Client Intake Form

Name: _____ Nickname: _____ Date: _____

Address: _____
Street Address City State Zip Code

Primary Phone #: _____ Type (Circle): HOME CELL WORK

Secondary Phone #: _____ Type (Circle): HOME CELL WORK

Email Address (required): _____

Date of Birth: _____ Sex: _____ Preferred Pronouns: _____

SSN: _____ Marital Status: _____ # of Dependent Children: _____

Employed? _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Contact Phone: _____ Contact Email: _____

Briefly describe reason for help: _____

Who referred you to Resource Connect? _____
(Name) (Phone #)

Have you ever received any type of counseling before? _____ If so, explain: _____

_____

List any current physical or medical problems: _____

Primary Physician's Name: _____ Last Exam Date: _____

List Current Medications: _____

Office Use Only:

_____ _____
Intake Therapist *DSM-V Codes*

Consent for Treatment

Your signature acknowledges that you consent to treatment with The Resource Group/Resource Connect. We agree to provide you with competent professional care and to do our best to be of help to you.

Your intake session at The Resource Group/Resource Connect will last 45-60 minutes and will consist of an initial interview with a clinician and may include self-assessment questionnaires.

Follow-up therapy sessions are usually 45 minutes in duration. Different treatment groups will meet for a variety of times. You will be informed of these times during your intake appointment.

Psychiatric consultation follow-ups regarding medication management are typically 20 minutes.

Mental health and/or substance abuse treatment is a collaboration between you and your clinician. It is also complex, so we cannot guarantee any outcome. We will meet with you, be timely and professional, and we will use our skill and experience for your benefit. You agree to pay us at the time of service for this care, and to give us 24-hour notice if you must miss a session. You also agree to notify us if you decide to terminate treatment.

I give permission for all persons acting on behalf of RG/RC to contact me and leave messages at the following address and phone number. To change this permission, I must contact RG/RC in writing:

Client Printed Name: _____

Address: _____

Phone: (H) _____ (C) _____

I have read this document and understand the above information.

_____ _____
Client Signature (14 and over) Date

_____ _____
Parent/Legal Guardian Signature Date
(for clients under age 18)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment t, payment activities and healthcare operations of the uses and disclosures we make of your protected health information.

Purpose of Consent; By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Client Name: _____

Client Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the client, complete the

following:

