## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**
This notice takes effect on October 12, 2002 and remains in effect until we replace it.

**1. Our pledge regarding Protected Health Information (PHI):**
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of protected health information.

**2. Our Legal Duty**
**Law Requires Us to:**
1. Keep your protected health information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

**We Have the Right to:**
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

**Notice of Change to Privacy Practices:**
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

**3. Use and Disclosure of Your Protected Health Information**
The following section describes different ways that we use and disclose protected health information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose protected health information. We will not use or disclose your information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us unless it is a non-revocable court release.

**FOR TREATMENT:**
We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to counselors, nurses, technicians, Interns, or other people who are taking care of you.

**FOR PAYMENT:**
We may use and disclose your protected health information for payment purposes with your written authorization.

**FOR HEALTH CARE OPERATIONS:**
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:**
In addition to using and disclosing your protected health information for treatment, payment, and health care operations, we may use and disclose protected health information for the following purposes.

**Disaster Relief:** We may share protected health information with a public or private organization or person who can legally assist in disaster relief efforts.

**Research in Limited Circumstances:** We may use protected health information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of protected health information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the protected health information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the protected health information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities

required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may disclose protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
**Workers Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
**Appointment Reminders:** We may use and disclose protected health information for purposes of reminding you of your appointment.
**Alternative and Additional Medical Services:** We may use and disclose protected health information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

**4. Your Individual Rights**

**You Have a Right to:**

1. Look at or get copies of your protected health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may schedule an appointment by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. We may request that you schedule an appointment to review your private health information in order that we may answer any questions you may have. If you request copies, we will charge you $.50 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your protected health information by different means or to different locations. Your request that we communicate your information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your protected health information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Signature _____

Date _____

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**
**Donya Jenkins, Office Manager**
**Community Counseling Center**
**205 South Pratt Avenue,**
**Carson City, Nevada 89701**

**COMPREHENSIVE ADULT INTAKE FORM**

Source of Referral:_____

What problem areas brought you here today?_____

_____

_____

How do you feel we can help you?_____

_____

_____

**Personal Information**

First Name:_____ Middle:_____ Last Name:_____

Alias:_____ Email:_____

Client's Address:_____

City:_____ State:_____ Zip Code:_____

Move in Date:_____ County:_____

Primary Phone Number: _____ Alternate Number: _____

Emergency Contact: Name_____ Relationship_____

Phone Number:_____

Are you a U.S. Veteran: YES or NO

Is an immediate family member a veteran? YES NO UKNOWN

If yes, please describe: _____

Health Insurance Company:_____

Medicaid: YES NO

**Current Living Situation:**

_____ Homeless
_____ Dependent Living
_____ Jail, Prison or Correctional Facility
_____ Independent Living
_____ Shelter
_____ Other : _____

**Race:**

_____ Alaskan Native _____ White

_____ American Indian
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ Two or More Races
_____ Other Single Race
_____ Declined to Specify

**Ethnicity:**

____ Puerto Rican Origin
____Cuban Origin
____Hispanic or Latino- South American
____Hispanic or Latino- Specific Origin Not Known
____Not of Hispanic or Latino Origin
____Mexican Origin
____Hispanic or Latino- Dominican Republic
____Hispanic or Latino- Other Spanish Culture or Origin including Spain
____Unknown

**Gender Identity:** _____ Male _____ Female _____ Trans-Male _____ Trans-Female

_____ Gender Queer/ Gender Non-conforming

**Sexual Orientation:** ____Heterosexual ____Homosexual ____ Bisexual ____Not Applicable

Height: _____ Weight:_____ Eye Color: _____ Hair Color:_____

Date of Birth: _____ Sex at Birth: _____ M _____ F _____ Unknown

**Marital Status:**

_____ Never Married
_____ Now Married
_____ Separated
_____ Widowed
_____ Divorced
_____ Unknown

**Citizen:**

Social Security Number: _____

_____ US Citizen
_____ Not a US Citizen

**Legal History**

Current Charge:_____

Charge Type:

_____ Civil/Petition
_____ Felony
_____ Misdemeanor
_____ Other
_____ Status Offense (Juvenile)

Incident Offense:

_____ New Criminal Offense
_____ New Petition
_____ Parole Violation Technical
_____ Parole Violation New Criminal Charge
_____ Probation Violation New Criminal Offense
_____ Probation Violation Technical

Arrest Date (if applicable): _____ Arraignment/ First Appearance Date:_____
Have you been Sentenced: _____ YES _____ NO

Sentence:_____

Jail Status:

_____ Detention
_____ Jail
_____ Not in Detention
_____ Not in Jail

Prior Convictions: _____ YES _____ NO

What are they? _____

_____

If yes, # of felonies and misdemeanors is required: _____ Felonies _____Misdemeanors

Number of arrests in the last year: _____ Number of arrests in the last 30 days: _____

How many total months have you been incarcerated in your life? _____

Which arrests were drinking/drug related?_____

Expain_____

Have you ever had Child Protective Service Activity? _____ YES _____ NO

If Yes, Why?_____

Current Charge or Previous Conviction of a Violent Crime or Sex Offense, Other than Domestic Violence? _____ YES _____ NO If Yes, what? _____

Previous Conviction for Domestic Violence? _____ YES _____ NO

Outstanding Warrants? _____ YES _____ NO

Current Probation Status: _____ On Probation PO's Name: _____

Currently on Parole: _____ On Parole PO's Name: _____

Pending Criminal Charges: _____ YES _____ NO

History of Previous Court Failures to Appear: _____ None ____ 1 _____ 2 _____ 3 or more

History of Previous Drug Court/ Drug Treatment:

____ None
____ Successfully Completed
____ Transferred to another Jurisdiction
____ Unsuccessful – Absconded
____ Unsuccessful – New Offense
____ Unsuccessful – Program Violation
____ Voluntary Withdrawal

