



Substance Abuse Evaluation Interview

Name: _____	Date: _____
Cell Phone: _____	Other Phone: _____
Address: _____	City: _____ State: _____
Zip: _____	Email: _____
RRP: _____	Dr Lic #: _____
Date of Birth: _____	Age: _____ Race: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Referral source: _____	
<i>In case of emergency please contact - Name: _____</i>	
Relationship: _____	Phone: _____

Education

What is your highest level of formal education?

GED High School Associates Bachelors Masters Doctorate Other

Name and city of the last school you attended? _____

What was your degree? _____ Did you graduate? Yes No

List any Trade or Professional Certifications: _____

Military Service? Yes No Branch: _____ MOS: _____ Discharge date: _____

Employment

Current employer: _____ City: _____

Job title: _____ Length of employment: _____

If you have worked at the above position less than five years, please list the names of the companies you worked for in the last five years (Please continue on reverse if needed):

Name: _____ City: _____

Job title: _____ Length of employment: _____

Legal / Arrest: History For what arrest are you receiving this evaluation? _____

List your charges at this arrest: _____

Arrest Date: _____ Time of Arrest: _____ City/County of Arrest: _____

If you were drinking at the time of the arrest, how many did you have? _____

Type of alcoholic drink? _____ Start time: _____ End time: _____

Total number of lifetime DUI arrests: _____ Total number of lifetime drug-related arrests: _____ Total number of DUI arrests in the past 10 years: _____

Other prior arrests: _____ Date: _____

Substance Use

Age when you first experimented with alcohol? _____ What type of drink? _____

Who were you with? _____ Where were you? _____

Since then, how often have you consumed alcohol?

___ Daily ___ Weekly ___ Bi-weekly ___ Monthly ___ Yearly ___ Other: _____

How many drinks per setting? _____

What is your alcoholic beverage of choice? _____

What date did you last consume alcohol? _____

How many drinks did you have? _____ Over what period of time? _____

How many drinks does it take for you to start feeling the effects of alcohol? _____

When was your last alcoholic drink? _____

What did you drink and how much? _____

Have you ever used any illegal or recreational drugs? Yes No Have you used prescription drugs not prescribed or used them in ways that they weren't prescribed: Yes No

If so, what? _____

Age when you first experimented with drugs? _____ What type of drug? _____

Who were you with? _____ Where were you? _____

Since then, how often have you used drugs?

Daily Weekly Monthly Yearly Other: _____

How much per setting? _____

What is your drug of choice? _____

What date did you last consume drugs? _____ What did you consume? _____

How much? _____ Over what period of time? _____

How much of the drug does it take for you to start feeling the effects? _____

Please list any and all other drugs you have consumed: _____

Has your current drug use increased or decreased compared to your past use? _____

Have you ever had withdrawal symptoms from alcohol or drugs? ___Yes ___No

If so, what are/were they? _____

Have you ever been violent while under the influence of alcohol or drugs? ___Yes ___No

If yes, please explain: _____

Has anyone ever complained about your use of alcohol or drugs? ___Yes ___No

If yes, who? _____

Recovery

What is the longest you have ever abstained from alcohol or drugs? _____

How did you do it? _____

Do you want to stop drinking or using drugs? ___Yes ___No ___Maybe

Why? _____

Have you ever been in a substance abuse treatment program? ___Yes ___No

Name of program: _____ City/State: _____

How long was the program? _____ Dates attended: _____

Did you graduate from the program? ___Yes ___No Date of graduation: _____

Have you ever attended DUI school? ___Yes ___No Date completed: _____

Have you ever completed an Alcohol Awareness class? ___Yes ___No

Have you ever completed a Victim Impact Panel? ___Yes ___No

Have you completed any other alcohol or drug related educational program? ___Yes ___No

Which one? _____ Where? _____

Have you attended AA, NA, Celebrate Recovery, Victorious Living or any other 12-step program? Yes No When? _____ How long? _____ Where? _____

Medical History

Please list any current or past medical conditions: _____

How often do you see your doctor? ___Weekly ___Monthly ___Semi-annually ___Annually

Please list any current medications including date prescribed, prescribing doctor and dosage:

Please list any hospitalizations: _____

Have you ever had symptoms of or been diagnosed with any of the following:

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> H.I.V | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Delirium Tremens | <input type="checkbox"/> A.I.D.S. | |
| <input type="checkbox"/> Other: _____ | | |

Do you take any over-the-counter medications?

