

If yes please rate pain_____ 0=none 5=mild(tolerable) 10=severe(referral)

THERAPY IMPLICATIONS: _____

_____

II. **INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS;** past and present

1. **Family Constellation**

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
Client			YES	NO	YES	NO
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives) *Specify Relationship*						

2) **FAMILY/EXTENDED FAMILY HISTORY**

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3) **Family History**

1. What City/State were you born? _____
2. Where did you grow-up? _____
3. Who raised you as a child? _____

4) **Parental Information**

- ☐ Parents legally married
- ☐ Parents ever separated
- ☐ Parents ever divorced
- ☐ Mother remarried (number of times)
- ☐ Father remarried (number of times)_____

Describe relationships with parents, step-parents

1. As a child_____

_____

2. Currently_____

_____

5) SIBLING INFORMATION

Number of living siblings/step siblings_____ Number of deceased siblings/step-siblings

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe relationships with siblings:

1. As a child_____

2. Currently_____

- ☐ Family will be involved in treatment
- ☐ Family uninvolved

Why/Why Not:_____

_____

6) **Marital Information**

□ Single □ Unmarried and living with significant other. Length of time_____

□ Legally married: Length of time:_____ Total number of marriages:
□ Separated: Length of time_____ □ Divorce in process: Yes □ No □

□ Divorced: Length of time_____ □ Widowed: Length of time

Are there problems in this relationship (check all that apply)

□ Money □ Chemical Dependency

□ Sexual □ Mental illness

□ Physical Abuse □ Religion

□ Child rearing/discipline issues □ Other

THERAPY IMPLICATIONS:_____

III. **SOCIAL INFORMATION**

1) **Support System** (check all that apply)

□ Adequate social support □ Recent move / relocation □ Conflict with peers

□ Transportation problems □ Lack of knowledge of resources □ Isolative

□ Problems establishing / maintaining relationships

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups) _____

THERAPY IMPLICATIONS:_____

2) **Sexuality**

What is your sexual preference □ Male □ Female □ Both □ Uncertain

Have you been tested for HIV □ Yes □ No

Are there sexual issues that you would like to discuss with your therapist? □ Yes □ No

Have you ever been sexually and/or physically abused? □ Yes □ No

THERPAY IMPLICATIONS:_____

3) **Interests/Hobbies**

Art_____ Book/Films_____
Music_____ Physical Fitness
Crafts_____ Outdoor Activity
Sports_____ Diet/Health

Current Memberships (church , clubs, organizations)
Do you participate in any cultural activities related to your ethnic background? □ Yes □ No

THERAPY IMPLICATIONS:_____

4) **Spirituality**

Do you believe in a god or a power greater than yourself? □ Yes □ No

What religion were you raised? _____

What religion are you currently affiliated?_____

At this point in your life, what is most important to you? _____

THERAPY IMPLICATIONS:_____

IV. **EDUCATION** (check all that apply)

□ High school diploma (GED) □ Currently enrolled: Last grade completed _____

□ Did not complete high school: last grade completed _____
□ □ Vocational training: □ Training completed, type_____ □ Currently enrolled
□ College: Degree earned, type_____ □ Currently enrolled/# of years completed_____
□ Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.)

THERAPY IMPLICATIONS: _____

V. **EMPLOYMENT/VOCATIONAL** (Beginning with most recent job, give employment history, include homemaker experience)

Employer	Dates	Job Description	Salary

THERAPY IMPLICATIONS: _____

VI. **MILITARY**

Branch_____ Type of Discharge
Date drafted/enlisted_____ Rank at Discharge
Combat experience □ Yes □ No Date of Discharge_____Where

Where _____

THERAPY IMPLICATIONS: _____

VII. **LEGAL DATA**

Are you presently on probation or parole: □ Yes □ No

If yes reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): □ Yes □ No

If yes, please describe and indicate the court hearing/trail date_____

_____

Past History (adolescent and adult)

Yes	No	
□	□	Traffic Violations
□	□	Civil Involvement
□	□	Criminal Involvement

If yes to any of the above, please complete the following

Charges	Date	Where	Results

THERAPY IMPLICATIONS:_____

VIII Nutritional Assessment

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION		
Do you have an illness/condition that made you change the type/amount of food you eat?	Yes=2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	Yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	No
Do you always have enough money to buy the food you need?	Yes	No=4
Do you eat alone most of the time?	Yes=1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