**Substance Use History**

Alcohol and other Drug Use: *Check all drugs you have used:*

| | **Past 30 Days** | **Lifetime Use (years)** | **Age at First Use** | Unknown | Nasal Inhalation | Smoking | Non-IV Injection | IV Injection | Other | No Use |
|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol (Any use at all) | | | | | | | | | | |
| Alcohol (To Intoxication) | | | | | | | | | | |
| Heroin | | | | | | | | | | |
| Street Methadone (non-treatment) | | | | | | | | | | |
| Other Opiates/ Analgesics (Opium/Demerol/Morphine/Talwin) | | | | | | | | | | |
| Barbiturates | | | | | | | | | | |
| Hypnotics/ Sedatives/Anxiolytics | | | | | | | | | | |
| Cocaine/ Crack | | | | | | | | | | |
| Amphetamines (Speed/Ice/Other Uppers) | | | | | | | | | | |
| Cannabis (marijuana/hashish) | | | | | | | | | | |
| Hallucinogens (LSD/Psychedelics/PCP/ Mushrooms/Peyote | | | | | | | | | | |
| Inhalants | | | | | | | | | | |
| More than one of the above substance per day (including alcohol) | | | | | | | | | | |

1st Drug of Choice(include alcohol): _____ How Consumed? _____

Frequency of use: ____No use in the past month ____ 1-3 days in the past month

____ 1-2 days in the past week ____ 3-6 days in the past week ____ Daily

Age of first use: _____ Prescribed? YES NO Not Applicable

2nd Drug of Choice(include alcohol): _____ How Consumed? _____

Frequency of use: ____No use in the past month ____ 1-3 days in the past month

____ 1-2 days in the past week ____ 3-6 days in the past week ____ Daily

Age of first use: _____ Prescribed? YES NO Not Applicable

Third Drug of Choice(include alcohol): _____ How Consumed? _____

Frequency of use: ____No use in the past month ____ 1-3 days in the past month

____ 1-2 days in the past week ____ 3-6 days in the past week ____ Daily

Age of first use: _____ Prescribed? YES NO Not Applicable

IV Drug User: _____ Yes _____ NO

Are you Currently in Substance Abuse Treatment Program? ____ YES ____ NO

Number of days since most recent discharge? _____

Current medication-assisted opioid therapy? ___NO ___N/A

___YES-Buprenorphine-Mono ___YES-Buprenorphine-Combo

___YES-Naltrexone-Injection ___YES-Naltrexone-Oral

___YES-Methadone ___YES-Other: _____

Number of prior Substance Abuse Treatment admissions: _____

Number of days since most recent discharge? _____

Total times hospitalized due to Substance Abuse problem: _____

Total times hospitalized due to non substance abuse problem: _____

Number of ER visits due to an overdose (substance use poisoning) in past 90 days: _____

Substance overdosed on leading to ER visits in the past 90 days: _____

Number of times in the past 90 days Naloxone was administered for opioid overdose reversal?

_____

Number of days attended AA/NA/Similar meetings in the past 30 days:_____

Do you currently use tobacco?

___No Tobacco Use ___Cigarettes ___Cigars/Cigarillos/Little Cigars

___Bidis ___Pipes ___Hookah

___Kreteks ___Chewing Tobacco ___Snuff-Spit/Snus (Smokeless)

___Dissolvable Tobacco-Strips/Sticks/Orbs ___E-Cigarette

___Other

If 'YES', daily frequency of tobacco/nicotine:

___NONE ___Between 10-20 per day ___<10 per day

___Between 21-40 per day ___<40 per day ___Unknown

**MEDICAL QUESTIONNAIRE**

Do you have access to a primary care physician? ___ YES ____ NO ____ UNKNOWN

Have you ever had any of the following? Please Check YES or NO

| | YES | NO |
|---|---|---|
| Severe Headaches---------- | ____ | ____ |
| Head Injuries---------- | ____ | ____ |
| Hearing loss or earache---------- | ____ | ____ |
| Hay-fever---------- | ____ | ____ |
| Chronic cough---------- | ____ | ____ |
| Shortness of Breath---------- | ____ | ____ |
| Asthma---------- | ____ | ____ |
| Heart Trouble---------- | ____ | ____ |
| High Blood Pressure---------- | ____ | ____ |
| Rheumatic Fever---------- | ____ | ____ |
| Stomach Ulcers---------- | ____ | ____ |
| Gallbladder Trouble---------- | ____ | ____ |
| Hernia (Rupture)---------- | ____ | ____ |
| Kidney Trouble---------- | ____ | ____ |
| Dislocation of Joints---------- | ____ | ____ |
| Broken Bones---------- | ____ | ____ |
| Bone, Joint Problems---------- | ____ | ____ |
| Rheumatism/ Arthritis---------- | ____ | ____ |
| Back Pain/Injury---------- | ____ | ____ |
| Knee Injury---------- | ____ | ____ |
| Varicose Veins---------- | ____ | ____ |
| Skin Problems or Rash---------- | ____ | ____ |
| Nervous Disorders---------- | ____ | ____ |
| Fainting Spells---------- | ____ | ____ |
| Epilepsy---------- | ____ | ____ |
| Complications from Childhood Disease---------- | ____ | ____ |
| Diabetes---------- | ____ | ____ |
| Cancer---------- | ____ | ____ |
| Tumor---------- | ____ | ____ |
| Jaundice---------- | ____ | ____ |
| Anemia---------- | ____ | ____ |
| ALLERGIES TO MEDICATIONS---------- | ____ | ____ |
| ALLERGIES TO OTHER SUBSTANCES---------- | ____ | ____ |

Please list all drugs/substances that cause adverse reactions.

