ADULT PACKET

INTAKE PACKET

Congratulations

On Your Decision to Make a Change Toward Recovery!

Must Read Before Completing This Packet

- ☐ **COMPLETELY Fill out this packet, LEAVING NO QUESTION UNANSWERED**
- ☐ **Answer ALL Questions, Write N/A On Questions That Do Not Pertain to You**
- ☐ **Write In Black or Blue Ink Only – NO PENCIL**
- ☐ **INCOMPLETE INTAKE PACKET WILL NOT BE PROCESSED UNTIL FULLY COMPLETED BY THE CLIENT**
- ☐ **IT IS THE CLIENT'S RESPONSIBILITY TO FOLLOW-UP THE FOLLOWING WEEK WITH COOK INLET COUNSELING TO SCHEDULE AN ASSESSMENT**
- ☐ **INTAKE PACKETS WILL EXPIRE AFTER 30 DAYS OF NO CONTACT FROM THE CLIENT**

Questions/Help with Intake Packet & Scheduling:

Please Contact Annette, Case Manager
Mon. – Fri. 8:00am to 4:00pm @ 907.283.3658

- **Once packet is FULLY COMPLETED, you can drop off, mail or email to either of the addresses below:**
  - **For Kenai: 10200 Kenai Spur Hwy, Kenai, AK 99611**
  - **For Homer: PO Box 2352 Homer, AK 99603**
  - **E-Mail: *officeadministrator@alaskacicada.org* Please call to verify if received**

Help Cook Inlet Counseling Help You
Provide A *FULLY COMPLETED* Intake Packet

PLEASE KEEP THIS PAGE FOR YOUR OWN INFORMATION

Thank You!

OFFICE USE ONLY	DATE REC'D:	DELPHI:	CLIENT ID:	COUNSELOR:	APPOINTMENT DATE & TIME:

10200 Kenai Spur Hwy
Kenai, AK 99611
Phone: 907.283.3658
Fax: 907.283.5046

Empower • Heal • Connect
People
Family
Community
Cook Inlet Counseling

1230 Ocean Drive, Unit 1
Homer, AK 99603
Phone: 907.235.8001
Fax: 907.283.8099

ADULT INTAKE PACKET

CLIENT INFORMATION

First Name:_____ Last Name:_____ MI: ____ Other Names Used:_____

Address: _____ _____ _____ _____
City State Zip

Mailing: _____ _____ _____ _____
City State Zip

Cell Phone: _____ Ok To Leave Detailed Message ☐ Yes ☐ No

Home Phone:_____ Ok To Leave Detailed Message ☐ Yes ☐ No

DOB:_____ Age: _____ Gender: _____ Sexual Orientation:_____

Birthplace: _____ Race: _____ SSN: _____

Referring Agency: (***What Agency(s) Referred You***)? _____
Examples: ASAP, Probation, PED, OCS

Reason for seeking services? _____

_____

Do you affiliate with a religious faith/belief? ☐ Yes ☐ No If yes, which?_____

Prior Military Service? ☐ Yes ☐ No If so, what branch & how long: _____

METHOD OF PAYMENT

PLEASE NOTE: **Medicaid covers specific treatment services. The cost of non-covered services is the Client's responsibility. If you have Medicaid and other insurance coverage, please complete the information below.**

☐ **Self-Pay - Client's** Initials:_____

☐ **Medicaid -** ID #_____

☐ Private Insurance

Policy Holder: _____
Policy Holder DOB:_____
Policy Number: _____
Group Number: _____
SSN: _____
Insurance Company:_____

☐ Secondary Insurance

Policy Holder: _____
Policy Holder DOB: _____
Policy Number: _____
Group Number: _____
SSN: _____
Insurance Company: _____

COPY OF ID & INSURANCE CARD(S) MUST BE PROVIDED

Are you currently under a Medical Providers Care? ☐ Yes ☐ No If yes, please list:

Health Care Provider: _____ Phone number: _____

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, please list: _____

_____ _____ _____ _____

If yes, are you currently taking as prescribe by your physician? ☐ Yes ☐ No ☐ N/A

When was your last dose taken? _____ Who is your prescribing physician? _____

Release of Information signed for this prescribing agency? ☐ Yes ☐ No ☐ N/A

How do you rate your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you currently have any medical conditions? ☐ Yes ☐ No If yes, please list them: _____

_____

Are you allergic to any medication or drugs? ☐ Yes ☐ No If yes, please list them: _____

_____

Any history of serious illnesses or surgeries? ☐ Yes ☐ No If yes, please list them: _____