TOTAL SCORE _____

0-2= Low Risk 3-5= Moderate Risk 6-21= High Risk* *Referral

THERAPY IMPLICATIONS:

_____

IX TRAUMA

Any history of trauma, abuse, neglect or exploitation? □ No □ Yes

If yes: When and type _____

_____

THERAPY IMPLICATIONS: _____

X Alcohol/Substance Use

Substance preferred _____

Date of last drink _____ / Date of last drug use _____

Type and amount of drink at last episode □ Beer _____oz □ Wine _____ oz □ Liquor ____ oz

Age drinking/ drug use began _____

Type of alcohol preferred: □ Beer □ Wine □ Liquor

How often do you drink/use drugs? □ Daily □ Weekly □ Monthly □ Other _____

Have you ever had any legal problems related to your use of alcohol/drugs? □ Yes □ No

Have you ever had any relationship problems related to your use of alcohol/drugs? □ Yes □ No

*****Has drinking or drug use ever become a problem? □ Yes □ No**

*****If YES, please complete next page. (Substance Abuse Addendum)**

If NO go to page 10

THERAPY IMPLICATIONS: _____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS:

ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST

Please check all that apply.

PHYSICAL	EMOTIONAL	BEHAVIORAL
_____ Blackouts	_____ Depression	___ A.M. Use
_____ Memory Problems	_____ Confusion	___ Sneaking
_____ Tremors/ Shakes	_____ Concentration Problems	___ Gulping
_____ Seizures	_____ Anxiety	___ Loss of Control
_____ DT=s	_____ Irritability / Restlessness	___ Relief Use
_____ Hallucinations	_____ Aggressiveness	____ Impulsive Use
_____ Overdose	_____ Mood Swings	____ Use less than before
_____ Appetite Problems	_____ Impulsivity	___ Use more than before
_____ Nausea/ Vomiting	_____ Euphoria	____ Use despite negative Consequences
_____ Sleep Problems	_____ Relaxation	___ Associate with using friends
_____ Sexual Problems	_____ Extreme Jealousy	___ Plan activities around use
_____ Injury	_____ Paranoia	___ Loss of interest in activities
_____ Accidents	_____ Feelings of Guilt/ Shame	___ Change in work/school performance
_____ Other Medical Problems	_____ Suicidal Thoughts	___ Work/school lateness/ absenteeism
_____ Other	_____ Homicidal Thoughts	___ Job loss due to use
	_____ Other	___ Frequent arguments
		___ Separation/divorce
		___ Financial problems
		___ Legal problems
		___ Physically abusive to self
		___ Physically abusive to others
		___ Suicide attempts
		___ Homicide attempts
		___ Other

If any of the above are checked off, please describe:_____
_____
_____
_____

III. SUBSTANCE ABUSE FAMILY HISTORY

Please describe the alcohol/drug problems of others in your family, past and present. Also describe treatment and recovery experience.

WHO/RELATIONSHIP	PROBLEM TYPE	TREATMENT/RECOVERY

XI. **MEDICAL INFORMATION** (past and present)

1. **Recent Treatment History**

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

2. **Review of Past/Present Conditions**

Please check any of the following medical problems you have, or have had in the past:

- ☐ Adrenal problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Seizures/Epilepsy
- ☐ Meningitis or Encephalitis
- ☐ Head Injury/Loss of Consciousness
- ☐ Kidney/Bladder problems
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Sexually transmitted disease
- ☐ Anemia
- ☐ Liver problems
- ☐ Lung problems
- ☐ Heart problems
- ☐ Allergies
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Glaucoma
- ☐ Asthma

If yes to any of the above, please describe and give dates:_____

_____

3) **Current Medical Symptoms/Problems:**

Please check all that pertain to you now:

EYES
- ☐ Double Vision
- ☐ Eye pain
- ☐ Problems with vision

EARS
- ☐ Hearing Aid
- ☐ Buzzing/Ringing in ears
- ☐ Infection in ears
- ❒ Problems with balancing
- ☐ Problems with hearing

NOSE
- ☐ Nose bleeds
- ☐ Stuffy nose

MOUTH
- ☐ Loss of taste
- ☐ Problems with teeth
- ☐ Dentures

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Sputum/mucus production
- ☐ Positive TB test
- ☐ Coughing up blood

