Intake Interview

Identifying Information

Name _____

Age _____ Date of Birth _____ Social Security # _____/_____/_____

Address: _____

_____

Phone: (cell) _____ (home) _____
Email Address: _____

Contact in case of emergency:

Name: _____

Relationship: _____

Phone #: _____

Have you ever received any type of treatment before for substance abuse? Yes No

If yes, where/when? _____

Do you have any health problems? Yes No

If yes, please list: _____

Are you taking any medication? Yes No

If yes, name medications: _____

Any family history of alcohol or drugs? Yes No

If yes, please list: _____

Have you completed an ASI? Yes No If yes, where? _____

Who referred you to O'Brien House? _____

Do you have an attorney? Yes No If yes, who: _____

Circumstances that you were stopped for: (To/From-stopped for what?)

_____

_____

What was your BAC? _____

Which day are you signing up for? [ ] Mon [ ] Wed

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Treatment Agreement Education Program (ASEP)

This contract and agreement is between O'Brien House, 446 N 12th St, Baton Rouge, LA 70802, and _____, hereafter referred to as the Client.

O'Brien House shall provide a Substance Abuse Education Program, and will provide the following services:

1. Provide (1) two-hour education class to be held at the **O'Brien House,** for three (3) continuous weeks at a cost of $300.00
2. Client must submit to a minimum of one (1) random drug screens during the 3-week course at a cost of $25.00 per drug screen.
3. All makeup / missed classes will be at **$50.00 per makeup** / missed session.

   The total payment for the Education Program is $325. This amount of $325 does not include an assessment screening or makeup/missed class fees. This total amount is due by the third session.

   Amount due: **$325.00**

Payment for services in the amount above can be taken in two forms:

1) ***BY MONEY ORDER*** to O'Brien House, 446 N 12th St, Baton Rouge, LA 70802 OR

2) You may **PAY ONLINE** with a credit or debit card at **obrienhouse.org** (Client Payment link) *If you choose to pay online a transaction fee will be applied to each payment, also please print out your receipt to give to Krystal or forward it to her at krystalfeltman@obrienhouse.org

This agreement shall be effective from date of acceptance and signature until completion of course. I have read this agreement and understand my obligations.

X_____ Date: _____
(Client)

X_____ Date: _____
(Witness)

Group Member Confidentiality Pledge

I _____, make this my pledge of confidentiality. I will not reveal anything I see, hear, or experience here other than about myself. I will not discuss anything that relates to another member of this group with anyone outside this group, other than with that person, and then only with their permission.

Client Signature: _____Date:_____

Counselor Signature: _____Date:_____

O'BRIEN HOUSE

ZERO TOLERANCE FOR VIOLENCE POLICY

Please be advised that this in order to ensure a safe environment for our staff, clients, and visitors to our campus.

We strive to provide quality service, care, and treatment to all of our clients. If some aspect of your care concerns you, we want to know and will do our best to address any concerns you might have.

However, O'Brien House will not tolerate threatening behaviors of any kind in any of our facilities (including harassment, profanity, verbal or physical threats toward our staff, clients, or visitors).

If you choose to engage in threatening behaviors in any of our facilities (including on the telephone or on at any O'Brien House properties) you risk termination of services from O'Brien House and may be referred elsewhere.

If your threatening behaviors result in termination of services, O'Brien House cannot guarantee that another provider of services will be found, but a good faith effort will be made to identify such a provider.

Client: _____ Date: _____

Witness: _____ Date: _____

Louisiana Office for Addictive Disorders
OAD Notification of Patient Rights, Authorizations

I understand the law and regulations governing licensure of alcohol and drug abuse programs assures me of certain rights, and these apply to me, as a patient, or to my minor child, if my child is in treatment. Copies of these rights are available to me, and also posted on the agency's bulletin board. Some of these rights, as set out in the STANDARDS MANUAL, are copied below:

1. I have the right to be served without discrimination as to sex, race, creed, color, religion, or national origin.
2. I have the right to have the nature of recommended treatment and any specific risks of such treatment carefully explained to me.
3. I have the right to help develop my own treatment plan to meet my own specific needs.
4. I have the right to confidentiality. Except as may be required by law, no information concerning me, or my treatment, may be given out without my consent in writing. I have the right to revoke any consent given.
5. I have the right to privacy: When the agency expects outside visitors, I have the right to be notified in advance of their arrival and to be shielded from such visitors. My case shall not be discussed by staff in front of visitors or other patients.
6. If the agency desires to use cameras or tape recorders to aid in diagnosis, evaluation or treatment, the personnel must have my written permission, and must fully explain to me how they plan to use the pictures or recordings. I understand that staff must obtain advance permission from the program manager before using such equipment. (OAD programs do not use cameras and recording devices routinely).
7. I have the right to be told if the program cannot provide the services that I need.
8. I have the right to uncensored communication with my family, my attorney, and my personal physician. I further understand that mail and packages delivered to me are to be opened in staff's presence to assure that nothing illegal for me to have has been sent to me.

