ADULT INTAKE APPLICATION
MANDATED PROGRAM-SERVICE

Confidentiality: The information you provide on this application is protected by our confidentiality policy and will be held in strict confidence. It is to be used for the evaluation. Any false or misrepresented information places you at risk of being discharged. If you have any questions or concerns, you may review the confidentiality policy with your counselor designate staff.

Date: | Intake Staff: | Referral *(Person)*: | Agency:

Client Information

Program: ☐ Anger Management ☐ Assessment ☐ Domestic Violence ☐ DUI Clinical Evaluation ☐ Parent Education Class ☐ Individual, Group, Couple or Family Counseling ☐ ASAM I Treatment ☐ Substance Abuse Education ☐ Substance Abuse Evaluation ☐ Life Skills Theft Course ☐ Other:

First Name: | MI: | Last Name: | S.S. #:

Age: | Date of Birth: | Gender: ☐ Male ☐ Female | County:

Current Address: | City: | State: | Zip:

Home Phone: | Fax: | Alternate: | Email Address:

Race: *(Choose only one)* ☐ Black/African American ☐ White/Caucasian ☐ Multiracial ☐ Asian ☐ American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Origin ☐ Yes ☐ No

Number of Individuals in Household:

Marital Status: ☐ Single never married ☐ Separated ☐ Divorced ☐ Married ☐ Widowed

Monthly Household Income:

Payor/Funding Source: ☐ Self Pay ☐ State Contract Services. ☐ Other:

Name of Insurance Co: | Insurance/Medicaid #: | Phone #

Referral Source: (check all that apply)
☐ Self ☐ Family or Relative ☐ DWI/DUI Referral ☐ DJJ
☐ Judge or Court ☐ Probation Officer ☐ DFACS ☐ Law Enforcement
☐ Concern Individual ☐ General Hospital ☐ Other (specify):

English Proficiency:
☐ Proficient ☐ Limited-Spanish Primary Language ☐ Limited - Primary Language Other

Have you ever been Hospitalized for an emotional and/or mental health concern? ☐ Yes ☐ No If yes, Describe:

Any Previous Therapy/Counseling? If Yes, Name and Phone Numbers of Therapists:

When and Number of Sessions: Type of Therapy/Counseling:

Medications:*)*:☐ Yes ☐ No If yes, *List up to four-Primary psychiatric only; Current prescription*

1.

2. | **3.** | **4.**

Living Situation: ☐ Independent House/Apartment ☐ Homeless Shelter ☐ Homeless not in Shelter ☐Residential Treatment Care ☐ Jail/Correction Facility ☐ Domestic Violence Situation ☐ Living w/friend ☐ Other:

Home long have you lived at the current address listed above: yrs months

Education: ☐ 8th or under ☐ 9th ☐ 10th ☐ 11th ☐12th ☐ H.S. Graduate ☐ Some College ☐ College Grad ☐ Advance Degree ☐ Technical School ☐ GED, If GED what year? ☐Other:

Religious preference: ☐ **Protestant** ☐**Catholic** ☐**Jewish** ☐ **Baptist** ☐ **Islamic** ☐**AME** ☐ **Christian** ☐**Other:** ☐ **None**

Justice System Involvement: Any involvement with criminal/justice system in the past year: ☐Yes ☐ No, If yes, are you on probation, parole, commitments, adjudications, diversions, or awaiting sentencing: ☐ Yes ☐ No, **If yes, please attach a copy of all order(s)**

Arrest: Number of arrests, regardless of nature of offense or outcomes, in the past 30 days:

Fines:$ | **Length of Probation:** | **Community Service hours:** | **Mandated classes:** ☐ Yes ☐ No

Military: ☐Yes ☐ No, If yes, what branch? | Dates of Served: | Type of Discharge:

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: | **Date Employed:**

Name of Employer: | **Address:**

Describe Presenting Situation:

1. Have you ever thought about harming yourself or someone else? ☐ No ☐ Yes, if yes, did you have a plan and when was the last time you thought about harming yourself or someone else?____
2. Have you ever harmed/injured yourself or someone else intentionally? ☐ No ☐ Yes, if yes, did you have a plan and when was the last time you harmed yourself or someone else?____

Type of Substance(s) Used:	☐ None ☐ Alcohol ☐ Drugs ☐ Both		
Name of Substance(s) Used:	Indicate the name of substances used/abused:		
	Primary Substance Used	Secondary Substance Used	Tertiary Substance Used
Route of Administration:	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown
Frequency of Use:	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month
Age at first use:			
Prior Treatment Episodes	How many previous treatment episodes has the consumer received in any drug or alcohol program?		
List any and all DUI charges	1st DUI Date: Place: BAC level	2nd DUI Date: Place: BAC level:	
3rd DUI Date: Place: BAC level	4th DUI Date: Place: BAC level :		

Fill Out This Section If The Police Were Involved In the Case That Brought You Here:

Please describe the incident that brought you to Positive Growth Counseling Center today:

Were you arrested for the above incident? ☐ Yes ☐ No If yes, Date:

Charged with: | Result: ☐ Convicted ☐Pending ☐ Charges Dropped

Have you been involved in other incidents where the police have been involved other than the incident described above? ☐ Yes ☐ No

If yes, How many times?