Parent/legal Guardian Name: _____

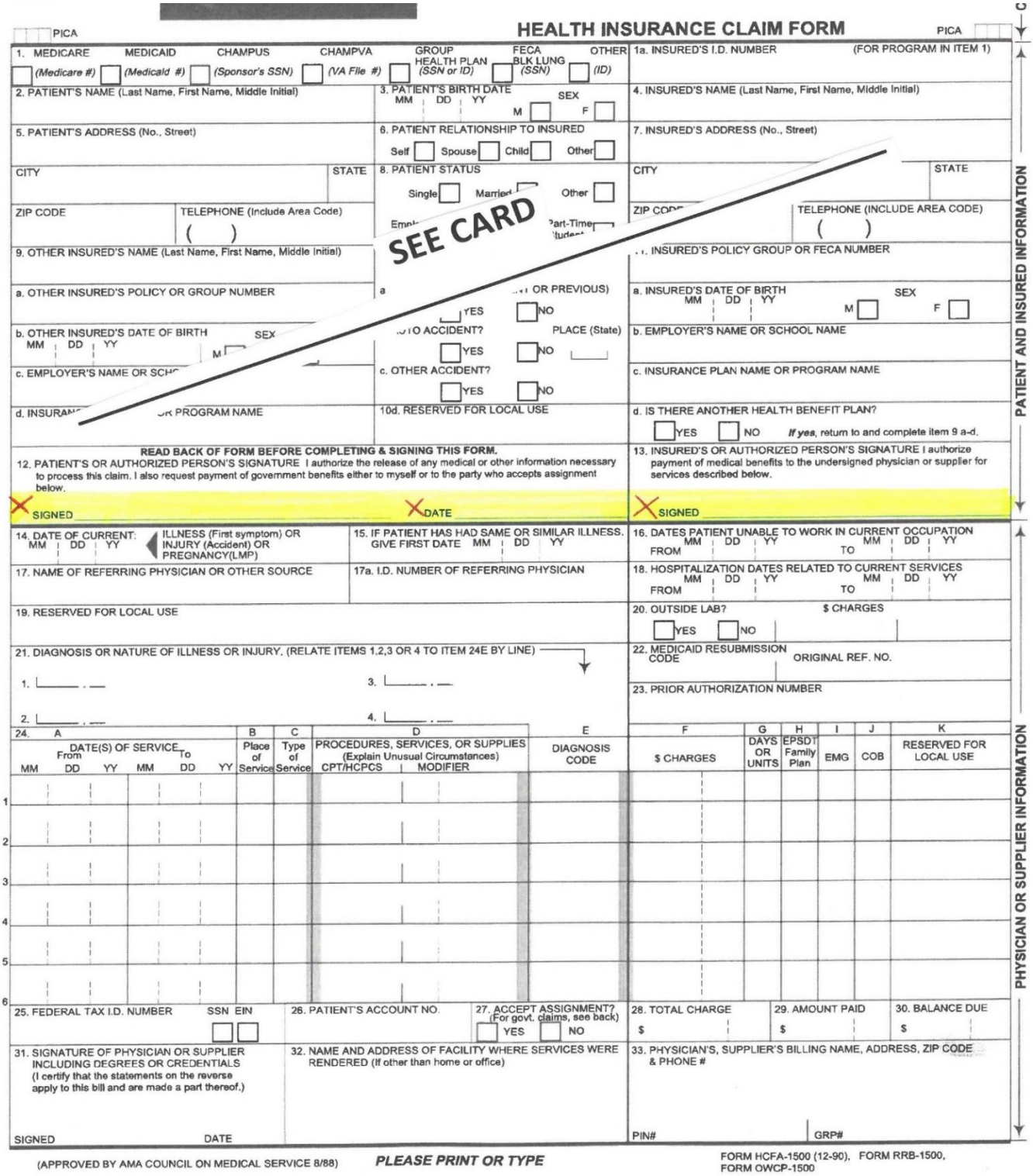
Signature: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- *Individual refused to sign*
- *Communication barriers prohibited obtaining the acknowledgement*
- *Other (Please specify)* _____

Please sign at both signature lines marked with an "X", and date.



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Financial Agreement

Thank you for choosing The Resource Group Counseling and Education Center, Inc. This is our financial policy, which we hope will answer questions you may have, and will specify the financial contract for our work together.

Please read and sign this original. We can give you a copy for your files and include a copy of your provider's fee schedule upon request.

1. We expect full payment for services at the time treatment is provided. We accept cash, check, Visa, MasterCard, American Express, and Discover.

2. Missed appointments and late cancellations:

    a. Clients in Level II.1 IOP and Level I OP with private insurance will be charged a **$40 missed fee** when they no call; no show or call to cancel for a scheduled group. This fee will only be waived if the client makes up the group in the same week or has an excused absence (at the discretion of the clinical team). An excused absence will require formal documentation related to why they missed group. This documentation will be due to their case manager at their next scheduled group.

    b. Clients in Level II.1 IOP and Level I OP with Medicaid insurance will receive a strike when they no call; no show or call to cancel for a scheduled group. This strike will only be waived if the client makes up the group in the same week or has an excused absence (at the discretion of the clinical team). **After three strikes, they will be discharged** and allowed to complete a new intake 30 days post-discharge.

3. If you wish to have us bill your health insurance carrier for mental health and/or substance use services note the following: **To submit a claim, we are required to give you a psychiatric diagnosis which will be submitted with your claim. Insurance carriers may request additional information with your claim, such as your treatment plan, reasons for treatment, and information that describes the seriousness of your condition. Once this information is transmitted, The Resource Group Counseling and Education Center, Inc. no longer has sole protection or control of that information.**

4. Administrative fees are billed for services provided by Resource Group that cannot be billed to insurance, such as completion of letters and other paperwork, completion of records requests, correspondence with other providers/entities, etc. The standard administrative fee is $45 per 15 minutes; however, fees may vary based on service and provider.