_____

Any history of head injuries? ☐ Yes ☐ No If yes, describe (fighting, falling, car accident, been unconscious, etc.):

_____

_____

Did you receive medical attention? ☐ Yes ☐ No ☐ N/A

Do you have any medical condition that may interfere with treatment? ☐ Yes ☐ No If yes, please describe:

_____

_____

In the past 3 months have you used emergency room services? ☐ Yes ☐ No If yes, please describe:

When: _____ Reason: _____

<u>For Women Only:</u>

Are you currently or could you be pregnant? ☐ Yes ☐ No

Are you receiving prenatal care? ☐ Yes ☐ No

OB/GYN Clinician: _____ Location/Phone: _____

Have you used alcohol or other drugs during this or past pregnancies even prior to knowing that you were pregnant?

☐ Yes ☐ No ☐ N/A If yes: Did you or your child have any complications ☐ Yes ☐ No ☐ N/A

If yes, please describe: _____

_____

MUST COMPLETE THE FOLLOWING SUBSTANCE USE HISTORY

MUST CHECK ✓ APPROPRIATE BOX(ES): NEVER USED, PAST USE, OR CURRENT USE				PROVIDE: AGE FIRST USE AGE BECAME A PROBLEM		HOW MUCH YOU USED	HOW SUBSTANCE WAS CONSUMED	WHEN WAS LAST USE
Substance	**Never Used**	**Past Use**	**Current Use**	**Age Of First Use**	**Age It Became A Problem**	**Amount Used Last 6 Months**	**Method Of Use**	**Date Last Used**
Alcohol	☐	☐	☐					
Cannabis	☐	☐	☐					
Cocaine	☐	☐	☐					
Amphetamine/ Methamphetamine	☐	☐	☐					
Hallucinogens	☐	☐	☐					
Designer Drugs	☐	☐	☐					
Opiates/Heroin	☐	☐	☐					
Suboxone/Methadone	☐	☐	☐					
Benzodiazepines	☐	☐	☐					
Pain Killers	☐	☐	☐					
Sedative/Hypnotics	☐	☐	☐					
Synthetic Drugs	☐	☐	☐					
Other drugs:	☐	☐	☐					

Are you currently taking any of the medications listed below? ☐ Yes ☐ No

☐ Buprenorphine ☐ Suboxone ☐ Subutex ☐ Sublocade ☐ Naltrexone ☐ Vivitrol ☐ Other

If yes, are you currently taking as prescribe by your physician? ☐ Yes ☐ No ☐ N/A

When was your last dose taken? _____ Who is your prescribing physician? _____

Release of Information signed for this prescribing agency? ☐ Yes ☐ No ☐ N/A

Have you ever blacked out or passed out while drinking? ☐ Yes ☐ No

Have you experienced withdrawl symptoms after drinking or using? ☐ Yes ☐ No

If yes, what symptoms were present: ☐ Achy Joints ☐ Depression ☐ Nausea/Vomitting ☐ Seizures ☐ Unable to Sleep ☐ Tremors ☐ Hallucinations ☐ Sweating

Have you had prior substance abuse treatment? ☐ Yes ☐ No If yes, please list below

Name of Treatment Facility	Type of Previous Treatment (Outpatient, Residential, Detox)	Dates of Previous Treatment	Treatment Completed (Yes/No)

Release of Information signed for this/these agencies? ☐ Yes ☐ No ☐ N/A

LEGAL HISTORY

*__**REQUIRED***__ Are you currently involved in the legal system? ☐ Yes ☐ No If yes, please list below:

Provide the charge(s) that requires(d) you to have a Substance Abuse Assessment; open and or closed case(s).

Date of Arrest	Charge	Conviction	Pending	Open	Closed

Do you need your assessment released to the organization or entity? ☐ Yes ☐ No ☐ N/A

Release of information signed specifically for that organization or entity? ☐ Yes ☐ No ☐ N/A

Are you currently involved with Adult Probation or Pretrial Enforcement Division? ☐ Yes ☐ No

If yes, please list the Probation or Pretrial Officers Name/Phone #: _____

Release of information signed specifically for Probation and or Pretrial Offices? ☐ Yes ☐ No ☐ N/A

OFFICE OF CHILDREN SERVICES & TRIBAL COURT

☐ Do you have an open **Office of Children Services** case? **Or** Do you have and open **Tribal Court** Case? ☐

If yes, please list the Reason: _____

_____

_____

Case Workers Name: _____ Location/Phone: _____

If yes, Release of Information Signed for OCS or Tribal Court? ☐ Yes ☐ No ☐ N/A

EMOTIONAL/BEHAVIORAL HISTORY

Are you currently involved in AA or NA? ☐ Yes ☐ No If yes, do you have a sponsor? ☐ Yes ☐ No ☐ N/A

