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: _____

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: _____

Who Referred You to Resource Connect (Name, Contact Info): _____
Type of Referral:

☐ Google/Internet Search
☐ Inpatient Treatment Provider
☐ Outpatient Treatment Provider
☐ Legal Representative
☐ Family Member/Friend
☐ Self (Previous Client)
☐ Other: _____

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 60-90 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, either by text or voicemail. To change this permission, I must contact RG/RC in writing:

Client Printed Name: _____

Address: _____

_____ (initials) I agree to the use of text messaging and/or email to discuss rescheduling, cancelling, and lateness to appointments (Client Cell Phone #: _____)

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, 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)* _____

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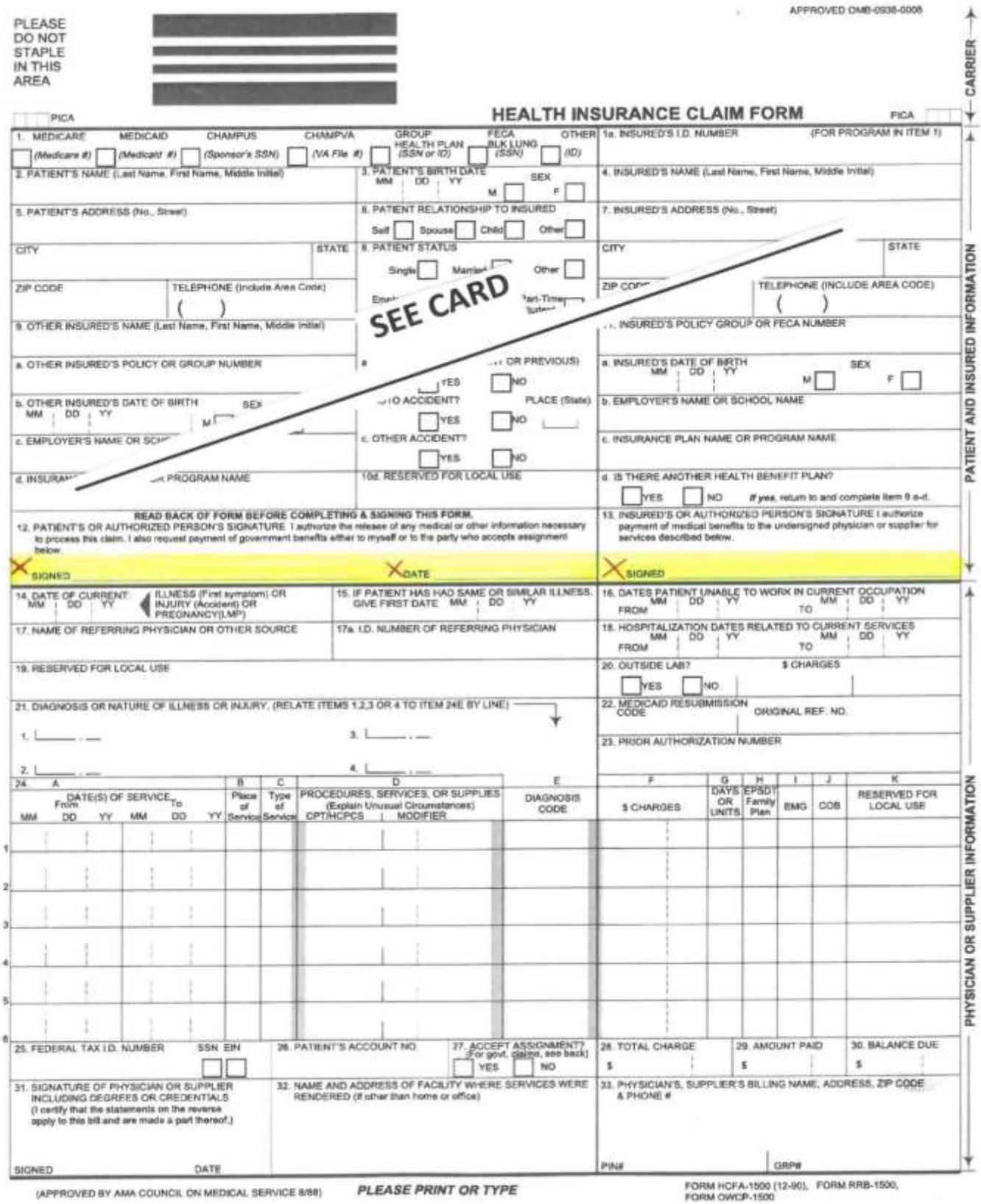
resource connect

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



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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) ( )

SEE CARD

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 F

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

PATIENT AND INSURED INFORMATION

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#

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 for Resource Connect Programs

I, _____, (print name) will act as guarantor for the services for _☐_ myself or for _☐_ a dependent _____ (print dependent name, if applicable) received from The Resource Group Counseling and Education Center, Inc. (Hereinafter referred to as the "Resource Group").