5. If you are enrolled with one of our providers who is Out of Network with your insurance and you have Out of Network benefits, our office can submit your primary insurance claims for you as a courtesy to most insurance providers. Please be aware that our contractual relationship is with you, not with your insurance company. We expect full payment at the time of service. It is your responsibility to ensure that you are reimbursed by your carrier. We cannot compel your insurance carrier to pay any claim if it is an Out of Network submission. You agree that it is your responsibility to follow up on reimbursements and

any payment irregularities.

6. If you are covered by a secondary insurance policy, we cannot submit claims to the secondary carrier. We can provide you with a monthly statement, which you can submit with your claims form for reimbursement from your secondary insurance carrier per your policy.

7. The Resource Group Counseling and Education Center, Inc expects clients to keep current on their accounts. If you owe more than $125 on your account, you will only be able to schedule one further appointment until you make a payment to reduce your balance below $125. If your balance is over $250, you are eligible to create a payment plan with the Finance Department. Payment plans are agreements that allow you to continue receiving services while working to reduce your outstanding balance. Continued service will be contingent upon adherence to the agreed upon plan.

_____ _____

Print Name of Client Date of Birth

_____ _____

Client or Client's Guardian Signature Today's Date

Payment Card Information Authorization Form

I, _____, authorize Resource Group Counseling and Education Center, Inc. to charge my credit card for the agreed upon services and agree to pay the amount charged in accordance with my cardholder agreement.

- I authorize the Resource Group Counseling and Education Center, Inc. to store my credit card electronically for future authorized payments for established and agreed upon rates or fees as dictated by my insurance policy, self-pay and missed appointment fees, and administrative fees.
- I may revoke this authorization at any time by submitting a written request to the Support Staff Manager.
- Upon my discharge or notice of withdrawal from services and payment of any balances due, the Resource Group Counseling and Education Center, Inc. will cease storage of my credit card information.

_____ _____
Cardholder Signature Date

_____ _____
Client Name (if different than Cardholder) Relationship to Client

By signing this form, you are giving permission for information to be shared only with the specific person or agency listed.

Office use only:

Exp date: _____ Health Fusion noted_____ Initials:_____

URINE TOXICOLOGY SCREENINGS

A toxicology screen is a test used to determine if an individual has been exposed to certain legal or illegal drugs. Toxicology screens are usually ordered to see if a Client has taken drugs that could endanger his or her health. If a Client is suspected of taking illegal drugs, a screen for specific drugs that are commonly abused may be ordered. Toxicology screens are often ordered by the Clinical Staff at Resource Connect when a Client appears to be or is suspected of being impaired.

The test can be performed quickly. Results can help our clinicians treat the patient effectively and safely. Resource Connect contracts with **DOMINION DIAGNOSTICS LABS** to perform urine testing.

There are several types of toxicology screens. The screening methods at Resource Connect uses a sample of urine to test for the presence of alcohol, illegal narcotics or prescription drugs. The urine screen can indicate if a person has been exposed to drugs or poisons.

If a urine sample is required, the client may be asked to urinate into a small sample cup in the presence of a staff member. This prevents the client from tampering with the sample. **All scheduled urinalyses are mandatory.**

Most legal and illegal drugs of abuse can be identified by toxicology screens. Common classes of drugs that may be detected by toxicology screens include:

- alcohol (including ethanol and methanol)
- amphetamines (such as Adderall)
- barbiturates
- benzodiazepines
- methadone
- cocaine
- opiates (including codeine, oxycodone, heroin, fentanyl)
- phencyclidine (PCP)
- tetrahydrocannabinol (THC)
- Other newer drugs like Ketamine, Spice, etc.

The frequency of urine analysis is determined by the program. The urine analysis done at Resource Connect will be billed through your insurance company. However, any portion of the cost that is NOT covered by your insurance is your responsibility. Please let us know if you personally receive a bill – in some cases we can intervene on your behalf.

_____ _____

Signature Date

Overdose Prevention Plan

An overdose is when you take more of a drug or combination of drugs that the body is able to handle, and as a consequence the central nervous system (CNS) is not able to control basic life functions. Some common symptoms include: heart failure, stop breathing, pass out, seizures, slow or faint pulse, blurred vision, and excessive drooling.

Anyone can overdose; first-time users, long-time users, old people, young people, men, or women**.** The amount of a drug that causes a person to overdose can fluctuate, so users should be advised that there is no such thing as a real "safe dose".