Outside of legal or treatment entities, where do you get your support? _____

Have you ever received mental health treatment? ☐ Yes ☐ No If yes, please list:

Where: _____ When: _____

Current mental health diagnosis? ☐ Yes ☐ No If yes, provide diagnosis _____

Any mental health concerns? ☐ Yes ☐ No If yes, provide concerns _____

_____

_____

Have you ever experienced suicidal thoughts? ☐ Yes ☐ No If yes, When: _____

Do you have any history of suicide attempts? ☐ Yes ☐ No

Have you ever experienced homicidal thoughts? ☐ Yes ☐ No If yes, When: _____

Personal strengths in life: _____

Personal current needs: _____

Abilities (Attributes about you, you are proud of): _____

Treatment preferences: _____

FAMILY HISTORY

Have you experienced a deeply distressing or disturbing experience? Please describe.

_____

_____

_____

_____

Briefly describe your childhood history. Who raised you (siblings, stepparents, etc.)? Drugs and alcohol in the home? History of abuse (physical, mental, verbal, emotional and sexual)?

_____

_____

_____

_____

_____

Current family relationships:

_____

_____

Current living situation/arrangement: ☐ Alone ☐ Own Home ☐ Rental ☐ Significant Other
☐ Family ☐ Roommate ☐ W/Parents ☐ Relations/Friends
☐ Shelter ☐ Group Home ☐ Homeless ☐ Transitional Housing

Current relationship status: ☐ Married ☐ Engaged ☐ Single ☐ In A Relationship
☐ Divorced ☐ Separated ☐ Widowed ☐ Other_____

Do you have children? ☐ Yes ☐ No If yes, please list them including their age and gender.

_____ _____

_____ _____

_____ _____

EDUCATIONAL HISTORY

Are you currently enrolled in school, college, or a job training program?

☐ Not enrolled ☐ Enrolled, Full Time ☐ Enrolled, Part Time ☐ Other (Specify) _____

Highest level of education you have completed?_____

If less than 12 years of education, do you have a GED? ☐ Yes ☐ No

EMPLOYMENT HISTORY & INCOME RESOURCES

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Homemaker

If Employed: Current employer?_____ Phone: _____

Length of employment? _____

Income Resources: ☐ No Income ☐ SSI/SSD ☐ Child Support ☐ Friends/Relatives
☐ Other ☐ Public Assistance ☐ Retirement/Pension ☐ Unemployment ☐ Employment

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

FINANCIAL CONTRACT

The cost for treatment at CIC is as follows:

• Substance Abuse Assessment	(Includes Screening & Assessment UA)	$311.61
• Integrated Assessment	(Includes Screening & Assessment UA)	$576.88

• Individual Counseling	$103.00	• Case Management	$112.28 per hr.
• Group Counseling	$57.68 per hr.	• Breath Test	$25.00
• ADIS Only	$200.00	• UA	$45.00

Monthly Service Payment *REQUIRED*

- **Monthly Service Payment Amount $_____ *No Less Than $25.00***
- **Payment Amount Is *REQUIRED* For *ALL* Clients *W/Medicaid*, *W/O Medicaid*, *Insured* Or *Uninsured*.**
- **Payment Begins 30 days from the date of your appointment.**
- **Payments are strongly encouraged as services are provided**

Your total annual household income is: $ _____

If you have a financial hardship, please ask for a sliding fee scale form.

For clients entering treatment, CIC offers a sliding fee payment agreement for those who need assistance financially. In order to be approved, you will need to bring in the financial information listed on the attached Eligibility Determination Worksheet within 10 days. If you do not bring the required information, you will be billed at the full fee. You will be notified what level you qualify for on the sliding fee scale by the finance department.

THIRD PARTY BILLING

If a third-party billing source is intended as a payment method, the following is required:

1. CIC is authorized to release any information required to process insurance or other third-party claims.
2. Payments from third party payers need to be paid directly to CIC.
3. You are responsible for paying any non-covered services and/or partially covered charges.
4. You are responsible for providing all information necessary to file a claim. Failure to do so will result in you being fully responsible for the cost of services.
5. Even with insurance, etc. you are responsible for keeping your account current. A payment is due on your account every month even if you expect insurance to cover the cost but has not paid.

COLLECTION

If your account becomes 90 days past due, CIC is authorized to turn your account over to a collection agency. Federal law regulating confidentiality (CFR 45 and HIPAA) allow CIC to disclose such billing information as is necessary to collect fees without written consent from you when an active business associate's agreement between the agency and CIC exists.