_____

| | | |
|---|---|---|
| Have you ever had a work-less injury or illness? ---------- | ____ | ____ |
| Have you ever received compensation for an industrial injury or illness? -- | ____ | ____ |
| Are you presently under a doctor's care for any condition? ------ | ____ | ____ |

List Doctor's name_____

Do you have any chronic medical problems which continue to interfere with your life?
YES NO
If "yes", what are the conditions?
__None __Seizures __GI Bleeding __Gastritis __Anemia __Hepatitis __HIV __STD

__TB __Heart Disease __Hypertension __Diabetes __Cancer __Chronic Pain

__Malnutrition __Respiratory/ Lung Disease __Injuries __Other

If other, explain :_____

How many times in your life have you been hospitalized for medical problems? (Include o.d.'s, d.t.'s, detox) _____
_____
_____

Have you had any operations? YES NO
List dates and nature of operations
1)_____
2)_____
3)_____

Are you taking any prescribed medications on a regular basis for a physical problem? YES NO

If "yes", what are the medications you are taking?_____
_____

Do you have a pension for a physical disability? (Exclude psychiatric disability) YES NO
If "yes", what is the disability?
__Mobility Impairment __Hearing Impairment __Visual Impairment __Physical Impairment

__Mental Illness __SSI Substance abuse disability __Learning disability __Brain Injury

__Unknown __Other medical disability

If you are a female, are you pregnant? __YES __NO __UNKNOWN
If yes, are you receiving prenatal care? __ YES __ NO

Dr. Name_____

Last physical examination
Date:_____ Doctor:_____

Last Chest X-ray

Date:_____ Doctor:_____

**Tuberculosis**

The following questions are to help you decide whether you are at risk for tuberculosis:

| | YES | NO |
|---|---|---|
| Do you work or live in a correctional institution, nursing home, mental Institution or health-care facility?..... | ____ | ____ |
| Do you live with or have close contact with someone who has TB?..... | ____ | ____ |
| Do you use needles to inject drugs?..... | ____ | ____ |
| Do you have any of the symptoms of TB, which include: coughing, tiredness, weakness, fever, weight loss, or spitting up blood?..... | ____ | ____ |

If you answered "yes" to any of the previous questions, you could be at risk of acquiring TB. This disease can cause serious illness or death unless it is treated properly. If you answered "yes" to any of these questions, please make an appointment with one of our medical practitioners for testing, and more information about prevention and treatment by contacting our scheduling office at (775) 882-3945. You may also contact the Nevada Health Division for testing and more information about prevention and treatment.

Nevada Health Division
4150 Technology Way
Carson City, NV 89706
(775) 684-5900

**Acquired Immune Deficiency; Human Immunodeficiency Virus**

It is the policy of the Center that medical information related to the positive antibody testing, AIDS related complex (ARC), TB or Hepatitis not be included as part of the client's record. A client's personal admission of AIDS in or during treatment sessions may bring to light treatment issues surrounding the disease. It is the policy of the Center to provide education for limiting the spread of HIV. If a referral is needed the counselor will provide it. Early intervention services are available here through any counselor. Please ask for additional information during your intake appointment.

**Mental Health/Psychiatric History**

Have you ever been diagnosed with a mental health condition? ___ YES ___ NO

If yes, please describe: _____

_____

Are you currently prescribed, and are you taking psychiatric medications?

____YES ____NO If yes, please list them. _____

_____

Have you ever talked to a psychiatrist, psychologist, therapist, social worker, counselor, or spiritual leader about an emotional problem? YES NO

If Yes, pleas describe._____

_____

_____

Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

If Yes, pleas describe. _____

_____

_____

Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problems? YES NO

If Yes, pleas describe. _____

_____

_____

Have you ever been in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES NO

If Yes, pleas describe. _____

_____

_____

Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, a natural disaster, war, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES NO

If Yes, pleas describe. _____

_____

_____

Was there a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

If Yes, pleas describe. _____

_____

_____

Can you manage your sexual impulses? ____ YES ____NO

If no, please describe. _____

_____

_____

Have you been distressed by your sexual behaviors? ____ YES ____ NO

If yes, please describe. _____

_____

_____

Have your sexual behaviors hurt your relationships, affected your work or resulted in negative consequences, such as getting arrested? ____ YES ____ NO

If yes, please describe. _____

_____

_____

Have you tried to hide your sexual behavior? ____ YES ____NO

If yes, please describe. _____

_____

_____

Have there been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?__YES __NO__N/A

Have you ever tried to stop, cut down, or control your gambling? ___YES ___NO___N/A

Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling? ___YES ___NO ___N/A

If 'YES' to any of the previous 3 questions, how many times Have you gambled in the past 30 days? _____

During the past 12 months have you become restless, irritable, or anxious when trying to stop/cut down on gambling? ____ YES ____ NO

During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled? ____ YES ____ NO

During the past 12 months , did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare? ____ YES ____ NO

*Please note, there are additional screenings that will need to be completed as they are a requirement of our screening and assessment process. These will be provided to you by our staff.

**Educational History:**

Highest Education Completed: _____

Current Educational Status: _____

Have you attended school at any time in the past 3 months?
___Yes, I have attended in the past 3 months.
___No, I have not attended in the past 3 months.
___Not Applicable

**Employment History:**

Current Employment Status:

_____ Unemployed _____ Employed Full-Time _____ Employed Part-Time
_____ Not in Labor Force ____ Homemaker ____ Student ____ Retired
_____ Disabled ____ Resident of Institution i.e. Jail, hospital, prison

Current Employer:_____
Occupation:_____

Months Employed:_____

Days of Work or School Missed: _____

Primary Source of Support:

_____ Adoption Subsidy
_____ Disability
_____ Family
_____ Foster Care Subsidy
_____ Retirement Plan
_____ Salary/Wages
_____ Social Security
_____ Social Security Disability
_____ Veteran's Benefits
_____ Welfare
_____ Workers Compensation
_____ Other
_____ None

Gross Monthly Income (from all sources): $_____
Expected Payment Source:
___Self Pay ___Blue Cross/Blue Shield ___Medicare

___Medicaid ___Workers Comp. ___Other Health Insurance
___No Charge (Free/Charity/Special Research/Teaching) ___Other
___Unknown

**Family History:**

Number of Children: _____ Number of Dependent Children (aged 17 or less): _____

Current Child Support: ___N/A ___Paying Current ___Paying Not Current __Not Paying

Custody Status:
_____ Temporarily Lost Custody _____ Regained Custody
_____ Parental Rights Terminated _____ Never Lost Custody
_____ N/A
Current Childcare Status:
___Need Childcare ___Have Childcare ___Family Provides Childcare
___Not Applicable ___Unknown