- Tylenol Advil/Motrin Aleve Other: _____

How many milligrams? _____ How often? _____

Mental Health History

Have you ever had any of the following:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stress | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Increased Appetite | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Frustration | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sadness | <input type="checkbox"/> Compulsive behaviors |

Other: _____

Have you ever attempted suicide? Yes No

If so, were you under the influence of alcohol or drugs at that time? _____

Have you ever been diagnosed with a mental health disorder? Yes No

If so, what was the diagnosis? _____

Have you ever been in mental health or psychological counseling? Yes No

If so, where and when? _____

Family History

Place of birth: _____ How long have you lived in Georgia? _____

Who do you live with? _____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed Name and age of spouse: _____ How long married? _____

How many children do you have? _____ Please write their names and ages: _____

Any siblings? ___Yes ___No If yes, how many? _____ Males _____ Females

What is your birth order? (First second, third, youngest, oldest, etc) _____

Do any of your siblings have a problem with alcohol or drugs? ___Yes ___No

Do you parents have a problem with alcohol or drugs? ___Yes ___No

Do your maternal grandparents have a problem with alcohol or drugs? ___Yes ___No

Do you paternal grandparents have a problem with alcohol or drugs? ___Yes ___No

Do have any other relative who has a problem with alcohol or drugs? ___Yes ___No

If yes, who? _____

Do you have any relative who has been in counseling for substance abuse? ___Yes ___No

If yes, who? _____

Spiritual

I consider myself: ___Christian ___Jewish ___Buddhist ___Hindu ___Muslim ___Atheist
___Unknown ___Other: _____

Are you happy with your spiritual journey? ___Yes ___No If no, why? _____

I am visiting a Christian counseling center because:

- ___ 1) I hope to get counseling from a Christian perspective. ___ 2) I am open to hearing a Christian perspective on my issues.
- ___ 3) I was referred her by a friend and hope to get a good result. ___ 4) This is a Christian counseling center?

Disclosures

Informed Consent and Contract for SA Evaluation or Treatment

Thank you for choosing Eagle's Landing Christian Counseling Center as your evaluation and treatment provider. We are committed to the success of your treatment. We are a non-profit organization. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning your substance abuse evaluation or treatment/education.

1. GENERAL FINANCIAL POLICIES:

- Payments are due at the time of service. Please pay the receptionist or service provider **before** your meeting. For substance abuse evaluation and treatment, we accept payment by cash, debit, Visa, Discover, and MasterCard. We do NOT accept checks.
- Fee Schedule: Substance Abuse Assessment w/Written Report for Court- \$150
"ASAM Level 1" Substance Abuse Treatment: \$25 per 1.5 hour group; \$50 for 3 hr group.
An evaluation with an evaluator other than the treatment provider whose class you will be attending is required before attending the treatment group. Evaluations from outside ELCCC must be provided prior to your attending the treatment group.

2. MINORS RECEIVING TREATMENT:

- The parent/guardian(s) is responsible for payment at the time of service. We will not bill absent parents or others for a minor's session.
- No minor can be treated without signed consent of a parent or guardian.
- Unaccompanied minors will be denied services (except in the case of an emergency). Parent/guardian must be in the office while minor is being treated.
- Parents are expected to be involved with treatment of a minor. If a parent or guardian is unwilling or unable to participate, parent must consult with provider before minor begins treatment. (Note: Additional fees may apply)

3. HIV/AIDS CONFIDENTIALITY STATEMENT

- ELCCC does NOT perform HIV/AIDS testing.
- ELCCC does everything within its reasonable power to follow the Georgia Laws regarding the disclosure or non-disclosure of HIV/AIDS. This includes:
- If a client discloses their HIV/AIDS status to ELCCC personnel, ELCCC personnel or contractors will not, pursuant to Georgia legal code, knowingly or intentionally disclose that information to another person or legal entity, nor can they be compelled by subpoena, court order, or other judicial process to disclose that information.
- However, HIV/AIDS confidential information may be disclosed to the person identified by that information or, if that person is a minor or incompetent person, to that person's parent or legal guardian.
- In addition, HIV/AIDS confidential information may be disclosed to any person or legal entity designated to receive that information when that designation is made in writing by the person identified by that information or, if that person is a minor or incompetent person, by that person's parent or legal guardian.
- AIDS confidential information may be disclosed to any agency or department of the federal government, this state, or any political subdivision of this state if that information is authorized or required by law to be reported to that agency or department.

