ASEP **VIRTUAL** REGISTRATION PACKET

Adult Substance Education Program

Name: _____

Age: _____ Race: _____ DOB: _____ SS #: _____/_____/_____

Address: _____

City, State, Zip: _____

Cell #: _____ Home #: _____

Email Address: _____

Contact in case of Emergency: Name: _____

Relationship: _____

Phone #: _____

Have you ever received any type of treatment before for substance abuse? (Circle one) *Yes* *No*

If yes, where/when? _____

Do you have any health problems? (Circle one) *Yes* *No*

If yes, please list: _____

Are you taking any medication? (Circle one) *Yes* *No*

If yes, name medications: _____

Any family history of alcohol or drugs? (Circle one) *Yes* *No*

If yes, please list: _____

Have you completed an ASI? (Circle one) *Yes* *No* If yes, where? _____

Who referred you to O'Brien House? (Circle one) Mrs. T Heidi Susana _____

Do you have an attorney? (Circle one) *Yes* *No* If yes, who: _____

Circumstances that you were stopped for: (To/From-stopped for what? Wreck? Check point? Etc...)

_____

What was your Blood Alcohol Content? (The legal limit is below 0.08): _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

O'Brien House
RECOVERY CENTER

VIRTUAL ASEP Treatment Agreement

This contract and agreement are between O'Brien House, 446 N 12th St, Baton Rouge, LA 70802, and _____, hereafter referred to as the Client.
(Print Your Name)

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

1) two-hour education class to be held virtually via Zoom for three (3) consecutive weeks at a cost of $300.00.
2) All make up/missed classes will be at **$50.00 per makeup** / missed session. (Also referred to as a No Call No Show Fee)

**The total payment for the Virtual Education Program is $300. This amount of $300 does not include makeup or missed class fees or no call/no show fees.

Amount due: **$300.00.**

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

1) ***BY MONEY ORDER*** to O'Brien House or OBH, 446 N 12th St, Baton Rouge, LA 70802
2) **PAY ONLINE** with a credit or debit card at **https://obrienhouse.org** click Resources at the top of the screen, then Client Accounts, then "Make a Payment". Enter your personal information and check the box that says ASEP. You can leave the client # section blank. Once you submit payment, a receipt will be emailed to you and me.

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

Signature: _____ Date: _____

Witness: _____ Date: _____

O'Brien House
RECOVERY CENTER

Group Member Confidentiality Pledge

I _____, make this my
(PRINT NAME)
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: _____

Witness: _____ Date: _____

O'BRIEN HOUSE
ZERO TOLERANCE FOR VIOLENCE POLICY

Please be advised that this is to ensure a safe environment for our staff, clients, guests, and any other visitors to our campus.

We strive to provide quality service, care, and treatment to all 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 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.

Signature: _____ 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 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 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: _____ Date: _____

Authorization for Treatment

I understand that my admission to the O'Brien House Adult Substance 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: _____ Date: _____

Adult Substance Education Program
Rules & Regulations

1) You must register/sign up for ASEP at least 1 week in advance. You cannot register on the same day you want to begin class.
2) Once you have signed up for ASEP, you will attend 3 sessions virtually via Zoom. I will send a link each week to your email with that weeks Topic in the description.
3) Make sure you keep your camera on so I can verify that you are present during the entirety of the Zoom.
4) Please keep your Mic on mute. It helps to keep the feedback/background noise to a minimum. Feel free to unmute if you have a question or comment. We appreciate when clients engage.
5) Class starts at 6:00 pm. BE ON TIME!
6) If you must miss class or an emergency occurs, call me (Krystal Feltman) BEFORE class begins at 6:00pm to explain the situation. Call or Text: 225-396-0606 or you can email me at kfeltman@obrienhouse.org

   There are certain circumstances which will be excused (illness, work related excuse, death of family, etc.). However, if you are a no call/no show, that is considered an unexcused absence and you will be charged a $50 fee.
7) If you are late, and you have not called to let us know, you will not be allowed to enter the Zoom and will be required to pay the $50 no call/no show fee.
8) The $300 fee must be paid in full by the 3rd week/Final Class. You can pay portions each week or you can pay at once in full. The 2 options to pay are by money order or with a credit or debit card on our website, https://obrienhouse.org, (click "resources", then "client accounts", then "Make a Payment")
9) You must agree & obey the Confidentiality statement that you signed.
10) If you begin a new prescription medication during the program, please notify me as soon as possible.

Signature: _____ Date: _____

Witness: _____ Date: _____

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

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Last 4 of SSN:

I authorize:

Name: **O'Brien House**

Mailing Address: **446 N 12th 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 Investi☒tion or Action Changing Physicians Research related treatment Creating health information for disclosure to a third party.

Other: **ASI ASSESSMENT/EVALUATION**

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_____

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 **Date**

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

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

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Last 4 of SSN:

I authorize:

Name: **O'Brien House**

Mailing Address: **446 N 12th Street**

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

Relationship: **Substance Abuse Treatment** 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**:** **EBR District Attorney's Pretrial Office (PTI)**

Mailing Address**:** **8894 Airline Hwy, Suite Q**

City, State, Zip Code: **Baton Rouge, LA 70815**

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) **Adult Substance Education Program Client Records**

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_____
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 Date

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