Are you currently in a relationship? YES NO
If Yes, please describe your relationship. If No please describe previous relationships_____
_____
_____

Describe your relationship with your parents_____
_____
_____

Give the ages and sex of sibling(s) (brothers/sisters)_____
_____
_____

Describe the atmosphere at home when you were growing up_____
_____
_____

Did your parents show affection? YES NO
How?_____
_____

Did anyone in your family of origin have a serious drinking problem or drug problem?
YES NO
If Yes, who?_____

How do you think this affected you as you grew up?_____
_____

Do you live with anyone who uses non-prescribed drugs? YES NO

## COMMUNITY COUNSELING CENTER

## CONSENT TO TREATMENT

I understand that as a client of the Community Counseling Center, I am entitled to the services offered for substance abuse treatment. I understand that recommendations for treatment and referrals will be developed for and will become a part of my file. I understand that I have the right to refuse any or all parts of the recommendations for treatment except for emergency treatment designed to protect the health and safety of myself and others. Before these recommendations for treatment are put into effect, I understand that I have a right to be informed as to the nature and consequences of the recommendations for treatment, the reasonable risks, benefits and purposes of the recommendations, and any alternative recommendations for treatment available to me. I further understand that I may withdraw my consent to any and all parts of the recommendations for treatment and referral, in writing, at any time.

## CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law Regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS the patient consents in writing, the disclosure is allowed by a court order or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Sometimes the Substance Abuse Prevention & Treatment Agency (SAPTA) sends questionnaires to certain clients of our center for the purpose of research and gathering statistics. This gathering of information assists our center in receiving federal money.

Violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with the Federal regulations. Federal law and regulations do not protect information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW AR APPROPRIATE STATE OR LOCAL AUTHORITIES. THREATS OF SUICIDE OR BODILY HARM TO OTHERS WILL ALSO BE REPORTES. THESE ARE NOT PROTECTED UNDER THE FEDERAL LAW.

See 42 U.S.C 29 Odd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for the Federal regulations.

_____

Client Signature Date

_____

Parent/ Guardian's Signature Date

# Community Counseling Center

# Client Complaint Procedure

A client may file a complaint, in writing, within ten (10) days of the occurrence of the incident or discovery of the event to the Chairperson of the Board of Directors of the Community Counseling Center, at 205 South Pratt Avenue, Carson City, Nevada 89701. The chairperson will then appoint a committee of two in order to investigate the client's grievance within thirty (30) working days and report the findings to the Board of Directors.

The Board will then review and a determination will be made within ten (10) working days to the validity of the grievance and, when necessary, appropriate action will be taken by the Board.

There is no threat of retribution or other adverse consequences to the client as a result of filing a grievance.

CLIENT ACKNOWLEDGMENT

I have read, understand, and been provided with a copy of the above Client Complaint Procedure.

_____ _____

Client Signature Date

_____ _____

Parent/ Guardian Signature Date

**Substance Abuse Prevention and Treatment Agency**
**Sliding Fee Scale**
**Policy Statement**
**July1, 2010**

The purpose of the Substance Abuse Prevention and Treatment Agency (SAPTA) funding of services for abuse of alcohol and other drugs is to ensure that such services are made available to all Nevadans independent of the person's ability to pay. Accordingly, a person may not be denied access to SAPTA-funded services for abuse of alcohol and other drugs due to his or her ability to pay for the service.

Assessment of fees according to a sliding schedule of fees does not, in itself, ensure access to services due to ability to pay because the client may lack the funds to pay even reduced fees. In these cases, no co-pay percentage will be collected.

Any practice which established a fiscal barrier to client access to SAPTA-funded services can result in SAPTA withholding or terminating all or part of the funding to the program operator. Examples of such practices are:

1. Requiring an administrative processing fee be paid prior to access to SAPTA-funded services;
2. Requiring an assessment or evaluation fee to be paid prior to access to SAPTA-funded services;
3. Requiring that a deposit be made towards the anticipated bill prior to access to SAPTA-funded services;
4. Requiring that the person pay his or her fee prior to access to SAPTA-funded services.
5. Termination of services due to failure to pay in a manner other than that specified by SAPTA concerning individuals who are able to pay, but refuse to do so.
6. Failing to inform persons inquiring about availability of services that funded by SAPTA are available independent of ability to pay; and cannot base client's ability to pay on future earnings.
7. Denial of services due to client's ability to pay for additional services or materials which are not funded by SAPTA. For example, if the program design is such that access to SAPTA-funded Level II services requires co-enrollment in un-funded Transitional Housing provided by the program operator, the program operator must make the Transitional Housing service also available independent of client ability to pay. To do otherwise result in tacit denial of access to SAPTA-funded Level II services due to ability to pay.

The foregoing are independent of the client's referral source and independent of whether the client has stated motivation to enter treatment subsequent to assessment. This has important implications for forensic clients:

- If a client is seeking assessment solely for the purpose of obtaining a report to a court, the client is still to be provided assessment independent of his or her ability to pay. However, the program may unbundle the report on the findings of the assessment from the assessment itself. The client then is provided assessment independent of ability to pay, but any report to a court on the findings of the assessment is a separately billed service. The program then may choose to prepare and send a report to the court only after the client has paid the program a reasonable fee for doing so. If the program chooses to unbundle court reports as a separately billed service, it is incumbent upon the program to inform the client of this prior to the assessment being conducted.
- If a client is court-ordered to treatment, or is in treatment as a condition of parole, reports to verify client participation in, or completion of, treatment, may not be unbundled as a separately-billed service. Client being provided SAPTA subsidized treatment independent of ability to pay must also be provided reports of participation or completion also independent of ability to pay. Such reports or certificates of completion of treatment may not be withheld due to ability to pay.

he household. Multiply this percentage by SAPTA unit rate to determine client co-pay.