Factors That Can Influence Overdose Risk

Tolerance
A person's tolerance for a drug (or combination of drugs) can change for a variety of reasons. If a person has gained or lost weight, started taking new medications, is experiencing depression or exhaustion, or beginning to use after a period of abstinence. It is likely that a smaller dose than they previously used will get them high, and that the usual dose may cause overdose.

Mixing drugs
Mixing drugs of the same class is one of the most common reasons of overdose (i.e. mixing multiple depressants such as opiates, pulls, and alcohol). Mixing drugs of different classes is also dangerous (i.e. mixing stimulants with depressants). Mixing alcohol with any drug can be very dangerous as it is a powerful sedative and causes dehydration. Mixing prescription drugs with street drugs is very dangerous because both illegal and legally prescribed drugs are very often metabolized by the same systems in the body. One should also be careful when prescribed methadone or buprenorphine by a doctor, or given naltrexone by a doctor, as these medically assisted treatments may prevent a high and can result in overdose.

Accumulation
Sometimes an individual may overdose because they simply used too much in too short an amount of time. A user may be tempted to re-dose before the body is ready because the high often wears off before the drug is sufficiently cleared from the body.

Past overdose events and Health Status
Research shows people who have overdosed in the past are at much greater risk of future overdose. Overdose is more likely when there may be weakness in your immune system due to: recent illness, dehydration, under-nutrition, and particularly when liver and/or kidneys are not working well.

Inconsistent drug quality and potency
There is no "quality control" for street drugs, so it's hard to tell what you are getting. It is important to know that the strength and quality of the drug may vary from day to day

Using alone
While using alone does not cause an overdose, it does increase the chance of overdose, because no one is around to help.

Route of administration
The route of administration determines how quickly the drug takes effect. One is more likely to overdose from injecting drugs than snorting or smoking drugs.

Overdose Prevention

You are engaged in treatment at Resource Connect in order to develop skills to avoid substance use and to cultivate your recovery and life. However, it is important to be prepared with an overdose prevention plan in case a relapse occurs. Below you will find several statements that may be included in your prevention plan, but not all of them will apply to everyone. Choose the ones that will be most helpful to you. Remember that the best way to prevent overdose is *abstinence*.

My Overdose Prevention Plan

I,_____, have been given information about overdose and risk factors. I understand that abstinence is the only way to ensure that overdose doesn't happen to me. However, in case I do relapse, I agree to take the following precautions to prevent overdose:

- ☐ I will consider that my tolerance may be lower after a period of abstinence and avoid using large amounts of opiates, benzodiazepines, and/or alcohol.
- ☐ I will avoid mixing drugs, particularly of the same class of drug, and will avoid mixing drugs and alcohol.
- ☐ I will avoid mixing medications prescribed by a doctor with street drugs.
- ☐ I will avoid abusing my prescription medication and only take them as prescribed.
- ☐ I will be cautious about where I get my drugs and aware that the strength of the drug may vary from dealer to dealer.
- ☐ I will avoid using alone in order to have someone around to help in case of an overdose.
- ☐ I will avoid using drugs by injection
- ☐ If I relapse, I agree to inform my counselor and discuss possible changes in treatment in order to avoid future relapse.
- ☐ I do not have an opioid problem

_____ _____

Client Signature Date

Discharge for Treatment Non-Compliance

It is a Resource Connect policy within all substance abuse treatment programs to care for clients on an individual basis without bias or judgement. However, there are times when it is in the client's best interest to encourage responsibility for one's own actions and minimize self-destructive behavior through discharge from the program and referral to a higher level of care.

Successful and sustainable recovery requires that a client take ownership of and be accountable for their progress. Simultaneously, recovery requires a commitment from clients to focus on remaining abstinent from drugs and alcohol.

Attitude, attendance, and abstinence are the three principal areas of progress evaluation. Clients are not removed from the program for relapse, which can be viewed as a learning opportunity, if they are still making progress in their recovery. It is expected that participants attend all sessions drug and alcohol free.