Describe:

Are you on probation for this incident? ☐ Yes ☐ No | How long is your probation? (months)

Probation Officer: | County: | Phone: | Cell:

Address | City | State | Zip

Sentencing Judge: | City Attorney:

Sentence: | Number of Jailed days sentenced: | How many days did you serve?

Legal History Current :

Legal History Past:

Probation conditions:

☐ Attend a Mandated Program Group ☐ Community Service ☐ Assessment / Evaluation ☐ Abstain from Alcohol

☐ Substance Abuse Treatment ☐ Substance Abuse Education If so, where:

Name of Program:	City:	State:	Zip:
Phone:	Fax:		

EMERGENCY CARE, CONSENT AND CONTACTS

In the case of a medical emergency while the client is participating in a program, the staff will provide first aid. In the event that the emergency room, hospitalization, or other appropriate medical or dental care is needed, appropriate transportation to the appropriate facility will be arranged. The parent/guardian/custodian (or designated contact person) will be contacted to meet the client at the facility. If the parent/guardian/custodian (or designated contact person) cannot be reached, the staff member may authorize the physician/dentist/facility to provide emergency treatment.

I, ____ (Client/Legally Responsible Person), authorize Positive Growth to contact the individual and/or physician I have indicated below in the event I become incapacitated due to emergency illness or accident while in treatment. This emergency contact consent will be in lieu of any other authorizations, if any, I have granted, or not granted to the below individual.

Emergency Contact Person: ______________________________ Relationship____________________ Contact #:__________________

Alternate Contact Numbers/Person (s):____

I also will hold harmless Positive Growth, Inc. against any liability caused by their taking of any emergency procedures and/or contacts. I agree to the Emergency Care Process as outlined above. I will assume the full responsibility of all incurred emergency treatment expenses.

________________________________ ___ /___ /___ __________________________ ___ /___ /___

Client/Legally Responsible Person Date Employee Signature Date

CONSENTS FORM

CONSENT FOR SERVICES: Positive Growth Intervention Center provides services to individuals who may have behavioral, emotional, developmental, and/or substance abuse problems. The staff members are trained to provide appropriate treatment as needed to help the individual.

I agree to treatment/services as offered by Positive Growth Intervention Center for:

☐ Myself ☐ The person for whom I am legal guardian/custodian ☐ Other:_________________________________

CONFIDENTIALITY: In accordance with state and federal laws, information maintained about you at this agency will be protected from unauthorized disclosure. No information will be sent to your employer, family members, friends, or anyone else, unless it is discussed with you ahead of time and permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you such as:

1. In the interest of public safety (life threatening situations)
2. In response to a court order
3. Where state laws require that information be disclosed (e.g., suspected child or adult abuse, Communicable disease)

CLIENT RIGHTS AND RESPONSIBILITIES: I have read and understand the client rights handout and the relevant handouts outlining my responsibilities as a client of Positive Growth Intervention Center. I understand that it is my right to ask questions if I need clarification or have concerns.

RELEASE OF INFORMATION FOR PAYMENT: I hereby authorize Positive Growth, Inc. Intervention Center to release the necessary information from my record as requested to ____.
This data will include dates of service, types of services, diagnosis, name of person providing services, and the relevant charges. Other information requested may also include any alcohol/drug or HIV/AIDS related treatment. This information will be used to process claims only.

AGREEMENT TO PAY: I agree to pay the established fee of _________________ or pay each session ______. I understand that:

- I may be denied an appointment and/or sent to Small Claims Court if I refuse to pay.
- It is my responsibility to inform the agency of any changes, which affect the billing or charges to my account.
- I will be charged for a scheduled appointment if not canceled 24 hours in advance.
- I understand that my probation officer, judge or court appointed personnel will be notified of my failure to pay.

I, ____ (Client/Legally Responsible Person) have read and understand the Clients' Contract, Rules and confidentiality statement and each has been explained to me.