## SLIDING FEE SCALE WORKSHEET/AGREEMENT

**AGENCY NAME:** _____ **DATE**: _____

**CLIENT'S NAME:**

**UNIQUE CLIENT ID:** _____ **PROGRAM LOCATION:** _____

As a client of a treatment program receiving funds administered by the Nevada Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to a determination of fees according to a sliding fee scale that takes into account income and family size. Reduction of your fees according to this scale is contingent upon your providing verifying information. Such documentation should be provided at the intake session at which your share of costs is determined. Indigent clients, including those who are non-citizens and/or homeless may not be able to provide any of the documentation requested below. If you can provide a letter from any other agency, local service provider verifying your status, you will be assessed fees based on $0 income for the provision of services. Should a letter be unavailable, the program's no documentation policy may be used. No prepayment or deposits can be a condition of any aspects of the services. For further information refer to the Sliding Fee Scale policy.

1. **TOTAL ANNUAL INCOME:** Identify all income received by you and others residing in the same household during the past twelve months. (Gross money, wages, and salaries before any deductions.)
2. _____ **NUMBER IN HOUSEHOLD:** (Enter number including client.)

| ***Others: Name (first and last)*** | ***Age*** | ***Relationship to Client*** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

_____

| **Level of Service** | |
|---|---|
| **Check One** | |
| Outpatient (OP) | |
| Intensive OP | |
| Residential | |
| Detoxification | |
| OMT | |
| Trans Housing | |

| Family Size | **Tier 1** 0-100% | **Tier 2** 101-150% | **Tier 3** 151-200% | **Tier 4** 201-250% | **Tier 5** >250% |
|---|---|---|---|---|---|
| 1 | $12,760.00 | $19,140.00 | $25,520.00 | $31,900.00 | >38,280.00 |
| 2 | $17,240.00 | $25,860.00 | $34,480.00 | $43,100.00 | >51,720.00 |
| 3 | $21,720.00 | $32,580.00 | $43,440.00 | $54,300.00 | >65,160.00 |
| 4 | $26,200.00 | $39,300.00 | $52,400.00 | $65,500.00 | >78,600.00 |
| 5 | $30,680.00 | $46,020.00 | $61,360.00 | $76,700.00 | >92,040.00 |
| 6 | $35,160.00 | $52,740.00 | $70,320.00 | $87,900.00 | >105,480.00 |
| 7 | $39,640.00 | $59,460.00 | $79,280.00 | $99,100.00 | >118,920.00 |
| 8 | $44,120.00 | $66,180.00 | $88,240.00 | $110,300.0 | >132,3620.0 |

For family units of more than eight (8) members, add $4,020 for each additional member

Based on 2014 Poverty Annual Guidelines

If you are a non-emancipated minor under 18 years of age, your parent or legal guardian must sign the application. If you are a dependent adult under a conservatorship of estate, your conservator must sign the application.

By signing below, I acknowledge that I have received a copy of this information. I understand that I will be responsible for % of my substance abuse treatment costs. The costs of my treatment will be based on the number and types of services offered me. I can review my costs for treatment at any time. I understand that if my financial situation changes during treatment, revised sliding fee calculations will be made and will be effective for services provided after the date the new scale is signed. I further acknowledge that all information provided by me is accurate to the best of my knowledge.

**CLIENT SIGNATURE:**_____ **DATE:** _____

**WITNESSED BY (program staff):**_____ **DATE:** _____

# SLIDING FEE SCALE

| Service/Procedure | CPT Code | HCPC Code | Normal Chrg | Tier 5 >251% FPL Chrg 100% | Tier 4 201%-251% FPL Chrg 75% | Tier 3 151-200% FPL Chrg 50% | Tier 2 101-150% FPL Chrg 25% | Tier 1 0-100% FPL Chrg 0% |
|---|---|---|---|---|---|---|---|---|
| Assessment-Substance Abuse Individual | | | | | | | | |
| Comprehensive Evaluation - Substance Abuse - Adolescent | 90791 | H0001 | $ 139.46 | $ 139.46 | $ 104.60 | $ 69.73 | $ 34.87 | 0 |
| Comprehensive Evaluation - Substance Abuse - Adult | 90791 | H0001 | $ 139.46 | $ 139.46 | $ 104.60 | $ 69.73 | $ 34.87 | 0 |
| Outpatient Services - Individual (level 1) Adults - COD | 90834 | N/A | $ 73.92 | $ 73.92 | $ 55.44 | $ 36.96 | $ 18.48 | 0 |
| Outpatient Services - Group (level 1) Adults - COD | 90853 | N/A | $ 29.85 | $ 29.85 | $ 22.39 | $ 14.93 | $ 7.46 | 0 |
| Outpatient Services - Individual (level 1) Adolescents - COD | 90834 | N/A | $ 73.92 | $ 73.92 | $ 55.44 | $ 36.96 | $ 18.48 | 0 |
| Outpatient Services - Group (level 1) Adolescents - COD | 90853 | N/A | $ 29.85 | $ 29.85 | $ 22.39 | $ 14.93 | $ 7.46 | 0 |
| Intensive Outpatient (Level 2.1) Adults - COD | 90853 | N/A | $ 140.45 | $ 140.45 | $ 105.34 | $ 70.23 | $ 35.11 | 0 |
| Intensive Outpatient (Level 2.1) Adolesents - COD | 90853 | N/A | $ 140.45 | $ 140.45 | $ 105.34 | $ 70.23 | $ 35.11 | 0 |
| Outpatient Services - Individual (level 1) Adults | 90834 | H0047 | $ 73.92 | $ 73.92 | $ 55.44 | $ 36.96 | $ 18.48 | 0 |
| Outpatient Services - Group (level 1) Adults | 90853 | H0005 | $ 29.85 | $ 29.85 | $ 22.39 | $ 14.93 | $ 7.46 | 0 |
| Outpatient Services - Individual (level 1) Adolesents | 90834 | H0047 | $ 73.92 | $ 73.92 | $ 55.44 | $ 36.96 | $ 18.48 | 0 |
| Outpatient Services - Group (level 1) Adolescents | 90853 | H0005 | $ 29.85 | $ 29.85 | $ 22.39 | $ 14.93 | $ 7.46 | 0 |
| Intensive Outpatient - Group (Level 2.1) Adults | 90853 | H0015 | $ 140.45 | $ 140.45 | $ 105.34 | $ 70.23 | $ 35.11 | 0 |
| Intensive Outpatient - Group (Level 2.1) Adolescents | 90853 | H0015 | $ 140.45 | $ 140.45 | $ 105.34 | $ 70.23 | $ 35.11 | 0 |
| Transitional Housing Adult | N/A | H0044 | $ 43.64 | $ 43.64 | $ 32.73 | $ 21.82 | $ 10.91 | 0 |
| Transitional Housing Adolescent | N/A | H0044 | $ 43.64 | $ 43.64 | $ 32.73 | $ 21.82 | $ 10.91 | 0 |
| Opioid Maintenance Therapy/Clinical Treatment - Individual | 90834 | H0047 | $ 73.92 | $ 73.92 | $ 55.44 | $ 36.96 | $ 18.48 | 0 |
| Opioid Maintenance Therapy/Clinical Treatment - Group | N/A | H0005 | $ 29.85 | $ 29.85 | $ 22.39 | $ 14.93 | $ 7.46 | 0 |