Our discharge policies are as follows:

1. Unexcused absences: Clients will receive advance notice after three "no call, no shows," and they will be suspended from the program. This includes non-attendance from both group and individually scheduled sessions. Readmission will require a new commitment that includes an individualized plan with expectations and contingencies. A discharge, and subsequent readmission could result in extended time in the program to ensure the client has experienced the entire curriculum.

2. Leaving group early or coming late: Anyone arriving later than 30 minutes past the group's start time will not be admitted. This will count as a "no call, no show," which after three occurrences leads to suspension, as outlined above.

3. Calling to Cancel: Clients are strongly encouraged to take responsibility for calling to cancel for any reason. Upon returning to treatment, clients must bring proof of their whereabouts, as well as explain their absence to their clinician in person. Due to the nature of the disease of addiction and its associated dangers, if we do not hear from the client we will call the emergency contact.

4. Violence/Physical Aggression: It is expected that clients apply the skills the group teaches in interpersonal effectiveness and emotion regulation. Healthy communication of the natural range of human emotions is encouraged. At no time is violence or physical aggression tolerated. These are grounds for immediate discharge and may result in contact with authorities.

5. Possession: Possession of illegal substances on the grounds of Resource Group/Resource Connect will result in immediate discharge. Possession of illicit substances that are not

illegal will result in a review of the occurrence with the client, family, clinical and administrative staff to determine the best course of action.

6. Relapse: Increase in urinalysis results that reveal the presence of illicit substances could result in suspension or discharge. If tests reveal that the levels of substances decreasing, the case manager will review the results in a clinical team meeting and a decision made from there. If it is deemed to be an indication of use from a previous incident already documented, this positive test will not be counted as a new relapse. However, at the discretion of the clinical team, client may be referred to a higher level of care at any point throughout their course of treatment should it be deemed of clinical necessity per individual client case.

With my signature below, I affirm that I have read and understand Resource Connect's Suspension and Discharge Policies. **I agree to comply with the above policies and will cooperate in this implementation.**

_____ _____

Client's Signature Date

Medical History Review

Please check any past or present health issues:

AIDS/HIV Positive	☐ Present	☐ Past	Hemophilia	☐ Present	☐ Past
Alzheimer's Disease	☐ Present	☐ Past	Hepatitis A	☐ Present	☐ Past
Anaphylaxis	☐ Present	☐ Past	Hepatitis B or C	☐ Present	☐ Past
Anemia	☐ Present	☐ Past	Herpes	☐ Present	☐ Past
Angina	☐ Present	☐ Past	High Blood Pressure	☐ Present	☐ Past
Arthritis/Gout	☐ Present	☐ Past	Hives or Rash	☐ Present	☐ Past
Artificial Heart Valve	☐ Present	☐ Past	Hypoglycemia	☐ Present	☐ Past
Artificial Joint	☐ Present	☐ Past	Irregular Heartbeat	☐ Present	☐ Past
Asthma	☐ Present	☐ Past	Kidney Problems	☐ Present	☐ Past
Blood Disease	☐ Present	☐ Past	Leukemia	☐ Present	☐ Past
Blood Transfusion	☐ Present	☐ Past	Liver Disease	☐ Present	☐ Past
Problem Breathing	☐ Present	☐ Past	Low Blood Pressure	☐ Present	☐ Past
Bruise Easily	☐ Present	☐ Past	Lung Disease	☐ Present	☐ Past
Cancer	☐ Present	☐ Past	Mitral Valve Prolapse	☐ Present	☐ Past
Chemotherapy	☐ Present	☐ Past	Pain in Jaw Joints	☐ Present	☐ Past
Chest Pains	☐ Present	☐ Past	Parathyroid Disease	☐ Present	☐ Past
Cirrhosis	☐ Present	☐ Past	Psychiatric Care	☐ Present	☐ Past
Cold Sores/Fever Blisters	☐ Present	☐ Past	Radiation Treatments	☐ Present	☐ Past
Congenital Heart Disorder	☐ Present	☐ Past	Recent Weight Loss	☐ Present	☐ Past
Convulsions	☐ Present	☐ Past	Renal Dialysis	☐ Present	☐ Past
Cortisone Medicine	☐ Present	☐ Past	Rheumatic Fever	☐ Present	☐ Past
Diabetes	☐ Present	☐ Past	Rheumatism	☐ Present	☐ Past
Drug Addiction	☐ Present	☐ Past	Scarlet Fever	☐ Present	☐ Past
Easily Winded	☐ Present	☐ Past	Shingles	☐ Present	☐ Past
Emphysema	☐ Present	☐ Past	Sickle Cell Disease	☐ Present	☐ Past
Epilepsy or Seizures	☐ Present	☐ Past	Sinus Trouble	☐ Present	☐ Past
Excessive Bleeding	☐ Present	☐ Past	Spina Bifida	☐ Present	☐ Past
Excessive Thirst	☐ Present	☐ Past	Intestinal Disease	☐ Present	☐ Past
Fainting Spells/Dizziness	☐ Present	☐ Past	Stroke	☐ Present	☐ Past
Frequent Cough	☐ Present	☐ Past	Swelling of the Limbs	☐ Present	☐ Past
Frequent Diarrhea	☐ Present	☐ Past	Thyroid Disease	☐ Present	☐ Past
Frequent Headaches	☐ Present	☐ Past	Tonsillitis	☐ Present	☐ Past
Genital Herpes	☐ Present	☐ Past	Tuberculosis	☐ Present	☐ Past
Glaucoma	☐ Present	☐ Past	Tumors or Growths	☐ Present	☐ Past
Hay Fever	☐ Present	☐ Past	Ulcers	☐ Present	☐ Past
Heart Attack / Failure	☐ Present	☐ Past	Venereal Disease	☐ Present	☐ Past
Heart Murmur	☐ Present	☐ Past	Yellow Jaundice	☐ Present	☐ Past
Heart Pace Maker	☐ Present	☐ Past			
Heart Trouble / Disease	☐ Present	☐ Past			

