
## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize
*(Name of Client or Guardian)*

Tahoe Youth & Family Services to disclose the following information:

_____
*(Type of Information to be Disclosed)*

to: _____
*(Organization/Person to Which Disclosure is to Be Made)*

for the specific purpose of _____
*(Purpose of Information to be Disclosed)*

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, 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 in writing, except to the extent that actions had been taken in reliance on it, and that in any event this consent expires automatically as follows: _____.
*(Date, Event, or Condition Upon Which This Consent Expires)*

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Employee Signature: _____ Date: _____

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I, _____, decline to provide authorization for Tahoe Youth & Family Services to release information to any person or organization. I understand that Tahoe Youth & Family Services will only be authorized to talk to me regarding my services and/or records. I also understand that I may permit disclosure to an organization or person by completing a new consent form, which will supersede this refusal to disclose information.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Employee Signature: _____ Date: _____

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

# Consent for Mental Health Treatment

Mental health treatment may include assessment; diagnosis; crisis intervention; individual, group, or family therapy; medication (as needed by referral); substance abuse treatment; training in daily living and social skills; prevocational training; and/or case management services. Qualified professional staff members from TYFS provide outpatient services. (You may also be financially responsible for treatment planning and consultation activities that may take place without you being present)

Outpatient treatment may consist of contacts between qualified professionals and clients, focusing on the presenting problem and associated feelings, possible causes of the problem and previous attempts to cope with it, and possible alternative courses of action and their consequences. You and the treatment staff will plan the frequency and type of treatment. Every effort will be made to provide you with services in the language of your choice.

You are expected to benefit from treatment, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.

You will be expected to pay (or authorize payment of) all or some part of the costs of treatment received. The amount you pay is dependent upon your ability to pay based on your income and personal financial situation. If legal action is initiated to collect your bill, you will be responsible for paying all reasonable attorney fees and court costs in addition to any judgment against you.

Failure to keep your appointments or to follow treatment recommendations may result in your treatment being discontinued. If you cannot keep your appointment, you are expected to notify the clinic.

All information and records obtained in the course of treatment shall remain confidential and will not be released without your written consent except under the following conditions:

As specified in the HIPAA Notice of Privacy Practices which you were given;
You are a non-emancipated minor, ward of the court, or in the event another person such as your parent or guardian, the court, or your conservator, can obtain all information about you here;
Summary data about all clients may be reported if required by the state of Nevada for the purposes of tracking and research.
Under certain circumstances, as set forth in HIPAA regulations, which you may read upon request.
In the event HIPAA confidentiality guidelines and State of Nevada law are different, we will apply the one that provides your protected health information with greater protection.

You have the right to accept, refuse, or stop treatment at any time.

This form informs that acceptance and participation in the mental health system is voluntary and is not a prerequisite for access to other community services. Individuals retain the right to access other services and have the right to request a change of provider, staff person, therapist, coordinator, and/or case manager to the extent permitted by law.

***I have read the above, and I agree to accept treatment, and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.***

| | | | |
|---|---|---|---|
| Signature of Client | Date | Signature of Authorized Representative (if required) and description of representative's authority | Date |

**INFORMED CONSENT FOR TELETHERAPY**

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this consent carefully.

**Benefits and Risks of Teletherapy**

Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone therapy. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist are in a situation where they are unable to continue to meet in person due to extenuating circumstances. It can also increase the convenience and time efficiency of both parties.

There are benefits of teletherapy, as well as some inherent risks of teletherapy. There are some differences between in-person psychotherapy and teletherapy.

Risks to confidentiality: Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. We will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology: There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.

Crisis management and intervention: As a general rule we will not engage in teletherapy with patients who are in a crisis. Before engaging in teletherapy, we will develop an emergency response plan or safety plan to address potential crisis situations that may arise during our teletherapy work. It is urgent that you share with your therapist any thought that you may have of harming yourself; and any history that you may have of suicide attempts or hospital treatment which you received for suicidal thoughts.

Efficacy: While most research has failed to demonstrate that teletherapy is less effective than in person psychotherapy, some experienced mental health professionals believe that something is lost by not being in the same room. For example, there is debate about one's ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between you and your therapist related to the use of technology, please bring up such concerns immediately and your therapist and you will address the potential misunderstanding.