SKIN/JOINT/MUSCLE
- ☐ Changes in skin
- ☐ Changes in nails
- ☐ Changes in hair
- ☐ Skin rash
- ☐ Skin itchy/dry
- ☐ Cramps in legs/arms
- ☐ Stiff/swollen joints
- ☐ Difficulty walking

GASTROINTESTINAL
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Abdominal pain

GENITO/URINARY
- ☐ Pain/burning with urination
- ☐ Frequent urination at night
- ☐ Bloody/brown urine
- ☐ Difficulty starting urine flow
- ☐ Constant need to urinate

.**NERVOUS SYSTEM**
- ☐ Headaches
- ☐ Numbness
- ☐ Fainting spells
- ☐ Convulsions/seizures
- ☐ Memory problems
- ☐ Coordination problems
- ☐ Tremor/shakes
- ☐ Loss of movement
- ☐ Loss of sensation

GENERAL HEALTH
- ☐ Overweight
- ☐ Underweight
- ☐ Chills
- ☐ Fever
- ☐ Tire easily
- ☐ Night/day sweats

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart skips a beat
- ☐ Palpitations
- ☐ Fast heart rate
- ☐ Chest pains
- ☐ Swollen ankles

FEMALES ONLY
- ☐ Menstrual irregularities
- ☐ Menopause
- ☐ Problem pregnancy
- ☐ Miscarriage #_____
- ☐ Abortion # _____
- ☐ Premenstrual problems
- ☐ Infertility
- ☐ Currently pregnant

If you checked any of the above, please describe:_____

4) **Medication and Drug Use**

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose: □ Yes □ No If yes, please describe:

Any medication allergies? □ Yes □ No If yes, please describe:_____

_____

Do you believe you would benefit from any of the following?

□ Anger Management Education Series □ Substance Abuse Education Series □ Grief Group

- -

STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 10
□ yes □ no □ n/a

Referred for physical □ yes □ no

_____ _____

CLINICIAN SIGNATURE/CREDENTIALS **DATE**

_____ _____

PSYCHOLOGIST SIGNATURE **DATE**

Physician □ agrees □ disagrees with referral

If disagree reason _____

_____

_____ _____

PHYSICIAN SIGNATURE **DATE**

The Center for Counseling
Your Life Is Precious.℠
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047-1985
Phone: 586.273.7095 Fax: 586.273.7196

Request/Authorization for Release of Information

I, _____, _____ hereby authorize the staff of
(Client's Name) DOB
The Center for Counseling to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to who disclosure is to be made:

   _____ Attention: _____

   _____ Approximate dates of service at site from which information is

   _____ requested: _____

2. Information to be disclosed:

   ❒ Diagnosis ❒ Drug/Alcohol History ❒ Treatment Summary

   ❒ Attendance ❒ Mental Status Exam ❒ School Records, specify: _____

   ❒ Progress ❒ Physical Examination ❒ Entire Record: _____

   ❒ Prognosis ❒ Discharge Summary ❒ Other _____

3. Purpose of disclosure:

   ❒ Provision of Mental Health Services ❒ Billing Purposes ❒ Aftercare Planning

   ❒ Continuity of Treatment ❒ Family Involvement ❒ P.O./Attorney/Judge/Court

4. Without expressed revocation, this consent expires 90 days after discharged from treatment.

5. This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

_____ _____
Client (Parent/Guardian) Signature Date

_____ _____
Staff Signature Date

The Center for Counseling
Your Life Is Precious.℠

Client Name: _____

Your therapist name is: _____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERENCY: CALL 911

If you believe you are in danger or in imminent risk, suicidal or homicidal with intent*: Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but proceed to the emergency room immediately.*

Business Hours:

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-273.7095. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = $45, 30-60 minutes = $90, and after 60 minutes, the charge will be $1.00 per additional minute. _____

Before/After Business Hours:

If an urgent matter arises which you would like to discuss with your clinician, **dial 1-586-273-7095** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100.** The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client Address _____

_____

Client Phone _____

_____
Client/Guardian Signature Date

_____
Clinician Signature/Credentials Date

The Center for Counseling
Your Life Is Precious.℠

Consent for Treatment Anger Management Education

1. I voluntarily consent to participate in the eight-week anger management education series.

2. I have been given the opportunity for discussion of any concerns that I have regarding the series.

3. I understand:

    A. That I may withdraw my consent at any time.

    B. My financial responsibility a $45 **registration fee** which will be applied to final group session, $45 **per group.**

    C. That if I miss an education date, I know that I need to make up that date in the next series or be discharged for non-compliance.