For and in consideration of the mutual covenants and considerations, the receipt and sufficiency of which are hereby acknowledged, the guarantor agrees to accept the terms of this agreement hereinafter set forth and shall be bound by its terms and that an executed copy has been provided to the undersigned.

Full payment is due at time of service. We accept cash, check, Visa, MasterCard, American Express and Discover. A check that is returned unpaid will incur a charge of $40 to the guarantor's account in addition to the uncovered payment amount.

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 requires formal documentation related to why they missed group. This documentation will be due to their case manager at their next scheduled group.

Clients in Level II.1 IOP and Level I OP with Maryland 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.

The $40 missed group fee is not covered by insurance and is expected to be paid in full prior to attending an additional group. Unpaid missed fees may result in being unable to attend your scheduled group.

If the guarantor wishes to have Resource Group bill a health insurance carrier for services note the following: In submitting a claim, Resource Group is required to provide Protected Health Information to the health insurance carrier. Most often this information is submitted electronically using Health Information Protection and Portability Act guidelines. However, once this information leaves Resource Group, Resource Group no longer has sole protection or control of that information. As such, Resource Group cannot guarantee its confidentiality.

Prior to the patient's visit, Resource Group will verify your insurance benefit as a courtesy. Please keep in mind that the verification is an estimate only, and that the actual cost cannot be determined until a claim has been processed by the insurance carrier that has been provided. The guarantor is ultimately responsible for all patient charges incurred and not paid by health insurance for any reason.

Resource Group does not send bills to insurance carriers for services that are considered out-of-network. Payment for these services is due in full at time of service. Similarly, we do not bill to any secondary insurance except for Maryland Medicaid.

Guarantors for patients in the Substance Use IOP/OP programs will accumulate a "strike" each time required patient responsibility or missed fees are not paid when checking in for group. When a client reaches 4 strikes,

they will not be given a check-in slip and will not be permitted in the group until a resolution is reached with their case manager and Billing. A "strike" is tallied when a client does not pay their full patient responsibility (including missed fees) at check-in. Strikes will be removed as the balance is paid.

Balances of $250 and more are eligible for management by entering into a payment plan acceptable to the Resource Group provided that the patient's account is in good standing. A payment plan is an agreement that will permit a client to continue to receive services pending payment in full.

A balance on a guarantor's account will be considered delinquent for any balance remaining unpaid after six (6) months in which event, the entire balance will be due and payable. In the event that the account is referred to an attorney for collection, the guarantor agrees to pay in addition to the balance, attorney's fees in the amount of twenty percent (20%) of the balance due at the time of referral to counsel for recovery which sum the undersigned agrees is reasonable and court costs.

The guarantor acknowledges that this agreement is a contract under seal and is subject to a twelve (12) year statute of limitations.

By signing below, I, as guarantor, do hereby acknowledge and affirm that I agree to each of the above items set forth in this Agreement.

_____ _____

Name of Patient Date of Birth

_____

Name of Guarantor (if different from Patient)

_____(SEAL) _____

Signature of Guarantor 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 (such as Xanax)
- 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 by Dominion Diagnostics. 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. The form on the next page could help with a reduced rate if needed.

_____ _____

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. 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".

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*. See Client Handbook for more information on overdose risk factors.

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 do not have an opioid problem

☐ 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.

_____ _____

Client Signature Date

Discharge for Treatment Non-Compliance

Resource Connect clients may be discharged from the program due to either successful completion of the program, for medical reasons, for inability to pay for services, either due to overdue fees or expiration of insurance coverage, or non-compliance with the program guidelines.

Each discharge scenario results in different subsequent actions by Resource Connect, which are described further in the *Suspension/Discharge Policy* in the Client Handbook. Recovery requires a commitment from clients to focus on remaining abstinent from drugs and alcohol. Successful and sustainable recovery requires that a client take ownership of and be accountable for their progress. Attitude, attendance, and abstinence are the three principal areas of progress evaluation.

