TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

Seeking Services Statement

To be completed by patient:

I am seeking services from Tahoe Youth & Family Services due to the following presenting issues:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's printed name: _____

Patient or Parent / Guardian Signature: _____

Date: _____

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

This form only needs to be signed if you are being treated for substance abuse or feel you might need substance abuse treatment in the future.

I understand that as a patient of Tahoe Youth and Family Services (TYFS), I am entitled to the services offered for substance abuse treatment. I understand that recommendations for treatment and referrals will be developed for me by TYFS Staff and, upon my approval, will become part of my personal file. I understand that I have the right to 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:

1. The nature and consequences of the recommendation for treatment.
2. The reasonable risks, benefits and purposes of the recommendations.
3. 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

Federal Law and Regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this program. (Title 42 CFR Part 2 and Title 45 CFR Parts 160 and 164) Generally, the staff 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:

1. The patient consents in writing.
2. The disclosure is made under a court order as allowed by said regulations.
3. The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal Law and Regulations by a person or program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal Law and Regulations do not protect any 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 or elder abuse or neglect from being reported under State Law to appropriate State and Local Authorities. (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.)

I hereby consent to have Tahoe Youth & family Services begin my treatment on this date.

_____

Patient's printed name

_____ _____

Patient or Parent/Guardian signature Date

PARTICIPANTS 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; www.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 known 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 you approve: _____

PARTICIPANTS RIGHTS AND SERVICES

I have received and understand the Participant's Rights and Services Contract

We will be more than happy to make you a copy if you'd like.

_____

Patient's name (printed)

_____ _____ /_____ /_____

Patient or Parent / Guardian Signature *Date*

_____ _____ /_____ /_____

Counselor Signature *Date*

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

PATIENT'S RIGHTS

As the patient of a program for treatment of abuse of/or 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 and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for 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 be informed of all program services, which may be of benefit to your treatment.
5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
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 our 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 estimated cost 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 be informed of the program's rules for your conduct at the facility.
11. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
12. You have the right to receive respectful and considerate care.
13. You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.
14. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.
15. You have the right to safe, healthful and comfortable accommodations.
16. 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 your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.
17. Waiver of any civil or other right protected by law cannot be required as a condition of program services.
18. You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.
19. 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.
20. 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 retaliation or other adverse consequences as the product of filing a grievance.

21. 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, 4126 Technology Way, 2nd Floor Carson City, Nevada 89706. Attn: Treatment Supervisor Phone: 1-775-684-4190
22. You have the right to be informed of your rights as a patient. The foregoing is 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 you beginning treatment.

Patient acknowledgement:

I have read, understand, and have been provided a copy of the "Patient's Rights" form.

_____

Patient's printed name

_____ _____

Patient or Parent/Guardian Signature Date

TAHOE YOUTH & FAMILY SERVICES
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Keep this for your records

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 activities, including data management or customer service. We may also contact you to provide 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 workers 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

Keep this for your records

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

- 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 protected 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 disclose your protected health information for treatment, payment, or health care operations. 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 restriction 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 communication, 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.

Keep this for your records

- 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 INFORMATION:

Tahoe Youth & Family Services Executive Director
1021 Fremont Avenue
South Lake Tahoe, CA 96150
Voice: (530) 541-2445
Fax: (530) 541-0517

1512 US Hwy 395 N. Suite 3
Gardnerville, NV 89410
Voice: (775) 782-4202
Fax: (775) 782-5055

Department of Health and 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

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.

_____

Patient's name (printed)

_____

Patient or *Parent / Guardian signature*

_____ /_____ /_____

Date

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

CLIENT GRIEVANCE

GENERAL POLICY:

Clients have the right to file a grievance or register a complaint without the fear of reprisal. Clients may document a grievance in writing about a staff person and give that complaint to the staff person's immediate supervisor. If the complaint is against a supervisor, the client may give the documentation to the Executive Director. If the complaint is against the Executive Director, the client may present the document to the Board of Directors. In each instance, the complaint will be investigated and every attempt made to resolve the situation to the client's satisfaction. If at any point, the client feels that the resolution is unsatisfactory, the client may proceed with the complaint up the chain of command.

The client also has the right to take the complaint or grievance to the appropriate state regulatory agencies. The client can contact the Board of Examiners if he/she wishes to file a complaint against a counselor and may contact Bureau of Alcohol and Drug Abuse if he/she wishes to file a complaint about the agency.

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 retaliation or other adverse consequences as the product of filing a grievance.

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
4126 Technology Way, 2nd Floor
Carson City, Nevada 89706.
Attn: Treatment Supervisor.
Phone: 775-684-4190

_____ _____

Patient's name (printed) Date

_____ _____

Patient or Parent / Guardian Signature Date

This form only needs to be signed if you are being treated for substance abuse or feel you might need substance abuse treatment in the future.