_______________________________ ___/___/___ _______________________________ ___/___/___

Client/Legally Responsible Person Date Employee/Witness Signature Date

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize ____ or any member of the clinical, court mandated programs or administrative staff at Positive Growth Intervention Center to disclose confidential information pertaining to the program I am currently enrolled in as described in this authorization to victim, victim liaisons, referring courts, law enforcement, Department staff and monitors, the Department's Probation Division, the Department of Family and Children Services, the Board of Pardons and Paroles:

Client Name: ____ Date of Birth: _______________________

SSN:______________________________________ Previous Name:__________________________________

Please release program information/data to:____

Print: First and Last Name

Name of Organization/Agency:____

Address:____

City/State: ____ Zip __________________________

Release the following information:

- ❑ All health care information
- ❑ Program attendance record
- ❑ Evaluation/Assessments
- ❑ Substance Abuse Evaluation
- ❑ Notification Form
- ❑ Fee Payment Status
- ❑ NEEDS Assessment
- ❑ DUI Clinical Evaluation
- ❑ Non-Compliant Notice
- ❑ Results of drug screen done on the following date: ____
- ❑ Dates of attendance for individual or group participation follows: ____________________________
- ❑ Other ____

This information may be transmitted ❑ verbally ❑ in writing ❑ both

<u>Expiration of Authorization:</u> This authorization will expire *(choose and complete one):* in 180 days or at the completion of the program that I am enrolled in or when the following occurs:

____

Other:____

I have had an opportunity to review and understand both pages of this form. By signing this form, I am confirming that it accurately reflects my wishes.

____ _____________________ ________________

❑ Client or legally authorized individual signature — Date — Time

(Please see the second page)

Right to Revoke: I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form, which is available from Person to Person Consulting.
2) Write, sign and date a letter to Positive Growth, Inc., 945 N. Indian Creek Drive, Clarkston, GA 30021, requesting that the authorization be cancelled; or
3) Sign, date and write "CANCEL" on this original form.

Potential for Redisclosure: Once this information is released, the person/organization releasing it has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

Right to Copy: I understand that I am entitled to receive a copy of this authorization.

Voluntary: I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party or parties I have designated.

Purpose of Authorization: I am requesting that my Protected Health Information be disclosed for the following purpose ("at my request" is all that is required if you do not desire to state a specific purpose):

Treatment not Conditional: I understand that my treatment is not conditional on whether or not I choose to sign this authorization.

Photocopy or Facsimile: A photocopy of facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

______________________________________ ______________________ _________________

Client or legally authorized individual signature Date Time
****

Complete the following only if you are a Personal Representative signing the form on behalf of the individual:

If a Personal Representative executes this form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of:

☐ A power of attorney for health care purposes including the right to access protected health information (copy attached).

☐ A court order of appointment as the conservator or guardian of the individual (copy attached).

☐ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).

☐ Other: ____

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality may protected by Federal Law. Federal regulations may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information may not be sufficient for this purpose. Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient (42 CFR Part 2 applies only to substance abuse

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIONPLEASE REVIEW IT CAREFULLY

Our Commitment to Protect Your Mental Health and Medical Information

You have a right to privacy with respect to your past, present, and future mental health and medical information. Positive Growth, Inc. is required by law to protect your information and to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information. You have the right to receive a paper copy of this Notice. An electronic copy of this

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. In the event this Notice is revised, you may request a paper copy of the revised notice or view the revised notice at the above web address.

How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. In general, our use and disclosures fall within the following three categories: treatment, payment, and health care operations.

Treatment – We will use your protected health information and disclose it to others as necessary to provide treatment to you. For example, members of our clinical staff may access your record in the course of your care, or share information in the process of coordinating your care. Such staff members include physicians, psychologists, nurses, and other mental health professionals. Additionally, disclosure to another facility, community health center, or private practitioner may become necessary for your continued treatment.

Payment – We will use or disclose your protected health information as necessary to arrange for payment of services provided to you. For example, information about your diagnosis and the services we provide to you may be included in a bill that we send to a third-party payer.

Health Care Operations – We will use or disclose your protected health information in the course of operating Positive Growth, Inc. Centers or for the health care operations of another organization that has a relationship with you. For example, our quality assurance staff reviews records to ensure that our high standards of treatment delivery are reached consistently. In addition, Positive Growth, Inc. may contract with outside companies, or "business associates", such as consultants, accountants, lawyers, and medical transcriptions, to provide services that may involve the use of your protected health information.

Unless you instruct us otherwise, we may also send appointment reminders, information about treatment options and other health-related benefits that may be of interest, and other similar materials to you.