❖ Our discharge policies are as follows:

1. Attendance: Clients are expected to attend all scheduled group and individual sessions upon admission. Clients who miss up to three scheduled sessions without make up will be suspended or discharged from the program. Clients are strongly encouraged to take responsibility for calling to cancel for any reason. Documentation is required to excuse the absence, or the group will need to be made up in the same week. If we do not hear from the client, we will call the emergency contact.

2. Leaving group early or coming late: Anyone arriving later than 20 minutes past the group's start time will not be admitted, unless approved in advance. This will count as a "no call, no show," which after three occurrences leads to suspension or discharge, as outlined above.

3. Violence/Physical Aggression: It is expected that clients apply the skills learned in group like interpersonal effectiveness, emotion regulation, and healthy communication. At no time is violence or physical aggression tolerated. These are grounds for immediate discharge and may result in contact with authorities.

4. 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.

5. 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.**

_____ Date: _____

Client Signature

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 than via telehealth for some or all future group and individual 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

Verification of Vaccinaition Status

Please check only one:

☐ **I am fully vaccinated**

☐ **I am partially vaccinated**

☐ **I am not vaccinated**

If partially or fully vaccinated, I agree to provide proof of vaccinatuion within 48 hours of admission to the Resource Group.

_____ _____

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)

Information Release Authorization for Resource Connect Group Members

(All Blanks Must Be Completed)

I,_____, hereby give permission to **Resource Connect** to disclose general information to **current Resource Connect clients** about client's safety and whereabouts if client leaves the program without notice.

The purpose or need for such disclosure is: Clients participating in the program are part of a community of people who care about one another. The purpose of this release is to allow current group members to avoid excess anxiety when another group member is no longer present or is out unexpectedly for a period of time.

Specific information to be disclosed: General safety and health status, along with availability/appropriateness for contact with other clients.

The information may be given: ***IF CLIENT IS UNEXPECTEDLY NOT PRESENT IN SCHEDULED GROUPS FOR AT LEAST TWO GROUPS***

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon and will otherwise expire on: **DATE OF CLIENT DISCHARGE**.

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records whose Confidentiality is protected by federal law. Federal regulation (42 CFR-Part2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general Authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____

Signature of client Date

_____ _____

Witness Date

Release of Information for Emergency Contact

(all blanks must be completed)

I, _____, hereby give permission to _____
Client Name — Name of client's emergency Contact

to receive from/disclose to: ***The Resource Group / Resource Connect*** the following information:

Circumstances of client emergency and other interventions.

The purpose or need for such disclosure is: ***to coordinate emergency care***

The information may be given: ***in case of emergency or client is unresponsive to calls/emails***

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon and will otherwise expire on: ***six (6) months post-discharge***

Emergency Contact Information:

Relationship to Client: _____

Phone Number: _____

Email Address: _____

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records whose Confidentiality is protected by federal law. Federal regulation (42 CFR-Part2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general Authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____
Signature of client — Date

_____ _____
Witness — 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		

resource connect

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

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

SUD Questionnaire

Which of the following substances have you used? Mark "C" for current use if used in the last 90 days. Mark "P" for past use if used more than 90 days ago.

___Alcohol	___Fentanyl	___Benzodiazepines
___Marijuana (THC)	___Cocaine/Crack	___Psychedelics
___Opiates (prescription)	___Amphetamines	___PCP
___Heroin	___Methamphetamines	___Other: _____

Circle "YES" or "NO" for the following questions:

	YES	NO
1. Have you started to use substance(s) in larger amounts or for a longer period of time than was intended?	◯	◯
2. Do you/have you had a persistent desire to cut down or control use?	◯	◯
3. Have you devoted substantial time to activities necessary to obtain, use, or recover from effects of the substance(s)?	◯	◯
4. Have you experienced cravings, a strong desire, and/or urges to use?	◯	◯
5. Have you failed to meet your responsibilities at work, school, or home because of substance use?	◯	◯
6. Has the use of any of the above substances caused or exacerbated relationship or social problems, or conflicts with others?	◯	◯
7. Have you skipped activities or stopped doing activities you once enjoyed to use the substance?	◯	◯
8. Have you used any of the above substances in ways that are dangerous to yourself and/or others (i.e., overdosed, driven while under the influence, IV use, or blacked out)?	◯	◯
9. Has your substance use led to physical health problems, such as liver damage or lung cancer, or psychological issues, such as depression or anxiety?	◯	◯
10. Have you ever built up a tolerance to the substance so that you have to use more to get the same effect?	◯	◯
11. When you stop using the substance, have you experienced withdrawal symptoms such as, but not limited to, shakes, sweating, nausea, insomnia, muscle pain, etc.?	◯	◯