INFORMED CONSENT FOR FACE TO FACE, IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains guidelines for clients wishing to resume in-person services at the Resource Group Counseling & Education Center, Inc. Please read this carefully and let Resource Group staff know if you have any questions. Please sign this document to affirm that you have read and understood it, and that you agree to abide by it.

Decision to Meet Face-to-Face

We have agreed to meet in person rather that via telehealth for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, we may resume via telehealth. If you have concerns about meeting through telehealth, we will discuss it together and address any issues as best we can.

Unless your payer stops us from billing for these services you may decide, after giving us warning, to return to telehealth services.

Risks of Opting for In-Person Services

You understand that by coming to the Resource Group offices you are at higher risk of contracting exposure to the coronavirus (or other public health risk). We will do certain things to minimize that risk and, in turn we expect you to do your part.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which are designed to keep all parties safe from exposure.

You agree to:

1. Only keep your in-person appointment if you are symptom free.
2. Have your temperature taken by Resource Group staff before each appointment at Resource Group. If it is elevated (100'F or more), or if you have other symptoms you agree to proceed with the appointment using telehealth. Please ask staff for guidance if you need it.
3. Wash your hands or use alcohol-based hand sanitizer when you enter Resource Group offices.
4. Adhere to the safe distancing precautions we have set up in the waiting room and therapy rooms.
5. Wear a mask in areas of the office outside of your clinician's office
6. Keep a distance of 6 feet and avoid physical contact with non-family members.
7. If you are bringing your child, take responsibility for making sure your child follows these sanitation and distancing protocols.
8. If a resident of your home tests positive for COVID-19, you agree to call the Resource Group. In that circumstance, unless it is not supported by the payer, you agree to resume services via telehealth.
9. Resource Group will let your clinician know and anyone with whom you've had contact.
10. By signing below, you indicate that you have read and understood this document, and agree to abide by it.

Resource Group may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will post any changes to our policy to our website (www.resourcegrp.org).

If Resource Group staff to whom you have been exposed, test positive for the coronavirus, we will notify you so that you can take appropriate precautions.

If you have tested positive for the coronavirus, and you were in our offices three days or less before you were tested, we ask you or a designated other to call us and let us know.