    D. That I will be charged $25.00 for any non-sufficient fund checks.

    E. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.

    F. If a minimum of 24-hour notice for cancellations is not given I will be charged at the education series date rate. NO EXCEPTIONS!

    G. A release of information will have to be signed and payment in full prior to reports being released to court.

    H. That if my therapist or physician must write letters or fill out insurance forms there will be a $75 charge for this service and that it takes up to a week to complete.

4. I have read and received a copy of the fire evacuation/fire drill procedure. Tornado warning drill procedure, building map.

5. It will be the policy of The Center for Counseling to formally charge a fee for phone calls either before or after business hours. This fee will need to be paid before your next session. The fees are up to 30 minutes = $45.00, 31-60 minutes = $90.00, after 61 minutes, the charge will be $1.00 per additional minute.

_____

Student's Signature/Date

_____

Staff Signature/Date

The Center for Counseling
Your Life Is Precious.℠

CLIENT NOTICE OF CONFIDENTIALITY
THE CENTER FOR COUNSELING

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a patient as an alcohol or drug abuser,
Unless:

1. The client consents in writing.

2. The disclosure is allowed by court order, or

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel to research, audit, or program evaluation.
   (a medical emergency defined as suicidal, homicidal ideation's or any physical health issue).

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

This is to acknowledge that I have received the
"CLIENT NOTICE OF CONFIDENTIALITY"

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date

For further information about this Privacy Notice, please contact:

The Center for Counseling
Office Manager
586.273.7095

The Center for Counseling is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

This notice is effective as of July 7, 2003. (This date must not be earlier than the date on which the notice is printed or published.

The Center for Counseling
Your Life Is Precious.℠
32743 23 Mile Road, Suite 130
New Baltimore, MI 48047

www.thecenterforcounseling.net

Notice of Privacy Policies and Practices

Our promise to you on the privacy of your health information

The Center for Counseling
Your Life Is Precious.℠

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND MADE KNOWN, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for the purpose of providing you with quality mental health and substance abuse care.

- Your private healthcare information may be released to your insurance company for the purpose of The Center for Counseling receiving payment for providing you with needed healthcare services.

- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.

- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).

- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.

- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.

- You may be contacted by the agency to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

- You have the right to limit the use of your private healthcare information. However, the agency may chose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

- You have the right to receive private communication about your health status.

- You have the right to review and photocopy any/all portions of your healthcare information.

- You have the right to make changes to your healthcare information.

- You have the right to know who has accessed your private healthcare information and for what purpose.

- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

- The agency is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.

- The agency will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the agency:

  The Center for Counseling
  ATTN: Office Manager
  32743 23 Mile Road
  New Baltimore, MI 48047

  All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency.

CENTER FOR COUNSELING SUBSTANCE ABUSE EDUCATION

Clinician	Starting Date	Today's Date
Probation Officer Phone Fax	Case Number	Faxed Date

- -

Name ____

Home Phone_________________________ Alternate Phone _______________________

Address ____________________________City____________________ Zip __________

Age_________ Date of Birth _________________ Sex ☐ Male ☐ Female

Social Security Number ____

Drivers License Number ____

Emergency Contact ______________________________ Phone ___________________

Referred by (court number) ____

Previous therapy elsewhere? ☐ yes ☐ no Where? ______________________________

Please have your $55 evaluation fee.

The Center for Counseling
Your Life Is Precious.℠

SUBSTANCE ABUSE EDUCATIONAL GROUP
NO CALL NO SHOW/LATE CANCELLATION

If you fail to show up for your scheduled Substance Abuse evaluation there is a no call/late cancellation fee of $55. This means you will be forfeiting your registration and your P.O. will be notified.

Any no call/late cancellation (without 24 hour notice) will result in incurring a fee equal to your session fee for the date scheduled.

If you show up for a group under the influence of drugs and/or alcohol, you will be prohibited from participating in that day's group session and will be charged the session fee and your P.O. will be notified.

I have read the above no call/late cancellation guidelines and understand the consequences.

Group Participant Signature/Date

Group Facilitator Signature/Date