

ADULT PACKET



INTAKE PACKET

Congratulations
On Your Decision to Make a Change Toward Recovery!



Read Before Completing This Intake 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**
- PROVIDE COPIES OF YOUR DRIVERS LICENSE/ID, MEDICAID CARD & OR MEDICAL INSURANCE CARD(S)**

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 by Providing A *FULLY COMPLETED* Intake Packet

Thank You!

PLEASE KEEP THIS PAGE FOR YOUR OWN INFORMATION

OFFICE USE ONLY	DATE REC'D:	DELPHI:	CLIENT ID:	COUNSELOR:	APPOINTMENT DATE & TIME:
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10200 Kenai Spur Hwy
 Kenai, AK 99611
 Phone: 907.283.3658
 Fax: 907.283.5046



1230 Ocean Drive, Unit 1
 Homer, AK 99603
 Phone: 907.235.8001
 Fax: 907.235.8099

ADULT INTAKE PACKET

CLIENT INFORMATION

_____	_____	_____	_____
First Name	Last Name	MI	Other Names Used
_____		_____	_____
Physical Address		City	State Zip
_____		_____	_____
Mailing		City	State Zip
_____		_____	_____
Phone: () _____	Cell: () _____	Ok To Leave Detailed Message	<input type="checkbox"/> Yes <input type="checkbox"/> No
DOB: ____/____/____	Age: _____	Birthplace: _____	Race: _____
Gender Identity: _____	Sexual Orientation: _____	SSN: _____ - _____ - _____	
Referring Agency:	<input type="checkbox"/> ASAP <input type="checkbox"/> Probation <input type="checkbox"/> PED <input type="checkbox"/> OCS <input type="checkbox"/> Self <input type="checkbox"/> Other _____		
Reason for seeking services?	_____		
Treatment preferences?	_____		
Do you affiliate with a religious faith/belief?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which? _____		
Prior Military Service?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, what branch & how long: _____		

METHOD OF PAYMENT

Self-Pay - Client's Initials: _____

IF YOU HAVE MEDICAID AND OTHER INSURANCE COVERAGE, PLEASE COMPLETE THE INFORMATION BELOW.

Medicaid - ID # _____

Private Insurance

Secondary Insurance

Policy Holder: _____

Policy Holder: _____

Policy Holder DOB: _____

Policy Holder DOB: _____

Policy Number: _____

Policy Number: _____

Group Number: _____

Group Number: _____

SSN: _____

SSN: _____

Insurance Company: _____

Insurance Company: _____

Medicaid Covers Specific Treatment Services. The Cost Of Non-Covered Services Is The Client's Responsibility.

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

MEDICAL HISTORY

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: _____

For Women Only:

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: _____

SUBSTANCE USE & TREATMENT HISTORY

MUST <u>FULLY</u> COMPLETE THE FOLLOWING SUBSTANCE USE HISTORY CHART								
MUST CHECK ✓ APPROPRIATE BOXES: 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?
<u>Substance</u>	<i>Never Used</i>	<i>Past Use</i>	<i>Current Use</i>	<i>Age At First Use</i>	<i>Age It Became A Problem</i>	<i>Amount Used Last 6 Months</i>	<i>Method Of Use</i>	<i>Date Last Used</i>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Amphetamine/ Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Designer Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Opiates/Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Suboxone/ Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Sedative/Hypnotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Synthetic Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Other drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Did you fully complete the above Substance Use History chart? Yes No **If No, Must Fully Complete.**

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 or using substances? Yes No

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

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

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

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 an 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

Are you required by Adult Probation or Pretrial Enforcement Division to have a: Substance Abuse Assessment
 Integrated Assessment

OFFICE OF CHILDREN SERVICES & TRIBAL COURT

Do you have an open **Office of Children Services** case? **Or** Do you have an 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

EMOTIONAL/BEHAVIORAL HISTORY

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): _____

Emotional/Behavioral Health Treatment preferences: _____

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 & EMPLOYMENT 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 Status: Full Time Part Time Unemployed Retired Homemaker

If Employed: Current employer? _____ Phone: _____

Length of employment? _____

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

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 Cook Inlet Counseling is as follows:

• Substance Abuse Assessment	(Includes Screening & Assessment UA)	\$311.61	
• Integrated Assessment	(Includes Screening & Assessment UA)	\$576.88	
• Treatment Plan Review	\$135.43		
• 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 Payment Amount Is REQUIRED For ALL Clients W/ or W/O Medicaid, Insured or Uninsured.

*Monthly Payment Amount You Choose to Pay \$ _____ No Less Than \$25.00. *

- 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 financial hardship, please ask for a sliding fee scale form.

For clients entering treatment, Cook Inlet Counseling offers a sliding fee payment agreement for those who need assistance financially. 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. Cook Inlet Counseling 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 Cook Inlet Counseling.
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 to 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, Cook Inlet Counseling is authorized to turn your account over to a collection agency. Federal law regulating confidentiality (CFR 45 and HIPAA) allow Cook Inlet Counseling 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 Cook Inlet Counseling 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 INFORMATION

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 Cook Inlet Counseling

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 Cook Inlet Counseling 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.

Client Name (Please Print): _____ **Date:** _____

Date of Birth: _____ **Social Security Number:** _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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 (client name)_____ 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:

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Client Signature: _____ **Date:** _____

Parent/Guardian 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.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **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.



Read Before Completing A Release of Information (ROI)

COMPLETE A RELEASE OF INFORMATION (ROI)

- **One Must Be Completed for Each Referring Agency**
- **Example List & Example ROI is Attached – PLEASE REVIEW**
- **Provide Organization(s) Name, Address, Phone & Fax Numbers**

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 **one release per agency or person** that may apply to you:

Example List:

- 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 are very important to include on each form as they are required for the telephone exchange of information as well as information transmitted via facsimile (fax).**
- The Organizations Name and Address are to be provided.**
- 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 X Or a ✓ Are Not Valid on the Form.**

******Please Review the Example Release of Information on The Following Page**

******It Must Be Fully Completed to Be A Valid ROI**

Thank You!

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

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

**MUST PROVIDE THE ORGANIZATION
NAME, ADDRESS, PHONE & FAX**

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:

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

Initials
Only

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

Purpose of Disclosure: (INITIAL ALL THAT APPLY)

____ All Listed Below

OR:

JD Further Treatment/Coordination of Care
____ At the Request of Client
JD 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.

Jane Doe JANE DOE 01/01/21
SIGNATURE OF CLIENT PRINT NAME DATE

SIGNATURE OF PARENT GUARDIAN OR REPRESENTATIVE RELATIONSHIP TO CLIENT DATE

REVOCAION 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

REVOCAION 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

_____ U/A Drug Test Results

_____ Attendance

_____ Financial/Payment Information

_____ Other: _____

_____ Other: _____

Initials
Only

Purpose of Disclosure: (INITIAL ALL THAT APPLY)

_____ All Listed Below;

OR:

_____ Further Treatment/Coordination of Care

_____ At the Request of Client

_____ Legal Purposes

_____ Financial

_____ Payment & Health Care Operations

_____ Other: _____

Initials
Only

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:

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SIGNATURE OF CLIENT

PRINT NAME

DATE

**SIGNATURE OF PARENT
GUARDIAN OR REPRESENTATIVE**

RELATIONSHIP TO CLIENT

DATE

REVOCAION 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

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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.