REMINDER ***Monthly Service Payments are REQUIRED for ALL Clients; Please provide the total amount you choose to pay monthly. If an amount is NOT included, the minimal amount of $25.00 will be added for you.***

Client Name (Please Print):_____ Date: _____

Date of Birth: _____ Social Security Number:_____

Client Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Staff Signature:_____ Date: _____

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

THIRD PARTY BILLING CONSENT TO RELEASE CONFIDENTIAL INFORMAION

I (client name) _____ authorize Cook Inlet Counseling to mutually disclose and re-disclose the following information using verbal, written, electronic, and faxed communication:

Identification, diagnosis, services received, and other information required for billing and travel arrangements with:

Medicaid:_____ (Initials Only) Private Insurance: _____ (Initials Only)

Name of Insurance Provider: _____

Name of Policy Holder: _____ SSN:_____

Date of Birth of Policy Holder: _____ Phone Number:_____

Insured Policy Number: _____ Group #_____

This release covers both the insurance company and the policy holder.

The purpose of this release is to: *Exchange Information Necessary for Billing Purposes*

In addition, I hereby authorize: *My benefits to be paid directly to CIC*
I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

When all fees have been collected and or the account is closed
(Specification of the date, event, or condition upon which this consent expires)

I understand that generally CIC may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____ _____
Signature of Client Date of Birth Date signed

_____ _____
Signature of Witness Signature of Parent or Legal Guardian

PROHIBITION TO REDISCLOSE CONFIDENTIAL INFORMATION

This information disclosed to you concerns a client in alcohol/drug treatment and is made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, ALASKA 99611
KENAI PHONE 283-3658 ♦ HOMER PHONE 235-8001

CONSENT FOR FOLLOW UP CONTACT

I, _____ give Cook Inlet Counseling and their follow-up staff permission to contact me to follow-up on my status in recovery and my general wellbeing. I understand that my participation is voluntary and that the program will follow its confidentiality policies and procedures regarding my communication with them.

I understand that any and all information in my records is protected under Federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and HIPAA 1996, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (in a covered life-threatening emergency, child abuse or neglect, threatened or actual crime at this program or against staff or appropriate court order by a judge) With this understanding, I am authorizing release of the above specified information for the purpose(s) noted below. The recipient of this information may not disclose any of it without my further written consent except as provided for by Federal regulation 42 CFR Part 2 and HIPAA.

I understand that the purpose of the contacts will be to provide support and encouragement for my status in recovery as well as research documentation. All research information is used without patient identifying information. I further understand that I can withdraw this permission at any time by writing to: Cook Inlet Counseling, P.O. Box 882, Kenai, Alaska 99611 and will expire ***after the completion of the one year follow up contact.***

The best way and time of day to reach me is:

_____
Home Phone

_____
Cell Phone

_____
Work Phone

Personal e-mail address (optional)_____

I can also be contacted by mail at this address:_____

You also have permission to contact the following person(s) in order to get information as to where I may be contacted:

1. Name: _____ Relationship:_____

   Phone: _____

2. Name: _____ Relationship:_____

   Phone: _____

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
KENAI PHONE 283-3658 ♦ HOMER PHONE 235-8001

CONSENT FOR EMERGENCY CONTACT

Date Completed: _____

Client Name: _____ Date of Birth: _____

Phone/Cell: _____ SSN: _____ Driver's License/State ID: _____

Physical Address: _____ City, State, Zip: _____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Physical Address: _____ City, State, Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

For: In the event of an emergency.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE

Recipients:
If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ COMPLETE A RELEASE OF INFORMATION (ROI)

- **One Must Be Completed for Each Agency Referring You**
- **Example List & Example ROI is Attached – <u>PLEASE REVIEW</u>**

These directions are for completing the Releases of Information (ROI).
Releases of Information help facilitate your treatment.
Information may need to be exchanged with another agency(s) or person(s).