**Electronic Communications**

We will discuss which is the most appropriate platform to use for teletherapy services. You may be required to have certain system requirements to access electronic psychotherapy via the method chosen. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

For communication between sessions, that email exchanges and text messages with the office should be limited to mailers such as setting and changing appointments, and other related issues. You should be aware that no therapist can guarantee the confidentiality of any information communicated by email or text. Therefore, we will not include any clinical material by email and request that you do not as well.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however if an urgent issue arises, you should feel free to attempt to reach us by phone. We will make every effort to return your call on the same day you make it. If you are unable to reach us and feel that you cannot wait for us to return your call, please contact our on-call therapist or 911 in the case of an emergency.

**Confidentiality**

Counselors have a legal and ethical responsibility to make our best efforts to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential and/or that a third party may not gain access to our communications. Even though we may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third party.

The extent of confidentiality and the exceptions to confidentiality that are outlined in our Disclosure Statement still apply in teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

Every individual attending a group must make sure that confidentiality is kept. That means that no one in your residence may see your computer or hear anyone talking in your group session. This is a critical component of attending your on-line groups.

**Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, we will ask you where you are located at the beginning of each session and we will ask that you identify emergency resources that are near your location, that we may contact in the event of a crisis or emergency, to assist in addressing the situation. We may also ask that you sign a separate authorization form allowing us to contact your emergency contact person as needed during such a crisis or emergency.

If the session cuts out, meaning the technological connection fails and you are having an emergency, do not call us back but call 911or go to your nearest emergency room. Call us after you have called or obtained emergency services.

If the session cuts out and you are not having an emergency, disconnect from the session, we will wait (5) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within those five (5) minutes, then call us on the phone number we provided you.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

**Fees**

The same fee rates shall apply for teletherapy as apply for in-person psychotherapy.

**Consent**

This agreement is intended as a supplement to the general informed consent that we may have agreed to at the outset of treatment. Your signature below indicates agreement with its terms and conditions. This agreement is supplemental to the consent for treatment that is given when you sign a Client Disclosure Statement and does not amend any of the terms of that agreement.

I, _____, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

| | | | |
|---|---|---|---|
| Signature of Client | Date | Signature of Authorized Representative (if required) and description of representative's authority | Date |

# PARTICIPANT RIGHTS *and* SERVICES CONTRACT

***Participant Rights***

1. Tahoe Youth & Family Services provides services without discrimination by race, religion, sex, ethnicity, age, disability, sexual preference and/or ability to pay.
2. To be accorded clean, safe, and sanitary accommodations in an alcohol-free and drug-free environment to meet his or her needs.
3. To be free from intellectual, emotional and/or physical abuse.
4. The confidentiality of client records maintained by this program is protected by Federal law and regulations. Generally, the program may not reveal to a person outside the program whether a client attends the program, or disclose any information identifying the person as a client, UNLESS:

    a. The client consents in writing; *or*
    b. The disclosure is allowed by a court order; *or*
    c. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
    d. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
    e. Federal law and regulations do not protect any information about a crime committed by a client either in the program, or against any person who works for the program, or about any threat to commit such a crime. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws, and 42 C.F.R., part 2 for Federal regulations.)

Violation of the Federal law and regulations is a crime. Suspected violations may be reported to the U.S. Attorney in the district where the violation occurs.

- All grievances about the drug program or services not adequately addressed by Tahoe Youth & Family Services should be taken to the appropriate state regulatory agencies. A client in Nevada can contact the Nevada State Board of Examiners for Alcohol, Drug and Gambling Counselors at 625 Fairview Dr., Suite 124 Carson City, NV 89701; telephone (775) 884-8922 if he/she wishes to file a complaint against a counselor and may contact the Nevada Division of Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency if he/she wishes to file a complaint about the agency. For *program service complaints* call SAPTA at (775) 684-4190. For *counselor* complaints go to the State Board of Examiners for Alcohol, Drug & Gambling Counselors website at http://alcohol.state.nv.us/ or call (775) 884-8922. For *facility* complaints contact BLC at (775) 684-5900. A client in California can contact the Toll Free Number (877) 685-8333 In addition to the toll free number listed, complaints can be submitted in person, by telephone, in writing, or any automated or fax, at the following: Department of Health Care Services, Substance Use Disorder Care Services, P.O. Box 997413, MS 2601, Sacramento, CA 95899-7413; telephone number (916) 327-1753; fax number (916) 322-2658; dhcs.ca.gov
- Title 9, California Code of Regulations, Section 13065 requires the following: Within 24 hours of the time an alleged violation of the code of conduct specified in Section 13060 by a registrant or a certified AOD counselor becomes know to an AOD program, the program shall report it to the Department and to the registrant or counselor's certifying organization. Such report may be made

by contacting the Department and the certifying organization in person, by telephone, in writing, or by any automated or electronic means, such as email or fax.