- In addition, if any ELCCC employee, contractor, or staff member reasonably believes that another employee, contractor, or staff member, the spouse or sexual partner or any child of the client, spouse, or sexual partner is a person at risk of being infected with HIV by that client, the employee, contractor, or staff member may disclose to that employee, contractor, or staff member, spouse, sexual partner, or child that the client has been determined to be infected with HIV, after first attempting to notify the client that such disclosure is going to be made.

4. ADDITIONAL AGREEMENTS BETWEEN ELCCC AND CLIENT NAMED BELOW:

- I agree to conduct myself in an appropriate manner. I understand that minor children must be attended at all times. Illegal conduct onsite will be reported the appropriate authorities.
- **Confidentiality:** I understand that no information about me or my issues will be disclosed to anyone outside of the Counseling center unless exceptions are noted in this contract. However, for the purposes of supervision, billing, and training, some information will be shared with other staff and contracted employees. I will maintain the confidentiality of anyone I see in the counseling office or in my group.
- **Limits of confidentiality:** I understand that reasonable suspicion of physical abuse, sexual abuse or neglect, of children (under 18 years of age) or endangerment through the witnessing of domestic violence must be reported by law. I understand that reasonable suspicion of physical abuse, sexual abuse, or neglect of the elderly (65 years and older) or disabled must be reported by law. I understand that intent to do harm to another person will be reported to that person and the police. ELCCC does not guarantee that other counseling clients or family members will maintain confidentiality.
- **Court Evaluations:** I understand that court evaluations may last from 1 hour to 2 hours all together and I must stay to complete the entire process or a written evaluation cannot be provided. I understand that after completing my court evaluation I will receive a Proof of Attendance certificate which may be used for court, but a complete written six-dimension evaluation may not be available for 4-7 days after the evaluation has been completed.
- If I have a psychological emergency related to my treatment, I understand that I may contact my provider on his/her after-hours number found on their business card.
- For more urgent psychiatric care I may call Crescent Pines Hospital at (770) 474-8888.

I hereby attest to the fact that I have thoroughly read all enclosed information and I have completed the questionnaire fully to the best of my knowledge. I do hereby voluntarily request the services of Eagle's Landing Christian Counseling Center, in accordance with the terms stated herein. Specifically, I request that the provider named below provide professional services to myself, (print name) _____, and I agree to pay ELCCC's fee of:

_____ \$ 95 for Substance Abuse Evaluation Normal \$150 for 24 hour turn-around.

I may request a copy of this signed agreement at no additional charge.

Signature of Client (or person acting for client)

Date

I, the provider, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give information and willing consent.

Provider Name: _____ Provider Signature: _____

_____ Client's copy

_____ Provider's copy

Client Rights and Responsibilities

Clients have the right to:

1. Be treated with dignity and respect.
2. Fair treatment; regardless of their race, religion, ethnicity, age, disability, gender, sexual orientation, or source of payment.
3. Their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
4. Easily access timely care in a timely fashion.
5. Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
6. Share in developing their plan of care.
7. Information in a language they can understand.
8. A clear explanation of their condition and treatment options.
9. Information about their benefit plan, its practitioners, services and role in the treatment process.
10. Information about clinical guidelines used in providing and managing their care.
11. Ask their provider about work history and training.
12. Know about advocacy and community groups and prevention services.
13. Freely file a complaint or appeal and to learn how to do so.
14. Know of their rights and responsibilities in the treatment process.
15. Receive services that will not jeopardize their employment.
16. Request certain preferences in a provider.
17. Have provider decisions about their care made without regard to financial incentives.