**SUBSTANCE ABUSE**

**PREVENTION AND TREATMENT AGENCY**

## POLICY-HOLDER'S INSURANCE FORM

Name (As shown on Card)_____

Social Security Number:_____

Date of Birth:_____

Physical Address:_____

Phone#_____

Place of Employment:_____

Employment Phone #_____

Insurance Company:_____

Mailing
Address:_____

Policy Number:_____ Group Number:_____

Note: If you or a dependent will be using insurance, the POLICY-HOLDER will need to fill this form out completely. *This form is for the policyholder's information* ONLY.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the Community Counseling Center, Counselor on record or the billing company, (Sierra Health Billing Service) to release information to my insurance company/ companies the information it/ they need to process my insurance claim(s). I acknowledge that the information to be released may include PSYCHIATRIC, ALCOHOL, and/ or DRUG ABUSE information. These records are protected by Federal Regulations. My signature authorizes release of such information.

SIGNATURE_____DATE_____

**AUTHORIZATION TO PAY PROVIDER**

I authorize any insurance benefits to be paid directly to Community Counseling Center/ Mary Bryan I understand that I am financially
responsible for the unpaid balance in the event my insurance coverage does not pay this account in full, unless other arrangements have been made with the Community Counseling Center/ Mary Bryan.

SIGNATURE_____DATE_____

**Financial Terms and Co-pays:**

Fees: $150.00 per session (This includes Individual, Family, Couples, etc.)
50.00 per group for Substance Abuse

As a courtesy we will be glad to bill your insurance, however, the responsibility for total payment remains on the client. *Therefore, according to company policy, a fifty percent payment ($55.00 for individuals and $25.00 or $30.00 for groups) is required at time of service.* If and when the insurance company provides payment, we will gladly issue a credit for future service or a refund for those who are no longer clients here.

If I have been out of compliance for more than 30 days with the billing agency's request for payment, legal action may be initiated or a referral of the account to a collection agency may occur.

**Community Counseling Center**
**205 South Pratt Street**
**Carson City, Nevada 89701**

## Financial Status Worksheet

**Client Name*_____# of dependents_____**
*** If client is under 18 years of age, parent/guardian's will need to complete this form.**

| **Projected Monthly Income:** | | **Projected Monthly Expense:** | |
|---|---|---|---|
| **Job (self)** | **$_____** | **Rent/Mortgage** | **$_____** |
| **Job (spouse)** | **$_____** | **Transportation** | **$_____** |
| **ADC** | **$_____** | **Utilities** | **$_____** |
| **SSI** | **$_____** | **Medical/ Insurance** | **$_____** |
| **Alimony** | **$_____** | **Groceries** | **$_____** |
| **Retirement** | **$_____** | **Cigarettes/ Alcohol** | **$_____** |
| **Social Security** | **$_____** | **Nails/ Hair** | **$_____** |
| **Vet Benefits** | **$_____** | **Other** | **$_____** |
| **Rent Income** | **$_____** | | |
| **Stocks & Bonds** | **$_____** | | |
| **Child Support** | **$_____** | | |
| **Other** | **$_____** | | |
| **Total Monthly Income** | **$_____** | **Total Monthly Expenses** | **$_____** |

**The above information is a complete and accurate record of my current monthly finances. I understand that it is my responsibility to notify the office if there has been any change. If it is discovered that the sliding fee has been established due to misrepresented information, the full fee will automatically be in effect.**

_____ _____
**Client Signature** **Date**

_____ _____
**Parent/ Guardian's Social Security #** **Parent/ Guardian's Date of Birth**

_____ _____
**Parent/ Guardian's Signature (If client is a minor)** **Date**

## COMMUNITY COUNSELING CENTER
## CONTRACT FOR SERVICES

- Group Sessions (75 Minutes) $30.00/Substance Abuse
- Intensive Outpatient Groups (180 Minutes) $140.00
- Individual, Couples, Marriage and/or Family
- Counseling (50 Minutes) $150.00
- Adult Evaluation (Drug & Alcohol) $150.00
- Adolescent Evaluation (Drug & Alcohol) $150.00
- Comprehensive Mental Health Evaluation $200.00
- Intakes/Individuals $58.00
- Court Appearances $250.00/Per Hour
- Urine Screening for Alcohol & Drug $25.00

## CONDITIONS

I agree to the following financial conditions for my assessment and treatment by the Community Counseling Center:

1) I understand that the fees listed above are my responsibility unless other written arrangements are made.

2) I have been made aware that the sliding fee scale is available, and of the process to apply for it.

3) It is my responsibility to report any changes in income.

4) I understand that if I do not keep my scheduled appointments, I may be creating a barrier to treatment for another individual.