_____ _____

PRINT NAME Patient/Client Date of birth

_____ _____

SIGNATURE Patient/Client Today's Date

_____ _____

Resource Group Staff Name & Signature Today's Date

Consent for Telehealth Treatment

My signature below acknowledges that I, (print name) _____, consent to telehealth treatment with my **Clinical Team at Resource Connect**, who agrees to provide me with competent professional care and to do their best to be of help to me.
I understand that telehealth services require that I provide a confidential space of my choosing in which the session will not be interrupted. I am responsible for providing an internet connection for my computer or a data connection for my mobile device. I understand that telehealth service delivery requires a live-streaming video connection that may affect my internet service or data service plan limits, if applicable. I hold free from liability The Resource Group/Resource Connect and/or my affiliate clinician from any effect telehealth may have on my service plan limits.

I understand that my clinician will be in a confidential space free from interruption.

I acknowledge that during telehealth treatment we will discuss confidential HIPAA-protected treatment information over a secure video streaming platform with whom my clinician has signed a Business Associate Agreement per HIPAA guidelines.

Mental health and/or substance abuse treatment is a collaboration between my clinician and I. I agree to leave a card on file to pay my clinician at the time of telehealth service delivery, and to give at least 24-hour notice if I must miss a telehealth session. I also agree to notify my clinician if I decide to terminate treatment.
I give permission for all persons acting on behalf of RG/RC to contact me and leave messages at the following address, phone number, or email address. I understand that electronic communication brings potential risks that the information transmitted could be intercepted by a third party.
To change this permission, I must contact RG/RC in writing and let them know that I no longer consent to telehealth treatment. My contact info is below:

Client Printed Name: _____

Address: _____

Phone: (H) _____ (C) _____

Email: _____

I have read this document and understand the above information.

_____ _____
Client Signature (14 and over) Date

_____ _____
Parent/Legal Guardian Signature Date
(for clients under age 18)

Symptom Screening Form

		0: Not at all	1: Rarely	2: Some-times	3: A lot
D	1. Have you been feeling sad or blue?				
D	2. Does your future seem lonely or hopeless?				
D	3. Do you feel worthless or not as good as other people?				
D	4. Have you lost interest in activities you used to enjoy?				
D	5. Do you feel life is not worth living or you're better off dead?				
A	6. Do you feel nervous, shaky, tense, or restless inside?				
A	7. Do you feel afraid?				
A	8. Do you worry a lot?				
A	9. Do you have physical stress- tense muscles, headaches, trouble breathing or upset stomach?				
P	10. Do you hear voices other people say they don't hear?				
P	11. Do you believe others are against you or are watching you?				
P	12. Do you feel out of touch with other people or not close to them?				
P	13. Do you feel someone or something else controls you or your thoughts?				
H	14. Do you feel easily irritated or lose your temper?				
H	15. Do you feel like breaking or smashing things?				
H	16. Do you think about hurting other people?				
H	17. Do you hit or injure people?				
T	18. Do you ever have bad dreams or thoughts about troubling or harmful events have happened to you in the past?				
T	19. Are you jumpy or easily startled by noises or movements?				
T	20. Do you have periods of time in your life that you can't remember?				
T	21. Have you ever been through an event that has involved a physical threat or harmed you?				
T	22. Do you ever feel numb, apart, or without much feeling at all?				
E	23. Do you or have you ever eaten a very large amount of food within 2 hours?				
E	24. Have you worried about gaining weight or being fat even if you were underweight?				
M	25. Do you have intense mood ups and downs?				
M	26. Do your thoughts seem to race, or do you feel too active?				
M	27. Do you ever go without sleep, sometimes even for a few days?				
M	28. Do you do things without thinking about what will happen?				

Client Name: _____ Date: _____

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remem- ber what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.
You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes	No
Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	Yes	No
Can you stop drinking without a struggle after one or two drinks?	Yes	No
Do you ever feel guilty about your drinking?	Yes	No
Do friends or relatives think you are a normal drinker?	Yes	No
Are you able to stop drinking when you want to?	Yes	No
Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
Have you gotten into physical fights when drinking?	Yes	No
Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes	No
Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes	No
Have you ever lost friends because of drinking?	Yes	No
Have you ever gotten into trouble at work or school because of drinking?	Yes	No
Have you ever lost a job because of drinking?	Yes	No
Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
Do you drink before noon fairly often?	Yes	No
Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
Have you ever gone to anyone for help about your drinking?	Yes	No
Have you ever been in a hospital because of drinking?	Yes	No
Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times?_____)	Yes	No
Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times?_____)	Yes	No