Uses and Disclosures Requiring Your Authorization

We are generally prohibited from using or disclosing your protected health information for purposes other than treatment, payment, and health care operations without your written authorization, unless the use or disclosure is within one of the categories described below. In addition, we generally may not use or disclose psychotherapy notes written by your mental health provider without your written authorization, even for treatment, payment and health care operations. You have the right to revoke your authorization in writing at any time, except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures Not Requiring an Authorization

By law, we may use or disclose certain of your protected health information without an authorization in the following circumstances:

When required by law – We may disclose protected health information when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to certain criminal activity, or in response to a court order. We must also disclose protected health information to authorities that monitor our compliance with these privacy requirements.

For public health activities – We may disclose certain protected health information to public health agencies as permitted or required by law.

For health oversight activities – We may disclose certain protected health information to certain government agencies for oversight activities authorized by law.

Judicial and Administrative Proceedings – We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information in certain cases in response to a subpoena, discovery request, or other lawful process, subject to your notice and opportunity to object.

Relating to deceased individuals – We may disclose certain protected health information related to death to pursuant to a valid subpoena of a coroner or medical examiner.

To avert a serious threat to health or safety – We may disclose protected health information, in order to avoid a serious threat to your health or safety and the health and safety of the public or another person.

For specific government functions – We may disclose protected health information as required by military authorities, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security and intelligence reasons, such as protection of the President.

Uses and Disclosures of Alcohol/Drug Treatment Records

At Positive Growth, Inc., personally identifying information related to the treatment of substance abuse has special legal privacy protections. We will not disclose any information identifying you as a consumer of our services or provide any mental health or medical information relating to substance abuse treatment except in certain circumstances, including but not limited to: (1) you consent in writing; (2) a court orders disclosure of the information after a show cause hearing as required under Georgia Law; (3) medical personnel need the information to meet a medical emergency; (4) qualifying personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (5) it is necessary to report a crime or threat to commit a crime or to report child abuse or neglect as required by law. As applicable, you will be provided an additional notice regarding the confidentiality of substance abuse information.

Uses and Disclosures to Which You May Object

In the following situations, we may disclose a limited amount of your protected health information if we inform you in advance and you do not object, as long as law does not otherwise prohibit the disclosure:

To families, friends, or others involved in your care – We may share with these people certain information directly related to their involvement in your care, or payment for your care. We may share certain protected health information with these people to notify them about your location, general condition, or death.

Patient directories – Your name, location, and general condition may be put into a facility patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.

Your Rights Regarding Your Protected Health Information .

You have the following rights with respect to your protected health information:

To obtain access to your protected health information – You generally have the right to see and obtain copies of your protected health information upon written request. We may deny you access to review or copy your protected health information. If your request is denied, we must provide you with a reason for the denial and explain any right to have the denial reviewed. If we grant your written request for copies of your protected health information, we will advise you in advance of any fees we may impose for the costs of copying and mailing.

To request restrictions on uses and disclosures – You have the right to ask that we limit how we use or disclose your protected health information. We will consider your request, but are not legally bound to agree to the restriction. If we do agree to any restriction, we will put the agreement in writing and abide by it except in the case of emergency situations. We cannot agree to limit uses and disclosures that are required by law.

To receive confidential communications – You have the right to request that we communicate with you by using an alternative address or by alternative means. We must agree to your request as long as it is reasonable for us to comply.

To an accounting of disclosures – You have the right to receive upon written request an accounting of when; to whom, for what purpose, and what content of your protected health information has been released for the past six years. This list will not include the

following instances for disclosure: for treatment, payment, and health care operations; to you, to your family, or for a facility directory; or pursuant to your written authorization. The list of disclosures will not include any certain other disclosures, such as those made to law enforcement officials or correctional facilities, for national security purposes, or disclosures made before January 1, 2007. There will be no charge for the first accounting you request within a 12-month period. For additional lists within the same period, we will advise you in advance of any fees we may impose.

To request an amendment – If you believe that your protected health information is incorrect or incomplete, you have the right to request in writing that we amend the information. Your request must include the reason you are seeking a change. We may deny your request if (1) we did not create the information or the information is not part of our records; (2) the information is not permitted to be disclosed; or (3) the information is correct and complete. Any denial must be in writing and must state the reasons for the denial and explain your right to submit a statement of disagreement and to have your statement (and any rebuttal), along with your request and the denial, appended to your record.
Notice of Privacy Policy

ACKNOWLEDGEMENT OF RECEIPT

By signing this Acknowledgement of Receipt, you acknowledge that you have received a copy of the Notice of Privacy Practices of Positive Growth, Inc. Our Notice of Privacy Practices describes and contains information about our legal duties and privacy practices and about your legal rights with respect to your protected health information. We encourage you to read our Notice of Privacy Practices in full.

I acknowledge receipt of the Notice of Privacy Practices of Positive Growth, Inc.

Consumer's Signature: ______________________________________ Date: __________________

Parent/Guardian Signature: ____________________________________ Date: __________________