- Title 22, California Code of Regulations (CCR), Section 51341.1(p) mandates that providers must inform all beneficiaries of their right to a fair hearing at the State level if they disagree with action of denial, involuntary discharge, or deduction in DMC substance abuse treatment services. The written notice intended action and the notice must include specific information as outlined in Subsection (p) (1). Written requests should be directed to: California Department of Social Services, State Hearings Division, P.O. Box 944243, M.S. 19-37, Sacramento, CA 94244-2430. Oral requests should be directed to: telephone 1-800-952-5253; TDD Number 1-800-952-8349.

5. The client has the ultimate responsibility for decisions respecting his or her own health care, and possesses a right to information respecting his or her condition and care provided.
6. Participants shall receive a copy of all contracts they sign for payments or services. A sliding fee schedule is used to determine ability to pay and is available upon request. Fees are due at the time of the appointment(s). Donations are also accepted, if the client wishes to contribute to the program.

***Services Contract***

Each person receiving services from Tahoe Youth & Family Services understands and agrees, by signing below, to the following program rules:

1. Clients and/or their families will not be seen if they are under the influence of drugs or alcohol.
2. To contact us if a scheduled appointment needs to be cancelled. We request 24-hour notice of cancellation.
3. The parent/guardian of clients under the age of 12 is not to leave the facility during the child's session. Clients needing transportation must be picked up within 10 minutes of the scheduled end of session.
4. To attend therapy sessions on a regular basis. Being more than 15 minutes late will constitute a no-show. Clients with two no-shows for their appointments will have their cases closed.
   *If a SARB, Probation, School, or Teen Court-mandated client, your case will be closed after the second no-show, and* _____ *at* _____ _____ *will be notified of the discharge.*
5. To make a responsible effort to pay the established fees at each meeting.
6. To present no physical violence or threats of violent behavior.
7. To not use profane or vulgar language in the public areas.
8. Clothing, jewelry and personal items shall be free of writing, pictures or any other insignia which are crude, vulgar, profane or sexually suggestive; which bear drug promotions or likenesses; or which advocate racial, ethnic or religious prejudice.
9. To respond, if possible, to a staff person who, at 90 days after discharge, may call for a follow-up discussion of your progress.
10. To be willing to participate in a regularly scheduled, ongoing counseling program and treatment, including medical examination and laboratory testing if necessary.
11. Your case may be discussed in-house case management meeting with our counselors and clinical supervisors. This process allows each counselor to utilize the expertise of all the counselors in determining the best course for your family's counseling. Please initial below to approve your case being discussed in case management.

***Initial here if approval:*** _____

_____ _____ /_____ /_____

**Patient Signature** **Date**

_____ _____ /_____ /_____

**Parent or Guardian Signature** **Date**

_____ _____ /_____ /_____

**Counselor Signature** **Date**


# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided with a copy of Tahoe Youth & Family Services Notice of Privacy Practices (effective date 04/14/03) on this date.

____ /____ /____ _____

***Date*** ***Patient name***

____ /____ /____ _____

***Date*** ***Patient or Parent/Guardian signature***

# TAHOE YOUTH & FAMILY SERVICES
# NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Tahoe Youth & Family Services (referred to as "we") may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health condition, the provision of health care to you, or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

## HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care options, and treatment.

- Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

- Health Care Operations. We use and disclose your protected information in order to perform or plan activities, such as quality assessment activities or administrative activi- ties, including data management or customer service. We may also contact you to pro- vide appointment reminders or to offer information about treatment alternatives or other related services that may be of interest to you.

- Plan Sponsor. If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who may also be an employer.

- Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailing containing protected health information to the address that we have on record.

- As Required By Law. We must disclose protected health information about you when required to do so by law.

- Public health Agencies. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

- Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about neglect, abuse, or domestic violence.

- Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g.. state insurance departments) for activities authorized by law.