5) IF I HAVE BEEN REFERRED BY COURT ORDER, I AM RESPONSIBLE FOR THE COSTS OF TREATMENT INCLUDING RANDOM URINE SCREENING. FAILURE TO PAY MAY RESULT IN CONTEMPT OF COURT CHARGES.

6) If I discontinue treatment against staff advice, the total amount of my account will become due and payable within ten (10) days of discharge.

7) If I have been out of contact with the Center for thirty (30) days or more without notice, my case will be considered closed and my account will be due and payable.

8) If I fail to comply with the terms of this contract, the Community Counseling Center may initiate legal action or refer the account to a collection agency, unless other arrangements have been made with the Community Counseling Center Administration. I shall be responsible for attorney's fees and collection expenses.

9) I understand that I am financially responsible for the unpaid balance in the event my insurance coverage does not pay this account in full, unless other arrangements have been made with the Community Counseling Center.

10) If I withdraw/or am terminated from a specialty court, my outstanding balance will be due and payable immediately.

I have read and understand this contract:

Dated this_____ day of_____,20_____

_____ _____
Client Signature Signature of Parent/Guardian if Client is a Minor

OFFICE USE ONLY

Amount for Individual, Couples & Family Sessions: _____
Amount for Group Sessions: _____
Domestic Violence _____
Substance Abuse _____
Amount for IOP Groups: _____
Amount for Evaluation: _____

**COMMUNITY COUNSELING CENTER**
**CLIENT RIGHTS**

Client Name:_____

As the client of a program for treatment of abuse or of dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1 If the program receives funds from the Substance Abuse Prevention Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay it, and the program is prohibited from imposing any fee or contract which would be a hardship for you or your family.

2 You have the right to be provided treatment appropriate to your needs.

3 If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.

4 You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.

5 You have the right to be informed of all program services which may be of benefit to your treatment.

6 You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.

7 You have the right to be informed of your diagnosis, treatment plan, and prognosis.

8 You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimate of the costs of treatment, and a description of the alternatives to treatment.

9 You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.

10 You have the right to examine your bill for treatment and to receive an explanation of the bill.

11 You have the right to be informed of the program's rules for your conduct at the facility.

12 You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.

13 You have the right to receive respectful and considerate care.

14 You have the right to receive continuous care: To be informed of your appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.

15 You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.

16 You have the right to safe, healthful, and comfortable accommodations.

17 You have the right to confidential treatment. This means that, other than exceptions defined by law-such as those in which public safety takes priority-without you explicit consent to do so, the program may release no information about you including confirmation or denial that you are a patient.

18 Waiver of any civil right or other right protected by law cannot be required as a condition of program services.

19 You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.

20 You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.

21 You have the right to grieve actions and decisions of facility staff which you believe are inappropriate including but not limited to actions and decisions which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retribution or other adverse consequences as the product of filing a grievance.

22 You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to:

Substance Abuse Prevention and Treatment Agency (SAPTA)
Attention: Statewide Program Coordinator
4126 Technology Way, 2nd Floor
Carson City, NV 89706
(775)684-4190

23 You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where
they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon your beginning treatment.

Patient Acknowledgement

I have read, understand, and have been provided a copy of the above Client's Rights.

_____ _____
CLIENT'S SIGNATURE DATE

_____ _____
PARENT/ GUARDIAN'S SIGNATURE DATE

**CARSON JUSTICE COURT**

**EVALUATION REVIEW FORM**

I have read, reviewed and understand the recommendations contained in my evaluation.

_____ _____

Defendant Name (Print) Defendant Name (Signature)

_____

Evaluator

**NRS 629.051 – Health care records: Retention; disclosure to patients concerning destruction of records; exceptions; regulations.**

1 Except as otherwise provided in this section and in regulations adopted by the State Board of Health pursuant to NRS 652.135 with regard to the records of a medical laboratory and unless a longer period is provided by federal law, each provider of health care shall retain the health care records of his or her patients as part of his or her regularly maintained records for 5 years after their receipt or production. Health care records may be retained in written form, or by microfilm or any other recognized form of size reduction, including, without limitation, microfiche, computer disc, magnetic tape and optical disc, which does not adversely affect their use for the purposes of NRS 629.061. Health care records may be created, authenticated and stored in a computer system which limits access to those records.

2. A provider of health care shall post, in a conspicuous place in each location at which the provider of health care performs health care services, a sign which discloses to patients that their health care records may be destroyed after the period set forth in subsection 1.

3. When a provider of health care performs health care services for a patient for the first time, the provider of health care shall deliver to the patient a written statement which discloses to the patient that the health care records of the patient may be destroyed after the period set forth in subsection 1.

4. If a provider of health care fails to deliver the written statement to the patient pursuant to subsection 3, the provider of health care shall deliver to the patient the written statement described in subsection 3 when the provider of health care next performs health care services for the patient.

5. In addition to delivering a written statement pursuant to subsection 3 or 4, a provider of health care may deliver such a written statement to a patient at any other time.

6. A written statement delivered to a patient pursuant to this section may be included with other written information delivered to the patient by a provider of health care.

7. A provider of health care shall not destroy the health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law.

8. The provisions of this section do not apply to a pharmacist.

9. The State Board of Health shall adopt:

a. Regulations prescribing the form, size, contents and placement of the signs and written statements required pursuant to this section; and

b. Any other regulations necessary to carry out the provisions of this section.