Clients have the responsibility to:

1. Treat those giving them care with dignity and respect.
2. Give providers information that they need. This is so providers can give the best possible care.
3. Ask questions about their care. This is to help them understand their care.
4. Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
5. Tell the provider and primary care physician about medication changes, including medications given to them by others.
6. Keep their appointments. Members should call their provider as soon as they know they need to cancel visits.
7. Let their provider know about problems with paying fees.
8. Report abuse and fraud.
9. Openly report concerns about the quality of care they receive.

MY SIGNATURE BELOW SHOWS THAT I HAVE BEEN INFORMED OF MY RIGHTS AND RESPONSIBILITIES, AND THAT I UNDERSTAND THIS INFORMATION.

Client Signature

Date

HIPPA Consent for Purposes of Treatment, Payment and Healthcare Operations

HIPPA: Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ DOB: _____

I hereby consent to the use or disclosure of my protected health information by the practice of Eagle’s Landing Christian Center, hereinafter referred to as “ELCCC” for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ELCCC may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and ELCCC.

I understand that I do not have to use my health insurance, but that by doing so I will be given a mental health diagnosis and this diagnosis will be revealed to the insurance company. In addition, they will have access to my complete medical record. If I chose not to use my health insurance, they will not have access to my medical record nor will they receive any information on my diagnosis for any reason.

The disclosures ELCCC routinely makes are to 1) Client; 2) Minor client’s guardian of record; 3) Insurance biller (Barb Ifill); 4) Accountant (Rhonda Burchett); 5) Supervisor for purposes of training and supervision and other counselors on staff for the purpose of consultation and training; 6) Insurance company IF you are using insurance; 7) Company/Church providing scholarship for sessions IF you are using scholarship for billing purposes only; 8) To officials by law if abuse or neglect are determined or suspected; 9) To those people you request IN WRITING to have your information released to, i.e., probation officer, attorney, etc. NO OTHER disclosures are intended or planned or made.

ELCCC uses an online billing company (for insurance billing), MyClientsPlus.com, for billing and for record keeping which is also HIPPA compliant and encrypted.

My “protected health information” means health information, including my demographic information, collected from me and created or received by ELCCC, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice’s Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice’s duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 1944 Brannan Rd. McDonough, GA 30233. As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

I have the right to revoke this consent, at any time, in writing, except to the extent that ELCCC or the practice has taken action in reliance on this consent.

Printed Name of Patient Date

Signature of Patient or Personal Representative:

Description of Personal Representative’s Authority Date

Limits of the Therapy Relationship and Social Media

Psychotherapy is a professional service and it must be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship," which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

Dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts.
- I cannot provide therapy to people I used to know socially, or to former business contacts.
- I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you or trade or barter your services (things like tutoring, repairs, child care, etc.) or goods for therapy.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

Quiet Hours & Vacation

In an effort to better serve you and maintain appropriate self-care, I will not be available between the hours of 9:00 PM and 9:00 AM Monday through Friday. Saturdays and Sundays, please refer to the Crisis Needs section. If you need to cancel your appointment, please call my cell phone during my work hours and leave a message. Remember that cancellations need to be within 24 hours of your scheduled appointment. I will provide you with another counselor's name whom you may contact while I am away on vacation. **In the event that you are having urgent suicidal thoughts**, or need hospitalization, please go to the nearest emergency room or dial 911. You may also call the Georgia Crisis and Access Line, which can be reached at **800.715.4225** and **404.527.6700**.

Phone

By the Composite Board rules, phone conversations are limited to 20 minutes and will be primarily for scheduling changes and notifications only, unless we agree upon TeleMental Health Counseling. You can contact me by leaving a voicemail message on my confidential voicemail and I will return the call within 24 hours.

Email

Please do not email content related to our counseling sessions. Please bring content to your sessions. Email communication is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your legal record. I can email hand-outs to you without confidential information in the body of the email.

Text Messages

At this time, I will need to suspend text message reminders. Cell phone companies and internet service providers retain logs of messages and content may be accessible to unknown persons.

Friending & Following

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship. I will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines

It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If I have reason to suspect you are a danger to yourself or others and I have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, I will fully document the search and discuss it with you at your next session.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Signed: _____

Date: _____