- Law Enforcement. We may disclose protected information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.

- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

- To Avert a Serious Threat to Health or Safety. We may disclose protected information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- Special Government Functions. We may disclose information as required by the military authorities or authorized federal officials for national security and intelligence activities.

- Workers Compensation. We may disclose protected health information to the extent necessary to comply with state laws for worker compensation programs.

- Health Information That is Not Protected. We may disclose health information about you that is not "protected health information", that is, information used in a way that does not personally identify or reveal who you are.

## OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed, or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that we maintain about you.

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- Rights to Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, payment, or medical management records. Your request to review and/or obtain a copy of your pro- tected health information records must be made in writing. We may charge a fee for the costs of producing, copying, and mailing your requested information, but we will tell you the cost in advance.

- Right to Amend Your Protected Health Information. If you feel that protected health information maintained by us is *incorrect or incomplete*, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or you ask us to amend a record that is already accurate and complete.

- Your Rights if a Request is Denied. If we deny your request to amend your protected health information we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- Right to an Accounting of Disclosures Made by Us. You have the right to request an accounting of disclosures we have made of your protected health information. This list will not include our disclosures related to your treatment, or payment for health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the

same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- Right to Request Restriction on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or dis- close your protected health information for treatment, payment, or health care opera- tions. We may not agree to your request. If we do agree, we will comply with your request unless the information needed is for an emergency. Your request for a restric- tion must be made in writing. In your request for a restriction, you must tell us what information you want to limit; whether you want to limit how we use or disclose your information, or both; and to whom you want the restrictions to apply.

- Right to Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you, such as paper or electronic communi- cation, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communication must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of this Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- Contact Information for Exercising your Rights. You may exercise any of the rights described above by contacting our Executive Director. See the end of this Notice for the contact information.

## HEALTH INFORMATION SECURITY

Tahoe Youth & Family Services requires all its employees to follow the Tahoe Youth & Family Services confidentiality policies and procedures that limit access to health information about clients to those employees who need it to perform their responsibilities. In addition, Tahoe Youth & Family Services maintains physical, administrative, and technical security measures to safeguard your protected health information.

## CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make material change to the privacy practices described in this Notice. Anytime we make a material –change to this Notice, we will promptly revise and post the new Notice with the new effective date.

## COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or the Secretary of the Department of Health and Human Services. All complaints to Tahoe Youth & Family Services must be made in writing and sent to the privacy official listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

## CONTACT

**Tahoe Youth & Family Services**
**Executive Director**

1021 Fremont Avenue
South Lake Tahoe, CA 96150
(530) 541-2445
Fax: (530) 541-0517

1512 Hwy 395
Gardnerville, NV 89410
(775) 782-4202
Fax: (775) 782-5055

## CONTACT DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX, Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
Voice: (415) 437-8310
Fax: (415) 437-8329
TDD: (415) 437-8311

TAHOE YOUTH & FAMILY SERVICES
A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

# Health Questionnaire

Patient Name: _____ Date of Birth: _____

Date: _____ Social Security #: _____

Medi-Cal #:_____ **or** Private Insurance:_____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. **This information is confidential**.

## Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.
   ❑ Yes ❑ No _____ Date: _____
2. Have you ever had a stroke? If yes, please give details.
   ❑ Yes ❑ No _____ Date: _____
3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.
   ❑ Yes ❑ No _____ Date: _____
4. Have you ever had any form of seizures, delirium tremors or convulsions? If yes, please give details.
   ❑ Yes ❑ No_____ Date: _____
5. Have you experienced or suffered any chest pains? If yes, please give details.
   ❑ Yes ❑ No_____ Date: _____

## Section 2

6. Have you ever had a heart attack, or any problem associated with the heart? If yes, please give details.
   ❑ Yes ❑ No_____ Date: _____
7. Do you take any medications for a heart condition? If yes, please give details.
   ❑ Yes ❑ No_____ Date: _____
8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.
   ❑ Yes ❑ No_____ Date: _____
9. Have you ever had high-blood pressure or hypertension? If yes, please give details.