You will need ***<u>one release per agency or person</u>*** that may apply to you:

<u>Example List:</u>

- Adult Probation
- Office of Children Services (OCS)
- Alaska Safety Action Program (ASAP)
- Previous Treatment Center(s)
- Lawyer
- Medical Provider(s)
- Emergency Contact (optional)
- Parents (optional)
- Spouse (optional)
- Other

☐ **Read the form carefully and follow ALL directions exactly as they are listed to ensure that your Release of Information is valid.**

☐ **Phone numbers (and faxes if available) are very important to include on each form as they are required for telephonic exchange of information as well as information transmitted via facsimile (fax).**

☐ **The Releases of Information are NOT intended for your address or phone numbers.**

☐ **Review The Example Release of Information on the Next Page for Assistance on Completing the Form.**

☐ **Only Use Initials for Information You Want Released, An <u>X</u> Or a <u>✓</u> Are Not Valid on the Form.**

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: **JANE DOE** Date of Birth: **05/05/1985**

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: **ALCOHOL SAFETY ACTION PROGRAM**
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: **805 Frontage Rd Ste. 200B**

City: **KENAI** State: **ALASKA** Zip Code: **99611**

Phone: **907-283-3586** Fax: **907-283-4029** E-Mail:

Information to be disclosed: (***INITIAL ALL THAT APPLY***)

JD All Listed Below ***EXAMPLE:* INITIAL ALL LISTED BELOW**

OR: ONLY INITIAL WHAT YOU WANT TO DISCLOSE

Initials Only

____ Assessment/Interpretive Summary	**JD** U/A Drug Test Results
JD Treatment Plan or Summary	**JD** Attendance
JD Treatment Review/Progress	____ Financial/Payment Information
____ Psychological Evaluation	____ Other: ____
____ Discharge/Transfer Summary	____ Other: ____

Purpose of Disclosure: (***INITIAL ALL THAT APPLY***)

____ All Listed Below **OR:**

Initials Only

JD Further Treatment/Coordination of Care	____ Financial
____ At the Request of Client	____ Payment & Health Care Operations
JD Legal Purposes	____ Other: ____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☒ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**

☐ Upon a specific date, event, or condition as listed here: ____
(Specific date, event, or condition)

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Jane Doe	JANE DOE	01/01/21
SIGNATURE OF CLIENT	PRINT NAME	DATE
SIGNATURE OF PARENT GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE

REVOCATION PURPOSE ONLY: ☐ **This ROI is Revoked**: ____ DATE ROI IS ***REVOKED*** ____ SIGNATURE OF CLIENT

Recipients:

If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: _____ Date of Birth:_____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: _____
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____ E-Mail:_____

Information to be disclosed: (***INITIAL ALL THAT APPLY***)

_____ All Listed Below; **OR:**

_____ Assessment/Interpretive Summary
_____ Treatment Plan or Summary
_____ Treatment Review/Progress
_____ Psychological Evaluation
_____ Discharge/Transfer Summary

Initials Only

_____ U/A Drug Test Results
_____ Attendance
_____ Financial/Payment Information
_____ Other: _____
_____ Other: _____

Purpose of Disclosure: (***INITIAL ALL THAT APPLY***)

_____ All Listed Below; **OR:**

_____ Further Treatment/Coordination of Care
_____ At the Request of Client
_____ Legal Purposes

Initials Only

_____ Financial
_____ Payment & Health Care Operations
_____ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**

☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ _____ _____
SIGNATURE OF CLIENT PRINT NAME DATE

_____ _____ _____
SIGNATURE OF PARENT GUARDIAN OR REPRESENTATIVE RELATIONSHIP TO CLIENT DATE

REVOCATION PURPOSE ONLY: ☐ **This ROI is Revoked**: _____ _____
DATE ROI IS ***REVOKED*** SIGNATURE OF CLIENT

Recipients:
If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: _____ Date of Birth: _____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: _____
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Information to be disclosed: (***INITIAL ALL THAT APPLY***)

_____ All Listed Below; **OR:**

_____ Assessment/Interpretive Summary
_____ Treatment Plan or Summary
_____ Treatment Review/Progress
_____ Psychological Evaluation
_____ Discharge/Transfer Summary

Initials Only

_____ U/A Drug Test Results
_____ Attendance
_____ Financial/Payment Information
_____ Other: _____
_____ Other: _____

Purpose of Disclosure: (***INITIAL ALL THAT APPLY***)

_____ All Listed Below; **OR:**

_____ Further Treatment/Coordination of Care
_____ At the Request of Client
_____ Legal Purposes

Initials Only

_____ Financial
_____ Payment & Health Care Operations
_____ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**

☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE

REVOCATION PURPOSE ONLY: ☐ **This ROI is Revoked**: _____ DATE ROI IS ***REVOKED*** _____ SIGNATURE OF CLIENT

Recipients:
If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
KENAI PHONE 283-3658 ♦ HOMER PHONE 235-8001

AUDIT

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Question 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7,8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year.
(4) Yes, during the last year.

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year.
(4) Yes, during the last year.

Add up the points associated with answers. _____ A total score of 8 or more indicates harmful drinking behavior.