SUBSTANCE ABUSE PREVENTION & TREATMENT SERVICES

MEDICAL RECORD RETENTION POLICY

ACKNOWLEDGEMENT OF CONSUMER INFORMATION

I, _____, acknowledge receiving this copy of the MEDICAL RECORDS RETENTION POLICY.

In accordance with the provisions of SB17 of the 2009 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.

_____
Patient's name (printed)

_____ _____
Patient or Parent / Guardian Signature Date

_____ _____
Staff Member Signature Date

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

Consent for Mental Health Treatment

1. 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)
2. 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.
3. 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.
4. 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.
5. 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.
6. 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:
    a. As specified in the HIPAA Notice of Privacy Practices which you were given.
    b. 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.
    c. Summary data about all clients may be reported if required by the state of Nevada for the purposes of tracking and research.
    d. Under certain circumstances, as set forth in HIPAA regulations, which you may read upon request.
    e. 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.
7. You have the right to accept, refuse, or stop treatment at any time.
8. 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.

Patient's name (printed): _____

Patient or Parent / Guardian Signature: _____ Date: _____

This form only needs to be completed by clients who are ordered to be here.

An addition to the Intake Packet:

Whatever referral source has ordered you to attend services at Tahoe Youth, will be contacted within 24-hours, if you miss either a group session or an individual session.

_____

Patient's name (printed)

_____ _____

Patient or Parent / Guardian Signature Date

Tahoe Youth and Family Services is a State funded Agency; therefore, we report data to the state of Nevada. Will you allow Tahoe Youth and Family Services to report your Social Security number?

_____ Yes _____ Initials

I will allow Tahoe Youth and Family Services to report my Social Security Number.

_____ No _____ Initials

I do not allow Tahoe Youth and Family Services to report my Social Security Number.

Patient's name (printed)_____

Thank you for your assistance.

Karen S. Carey

Executive Director of

Tahoe Youth and Family Services

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: Generally, 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, agree to and understand the procedures and policies set forth in this informed consent.

Patient's name (printed): _____ Date: _____

Patient or Parent/Guardian Signature: _____ Date: _____

Admission-WITS

This form must be completed by all patients. It is a form that the state requires us to have. Thank you!

Patient's First Name: _____Patient's Last Name: _____

1. **Client Description?**
   ____ Substance Abuse Treatment or Substance Abuse Evaluation.
   ____ Transfer or change in Substance Abuse Services.
   ____ Mental Health Treatment.
   ____ Transfer or change in Mental Health Services.
2. **Days waited to enter Substance Abuse Treatment. _____**
3. **Are you Pregnant?** ___ Yes ___ No
   a. **If yes, Pregnant Due Date: _____**
   b. **If yes, Prenatal Care Description?**
   ____ Received before coming in for treatment.
   ____ Received after coming in for treatment.
   ____ No prenatal care.
   c. **If yes, do you have access to Primary Care Practitioner?** ___ Yes ___ No
4. **Have you overdosed on opioids in the last 90 days?** ___ Yes ___ No
   a. **If yes, how many times? _____**
5. **Are you seeking both Substance Abuse & Mental Health services?** ___ Yes ___ No
6. **County Resident:** ____ Douglas County _____ Homeless ____ Out of State
7. **Current Living Arrangement?** ___ Homeless ___ Jail/Prison ___ Dependent Living
   ___ Independent Living ___ Private Residence ___ Dependent Living: Residential Care
   ___ Dependent Living: Foster Home/Foster Care ___ Dependent Living: Crisis Resident
   ___ Dependent Living: Institutional Setting ___ Dependent Living: Jail & other institution under the justice system ___ Dependent living: Adults in private residence needing asst. in daily living
8. **Marital Status?** ___ Never Married ___ Divorced ____Widowed ____Married ____Separated
9. **Highest Education Completed?**
   ___ Less than one school grade ___ Kindergarten ___ Nursery School, Pre-school, Head Start
   ___1st Grade ___2nd Grade ___ 3rd Grade ___4th Grade ___5th Grade ___6th Grade ___7th Grade
   ___ 8th Grade ___9th Grade ___10th Grade ___11th Grade ___12th Grade or GED
   ___ 1st year of College/University
   ___ 2nd year of College/University or Associate's Degree
   ___ 3rd year of College/University
   ___ 4th year of College or Bachelor's Degree
   ___ Some Post-Graduate Study Degree not completed
   ___ Master's Degree Completed
   ___ Post Graduate study/research, **How many years?** ___
   ___ Graduate or Professional School
   ___ Vocation School