❑ Yes ❑ No_____ Date: _____

10. Do you have a history of cancer? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____

## Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.
    ❑ Yes ❑ No_____
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
    ❑ Yes ❑ No_____ Date: _____
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder. If yes, please give details.
    ❑ Yes ❑ No_____ Date: _____
19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details, including any ongoing pain or disabilities.
    ❑ Yes ❑ No_____ Date: _____
20. Please describe any surgeries or hospitalizations due to illness or injury that you have had.
    Date:_____
    _____
21. When was the last time you saw a physician? What was the purpose of the visit?
    Date:_____
22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
    ❑ Yes ❑ No_____
    Past (Please list)_____
23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.
    ❑ Yes ❑ No_____

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.
    ❑ Yes ❑ No_____
25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.
    ❑ Yes ❑ No_____
26. When was your last dental exam?Date: _____
27. Are you in need of dental care? If yes, please give details.
    ❑ Yes ❑ No_____
28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.
    ❑ Yes ❑ No_____
29. Are you pregnant?
    ❑ Yes ❑ No_____ Due Date: _____
30. In the past seven days what types of drugs, including alcohol, have you used?

| ***Type of Drug*** | ***Route of Administration*** |
|---|---|
| | |
| | |
| | |
| | |

31. In the past year what types of drugs, including alcohol, have you used?

| ***Type of Drug*** | ***Route of Administration*** |
|---|---|
| | |
| | |
| | |
| | |

**I declare that the above information is true and correct to the best of my knowledge:**

Patient Signature: _____ Today's Date: _____

Parent or Guardian Signature: _____ Today's Date: _____

# Authorization for Release of Psychiatric/Medical Records

Name:_____ Date of Birth:_____

Social Security #: _____

This authorization is for use or disclosure of psychiatric/medical information, including diagnosis and treatment of mental disorders and/or conditions related to alcohol/drug abuse.

Release to:_____
(Program Name and Address)

_____
(Program Director's Name)

I hereby authorize the following person/agency to furnish the above named recipient with the records and information listed:_____

_____

_____

The recipient may use the information authorized only for the following purposes: _____

_____

This authorization shall remain in effect until: _____
(Date)

I understand that I may revoke this authorization at any time, except to the extent that the person/agency has already acted in reliance on it.

I understand that the recipient may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

❑ Yes ❑ No Initial_____

**Information Requested:**

- ❑ Medical Examination
- ❑ Psychological Evaluation
- ❑ Psychiatric Evaluation
- ❑ Screening Evaluation
- ❑ Discharge Summary
- ❑ Other_____

_____

- ❑ Medication
- ❑ Diagnosis
- ❑ Financial
- ❑ Summary of Treatment
- ❑ Progress Notes

_____
Authorizing Participant Signature Date

_____
Authorized Program Representative, if applicable Date

## SECTION TO BE COMPLETED BY MEDICAL DIRECTOR

- ❑ Physical Exam Waived
- ❑ Physical Exam Recommended

_____ _____/_____/_____

*Doctor's Signature* *Date*

Doctor's Comments: _____

# Health Questionnaire Scoring Key

This self-administered questionnaire is designed to provide programs with a set of general guidelines to assist in determining an individual's suitability for treatment/recovery services in a non-medical facility. It is intended as a guideline only and should not be substituted for common sense or any other available data which contradicts this questionnaire. When in doubt, always consider the severity of the issue and, above all, the well-being of the client. The potential value of a thorough Health Screening administered by a nurse-practitioner or physician should never be underestimated.

## Section 1

A **Yes** answer to any of the questions in Section 1 indicates the existence of a potentially life-threatening condition. You should strongly consider referring the individual to a qualified physician, requesting that they provide you with a medical clearance to participate in a program. Enrollment in the program prior to receiving a medical clearance is at the discretion of the program.

## Section 2

A **Yes** answer to any of the questions in Section 2 indicates the existence of a serious health condition. Although admission into your program may be appropriate, a thorough Health Screening should be scheduled at the time of admission. Continuing participation in the program should be at the discretion of the program.

## Section 3

A **Yes** answer to any of the questions in Section 3 does not necessarily indicate the existence of a serious health condition. However, **Multiple Yes** answers could be cause for concern and indicative of a generally poor health condition. Multiple yes answers in Section 3 may warrant a Health Screening. At a minimum, information gathered in Section 3 should be available to staff in order to better serve the client.

The high incidence of illness at time of admission to a program calls for caution and attention to detail. No client can benefit from a program if he or she is too ill to participate fully. Conversely, no program can succeed if its clients are unable to utilize the services offered.