I have read the above statements and understand them. I also understand that this is only a partial listing of my rights. I certify this understanding by signing below.

Client Signature: _____

Authorization for Treatment

I understand that my admission to the **O'Brien House Education Program** is on a voluntary basis and I understand and accept the consequences of treatment as it has been explained to me. If my admission is on a voluntary basis, I am free to accept or reject any special type of treatment, including diagnostic procedures and/or hospitalization which staff may recommend. If my admission is based on a commitment or court order, I do not have this right.

Client Signature: _____

Education Program Rules and Regulations

1. You must attend three sessions in order to cover the six different topics (two topics per session).
2. Once you have signed up to commit to Monday night group you will attend the following sessions on Monday. If you have signed up for Wednesday night group you will attend the following sessions on Wednesday.
3. Group starts at 6:00 pm. Be on time.
4. A total of 1 urine drug screens will be done during the program. If you are asked to provide a sample, do not leave before doing so. Although 1 urine drug screen is required, it is possible that more may be requested. (upon counselor discretion)
5. During the three week education program you are to not use any mood altering substances. (Any alcohol, drugs, etc.)
6. If you have to miss group or an emergency occurs, call and leave a voicemail explaining the situation. **Call Krystal on the ASEP cell phone first and leave a message at 225-315-7494! You may also leave a message at O'Brien House 225-344-6345 ext. 314!** There are certain circumstances which will be excused (illness, work related excuse, death of family, etc.). However, unexcused absences will have a fee of $50.
7. Total payment must be paid in full by the 3rd week.
8. Confidentiality is extremely important. You must agree and obey the confidentiality statement.
9. If you begin a new prescription medication during the program please notify me as soon as possible.

Client Signature:_____ Date: _____

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: O'Brien House

Mailing Address: 446 North 12th Street

City, State, Zip Code: Baton Rouge, Louisiana 70802

Relationship: Substance Abuse treatment Center Telephone Number: (225) 344-6345

☑ **RELEASE Information TO or** ☑ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: (225)_____ Fax: (225)_____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians
☐ Research related treatment ☐ Creating health information for disclosure to a third party.
☒ Other: (Specify) Facilitating treatment

I authorize the release of the following protected health information.

(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☒ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes
☐ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both sides of this form.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

_____ _____
Signature of Witness (if signed with an" X" or mark) Date

For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: O'Brien House

Mailing Address: 1231 Laurel Street

City, State, Zip Code: Baton Rouge, Louisiana 70802

Relationship: Treatment Provider Telephone Number: (225) 344-6345

☑ **RELEASE Information TO or** ☑ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: Angelwood

Mailing Address: 1232 South Acadian thruway

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Assessor (ASI Assessment) Telephone Number: (225) 334-0851

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)
☐ Further Medical Care ☐ Personal ☒ Legal Investigation or Action ☐ Changing Physicians
☐ Research related treatment ☐ Creating health information for disclosure to a third party.
☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)
☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☒ Other: ASI Evaluation

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
☒ Alcoholism ☒ Drug Abuse ☒ Mental Health ☐Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☒ Psychotherapy Notes
☐ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.
I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both sides of this form.

☒_____ ☒_____
Signature of Individual or Personal Representative authorized by law Date

_____ _____
Signature of Witness (if signed with an" X" or mark) Date

For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

HIPAA 402P

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: O'Brien House

Mailing Address: 1231 Laurel Street

City, State, Zip Code: Baton Rouge, Louisiana 70802

Relationship: Substance Abuse treatment Center Telephone Number: (225) 344-6345

☑ **RELEASE Information TO or** ☑ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: Dusty Guidry – DA's Office /Pre-trail

Mailing Address: 233 St. Ferdinand Street Room #210

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Legal Telephone Number: (225) 389-3428

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)
☐ Further Medical Care ☐ Personal ☒ Legal Investigation or Action ☐ Changing Physicians
☐ Research related treatment ☐ Creating health information for disclosure to a third party.
☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)
☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☒ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
☒ Alcoholism ☒ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes
☐ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.
I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both sides of this form.

☒ _____ ☒ _____
Signature of Individual or Personal Representative authorized by law Date

_____ _____
Signature of Witness (if signed with an" X" or mark) Date

For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

HIPAA 402P