10. **Employment Status?**
    ___Full Time ___Part Time ___Unemployed ___Homemaker ___Student ___Retired ___Disabled ___Resident of institution/hospital/jails/prison ___ Other/Volunteer/Seasonal work ___ Shelter/Non-competitive employment
    Occupation? ___ None ___ Professional ___ Healthcare ___ Retail ___ State Gov. ___ Fed Gov. ___Private Industry ___ Small Business Owner ___Lawyer ___ Doctor ___ Engineer ___ Casino Related ___ Rancher ___ Sales ___ Crafts ___ Service ___Laborer
    Income Source? ___ Wages/Salary ___ SSI/SSDI ___ Temporary Assistance ___Welfare ___Other Public Assistance ___ Retirement/Pension ___ Unemployment Compensation ___ Family/Friend Support
11. **Veteran Status?** ___ Veteran ___ Not A Veteran
    a. **Is an immediate family member a veteran?** ___ Yes ___ No
12. **Insurance Type?**
    ___ Private Insurance ___ Medicaid ___ Medicare ___ No Health Insurance ___Other
13. **Prior Substance Abuse Treatment Admissions?** ___ Yes ___ No **If yes, how many?** _____
14. **Times Hospitalized Due to Non-Substance Abuse problems in the last 90 days?** _____
15. **In the past 90 days, Substance Abuse overdose leading to the ER?** ___ Yes ___ No
    a. **If yes, how many times?** _____
    b. **Substance Abuse Drug of choice?** _____
16. **# of arrests in the last 30 days?** _____
17. **# of arrests in the last year?** _____
18. **# of days attended NA/AA meetings in the last 30 days?** _____
19. **Referral source?** ___Self ___Residential Services ___Hospital ___School ___Employer ___State/Federal Court ___Probation ___Parole ___Other: _____
20. **Medication Assisted Opioid Therapy:** ___ Yes ___ No
21. **Do you currently use Tobacco/Nicotine?**
    ___ No Tobacco Use ___ Cigarettes___ E-Cigarettes ___ Other _____
    a. **If yes, Daily Frequency of Tobacco/Nicotine Use:**
    ___ 0-10 per day ___ 11-20 per day___ 21-40 per day ___41& + per day
22. **Have you spent time thinking about your gambling experiences or planning out future gambling ventures or bets?** ___Yes ___No
    a. **Have you ever tried to stop, cut down, or control your gambling?** ___ Yes ___ No
    b. **Have you ever lied to family members, friends/others about how much you gamble or how much money you've lost on gambling?** ___ Yes ___ No
23. **Primary Substance Abuse?** ___ None ___ Alcohol ___Crack ___Marijuana ___Heroin ___Other Opiates ___ Hallucinogens ___ Methamphetamine ___ Over-The-Counter Medications Other: _____
    a. **Frequency?** ___ 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 Use
    b. **Route of Administration?** (Oral, Smoking, IV, Etc.) _____
    c. **Age of first use?** _____
    d. **Is choice of Primary Substance Abuse Prescribed?** ___ Yes ___ No

24. **Secondary Substance Abuse?** ___None ___Alcohol ___Crack ___Marijuana ___Heroin ___Other Opiates ___ Hallucinogens ___ Methamphetamine ___Over-The-Counter Medications Other: _____
    a. **Frequency?** ___ 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 Use
    b. **Route of Administration?** (Oral, Smoking, IV, Etc.) _____
    c. **Age of first use?** _____
    d. **Is choice of Secondary Substance Abuse Prescribed?** ___ Yes ___ No
25. **Third Substance Abuse?** ___None ___Alcohol ___Crack ___Marijuana ___Heroin ___Other Opiates ___Hallucinogens ___Methamphetamine ___Over-The-Counter Medications Other: _____
    a. **Frequency?** ___ 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 Use
    b. **Route of Administration?** (Oral, Smoking, IV, Etc.) _____
    c. **Age of first use?** _____
    d. **Is choice of Third Substance Abuse Prescribed?** ___ Yes ___ No
26. **# of dependent children, aged 17 or less (birth, adopted, or stepchildren)** _____
    a. **Childcare Status?**
    ____ Need childcare.
    ____ Have childcare.
    ____ Have childcare after treatment.
    ____ Family provides childcare
    b. **Are Children living with someone else (child protection order)?** ___ Yes ___ No
    c. **With whom?** _____
27. **Have you been diagnosed with Severe Mental Illness?** ___ Yes ___ No
28. **Have you been diagnosed Seriously Emotionally Disturbed?** ___ Yes ___ No
29. **Have you currently attended school at any time in the past 3 months?**
    _____ Yes _____ No _____ Not applicable
30. **Have you ever been in a State Hospital?** ___ Yes ___ No **If yes, please check below**
    ___Voluntary-Self ___Voluntary-Civil ___Involuntary-Criminal ___Involuntary-Juvenile Justice