ADOLESCENT PACKET

INTAKE PACKET

Congratulations

On Your Decision to Make a Change Toward Recovery!

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611

KENAI PHONE 283-3658 ♦ HOMER PHONE 235-8001

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, parent or legal guardian of _____, a minor child, authorize Cook Inlet Counseling to provide treatment services for my child. Treatment would include the regular services provided by the agency including group and individual counseling, care coordination, and random drug/alcohol screens. Although a parent or guardian must provide authorization for a minor to receive treatment, CIC is required to have a signed, release of information from the minor in order for any information about the minor to be released to the parent or guardian. I also understand that I am legally responsible for the cost of any services provided.

I understand that in order for counseling to achieve success with any character, their confidentiality desires to be respected, even within the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

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.

_____ _____ _____

Parent or Guardian's Signature | Relationship to Minor | Date signed

_____

Parent or Guardian's Address (Street, City, State and Zip)

_____ _____ _____

Other Parent or Guardian's Signature | Relationship to Minor | Date signed

_____

Other Parent or Guardian's Address (Street, City, State and Zip)

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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*

- **Payment Amount Is *REQUIRED* For *ALL* Clients *W/ Or W/O Medicaid*, *Insured* Or *Uninsured*.**
- ***Payment Amount You Choose To Pay Monthly $_____, *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 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: _____

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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 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.

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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:** _____

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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!

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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:

Initials Only

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

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

_____ All Listed Below **OR:**

Initials Only

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

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.

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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:

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

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_____	_____	_____
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.

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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.