(Added to NRS by 1977, 1313; A 1993, 916; 1997,1123; 2009,2549)

**CONSENT FOR THE RELEASE**

**OF CONFIDENTIAL INFORMATION:**

***CRIMINAL JUSTICE SYSTEM REFERRAL***

**I,_____, authorize (initial whichever parties apply):**
**(Name of defendant)**

ð _____
**(Name or general designation of program making disclosure)**

ð _____

ð _____

ð _____ _____
**(Name of the appropriate court)** **(Name of prosecuting attorney)**

ð _____ _____
**(Name of criminal defense attorney)** **(Other)**

**To communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):**

**____ My diagnosis, urinalysis results, information about my attendance or lack of attendance at Treatment sessions, my cooperation with the treatment program, prognosis, and**

**____ _____**

**The purpose of the disclosure is to inform the person(s) listed above my attendance and progress in treatment.**

**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. I also understand that I may revoke this consent at any time except to the extend that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:**

**[Specify the date, event or condition upon which this consent expires. This could be one of the following:]**

**____ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or**

**____ _____**
**(Specify other time when consent can be revoked and/or expires)**

**I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.**

**I have been provided a copy of this form.**

**Dated: _____** **_____**
**Signature of patient**

**_____**
**Signature of person signing for if not the patient**

**Describe authority to sign on behalf of patient: _____**

## CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Name of patient)

_____

to disclose to _____ the
(Name of person or organization to which receipt/disclosure is to be made)

following information: _____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized is to: _____
(Purpose of disclosure, as specific as possible)

_____

**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 CFR 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 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:**

_____
(Specification of the date, event, or condition upon which this consent expires)

_____

**I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.**

Dated: _____ _____
Signature of participant

_____
Signature of person signing form if not patient

## SUBSTANCE ABUSE PREVENTION & TREATMENT SERVICES

## ACKNOWLEDGE OF CONSUMER INFORMATION

I, _____ acknowledge receiving a copy of the MEDICAL RECORD RETENTION POLICY. In accordance with the provisions of SB!& of the 209 Session, health care records of a consumer who is less than 23 years of age may not be destroyed. Records may be destroyed if retained for at least 6 years after the person has reached 23 years of age.

_____ _____

Consumer Signature Date of Signature

_____ _____

Parent of Legal Guardian Signature Date of Signature

_____ _____

Office Staff Signature Date of Signature

## CCC Rules

## Name:_____

Be on time. If you are late, you will not be permitted into group. THIS INCLUDES RESTROOM.

Must attend _____ twelve step meetings per week and bring proof of attendance to counseling groups. Must complete all homework assignments.

You must attend an individual session with a counselor once a month to be scheduled by the 25th of the previous month. For example, in order to have an appointment for November, you will have to have it scheduled by the 25th of October.

Clean after yourself after each group session. The room is expected to be left clean after each use.

No food, gum, or drinks are allowed in the building with the exception of water in a clear plastic bottle. If you are observed eating in the building you will get a missed group and be asked to stay.

Please do not leave trash anywhere in the building, outside of the building or on our neighbor's property, use trash cans and trash dumpster.

Dress appropriately every time you enter the building; this includes groups, individual sessions or if you are here to test. Shirts must have sleeves. No hats, sunglasses, tank tops, bikini/bathing suits, pajamas, slippers, short shorts, mini-skirts, cleavage revealing outfits or buttocks revealing outfits. No clothing with prejudicial or alcohol/drug related material, foul language, or rude/crude statements or pictures.

Do not cross talk. Raise your hand to speak.

No cell phones in the building at any time; this includes group, individual appointments or if you are here to test. Leave them in vehicles. If your cell phone rings or vibrates you will get a missed group and be asked to stay.

No tobacco products in the building and no smoking on the property, this includes vapes, e-cigarettes and tobacco chew. You may smoke in the back alley before and after your scheduled group, behind CCC building as you are not allowed to leave the building during group or break; you will see a cigarette receptacle.

No loitering on or around our neighbors property i.e. bank parking lot, in front of residents homes or in front of CCC building. If you are waiting for group please wait in the back alley of the CCC building.

Use the bathroom before group as it is disruptive to exit during the group and you may not be late to group. You are expected to stay in the room during the entire group.
Park your vehicle in assigned client parking, such as the parking lot behind CCC building and nearby public street parking. Do not park in front of neighbors parking or on personal property i.e. home driveways and other business parking lots or your vehicle may be towed.
Drive at the posted MPH, this is also a residential area and there are children on the street.

Drive to CCC building quietly. TURN OFF YOUR RADIO! Please note that there are sessions occurring throughout the day and having a vehicle with loud music is disruptive both to this agency and to our neighbors.

Be respectful of peers, CCC staff, property, and neighbors of the property. This includes sitting appropriately in chairs DO NOT SLOUCH ON CHAIR OR SLEEP IN GROUP and not destroying chairs i.e. don't pick the chairs or write on them. Do not take or remove any items from the agency.

Be attentive to those speaking (no sleeping or doodling).

No profanity, violence, or intimidation.

Pay on your bill and/or communicate with the office on payment arrangements.

Submit to random alcohol and/or drug testing.

Confidentiality: who you see here and what is said here will not be repeated outside of treatment, including individuals in other groups, or private sessions. Please be careful to remember that people may not wish to be addressed/acknowledged by you outside of treatment as it would break their confidentiality. Breaking confidentiality compromises that person's treatment as he/she can no longer trust in the group and receive proper therapy as a result.

You may be discharged or asked to meet with your individual counselor if you have two unexcused absences within the entire treatment period. These absences include groups and individual sessions. Lack of payment is not an excused absence.

If you are going to be missing group, please notify your counselor as to why ahead of time. If you want to be excused from group for being sick, you must either have a complete doctor's note or hospital discharge form validating the group time missed or you must show up to group and be sent home sick by your counselor.

Do not use any alcohol or drugs including prescription narcotics, sedatives, hypnotics, etc. while in treatment. Inform staff of all medications you are taking and get approval for any over the counter medications you intend to take. This is an abstinence only treatment program and you may be inappropriate for treatment here if you are on any mood-altering substance even with a doctor's prescription. A counselor may request a UA sample at any time to ensure that you are remaining substance free. If you are prescribed medication obtain approval from your Counselor PRIOR to taking it. You may only take what is on the approved medication list.

The violation of any of these rules will result in a missed group. Continued violation of these rules may lead to an unsuccessful discharge from treatment with a letter to your source of referral.

_____

Signature Date

# Aftercare/Discharge Plan

**To be completed at Admission**

Name of next level of care provider

Name, phone number, contact person, specific service

Supports needed, including referral to CMH (687-4195)

Referrals for Vocational,

Educational

Specialized services like interpreter

Future Goals with time frames

_____

**Client Acknowledgement** **Counselor** **Date**