CPH Behavioral Health
245 North Binkley St. Suite 202, Soldotna, AK 99669
Intake office: (907) 714-4521 Fax Number: (907) 260-4063

ATTENTION

New tobacco free policy for Behavioral Health Department locations, including the Behavioral Health Intake Office, Serenity House, Care Transitions and Diamond Willow buildings.

As of June 1st, 2017, the Behavioral Health department took an important step in supporting the health of individuals with substance addictions by adopting a tobacco free policy to protect the rights of clients, employees and visitors to breathe clean air. Individuals with a substance addictions smoke at rates two to four times higher than the general population and experience increased mortality and morbidity rates related to smoking. Recent research indicates that quitting smoking while in recovery can increase the chance of long term sobriety by 25%. Additionally, a large proportion of employees in substance abuse treatment facilities are smokers and therefore are less likely to discuss the benefits of tobacco cessation with clients during treatment. The commonality of smoking in this population and community exposes many individuals to secondhand smoke. On average, tobacco free workplace policies effectively reduce secondhand smoke exposure by 72%.

The overall goal of tobacco free policy on our campus is to protect the health of our clients, employees and visitors while reducing health care costs and increasing employee productivity. This is an important step in protecting the health of individuals who are heavily impacted by smoking related illness and exposed to dangerous secondhand smoke. The policy includes **NO** E-cigarettes, vapes, cigarettes, loose or chewing tobacco and cigars.

For more information on and help with quitting tobacco products, please speak with nursing staff, your medical provider, or contact the Alaska Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669) 24 hours a day, 7 days a week. Alaska Tobacco Quit Line free services include telephone coaching, free nicotine replacement therapy, self-guided materials, a secure website, information for those concerned about a tobacco user, referrals and expanded services for pregnant and nursing women.

I have read and understand NO TOBACCO POLCY.

Client signature:_____ Date:_____

Staff witness signature:_____

(Original copy to clients chart, second copy for client records)

CARE TRANSITIONS BEHAVIORAL HEALTH APPLICATION FOR DETOX ADMISSION

Date:_____

Individual/Company referring you to this program:_____

Applicant Full Legal Name:				SSN:	
Nickname/Maiden/Other names used:					
Date of Birth:		Place of Birth:			
Current Physical Address:					
City:		State:		Zip:	
Current Mailing Address:					
City:		State:		Zip:	
Current Phone Number:			Message Phone Number:		
Emergency Contact Name:			Emergency Contact Number:		
Emergency Contact Address:					
City:		State:		Zip:	
Identified Race:			Preferred Language:		
INSURANCE					
Do you have insurance:					
Primary Insurance Company Name:					
Primary Insurance Company Phone Number:					
Primary Insurance Company Address:					
Policy Holder:			Policy Holder D.O.B:		
Policy #:			Group #:		
Secondary Insurance Company Name:					
Secondary Insurance Company Phone Number:					
Secondary Insurance Company Address:					
Policy Holder:			Policy Holder D.O.B:		
Policy #:			Group #:		
MEDICAL HISTORY					
Current Health Provider:			Last Date Seen:		
How many times have you been to the ER in the past 12 months:					
Medication Allergies:					

CARE TRANSITIONS BEHAVIORAL HEALTH APPLICATION FOR DETOX ADDMISSION

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MEDICAL HISTORY CONTINUED	
Number of non-treatment substance abuse related hospitalizations in the past 6 months:	
Number of prior mental health treatment admissions:	
Number of prior mental health hospitalizations:	
Number of prior substance abuse treatment admissions:	

PERSONAL/SOCAIL HISTORY			
Employment status:		Occupation:	
Annual household income:		Is it enough to meet your needs:	
Primary income source:			
Are you receiving disability benefits:			
Number of children in residential setting:			
Number of children in residential setting receiving services:			
Number of people living with client:			
Number of children in household:			

Does Client Live with: (Check One)
☐ Significant other ☐ With significant other and children ☐ Alone
☐ With children ☐ With relatives ☐ With non-relatives

Living arrangements: (Check One)
☐ Homeless ☐ Private residence w/o supportive services ☐ Other
Other-Please Specify:

Marital Status:
☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabitating

Are you currently enrolled in school:			
Highest grade level completed 1-12:		GED or Diploma:	
Number of arrests in past 30 days:		How many nights spent in jail in the last 30 days:	
In the past 30 days, how many times have you been arrested for drug-related offenses:			
In the past 30 days, how many times have you committed a crime:			
Are you currently awaiting charges, trial, or sentencing:		Are you currently on parole or probation:	
Have you been here before:			
Referral?	If yes, who?		

CARE TRANSITIONS BEHAVIORAL HEALTH APPLICATION FOR DETOX ADMISSION

Have you ever experienced symptoms of detox before (either medical facility or at home)? Where/when?

Previously experienced withdrawal symptoms:

- ☐ GI upset
- ☐ Tremors
- ☐ Numbness/itching
- ☐ Confusion
- ☐ Increased yawning
- ☐ Anxiety/restlessness
- ☐ Headache
- ☐ Easily startled
- ☐ "Goose bumps"
- ☐ Agitation
- ☐ Visual disturbance
- ☐ Bone/joint aches
- ☐ Nausea/vomiting
- ☐ Sweating
- ☐ Increased resting
- ☐ Runny nose

Current prescription medications:

Current over-the-counter medications: (please include vitamins and supplements)

Current health conditions: (Diabetes, heart conditions, seizure disorder, breathing problems, blood diseases, etc.)

Do you have any health concerns not currently being treated:

Past medical history: (such as surgeries, hospitalizations, medical diagnoses, etc.)

Family medical history: (such as cancer, diabetes, heart problems, blood pressure concerns, etc.)

Are you currently experiencing any pain: Location:

On a scale from 0-10 (0 being none, 10 being unbearable), please rate your pain:

What makes your pain worse:

What makes your pain better:

Are you currently seeing a provider regarding your pain:

Name of Provider: Last Visit:

Last Menstrual Period: Last Pelvic Exam:

Are you sexually active: Do you practice safe sex (birth control):

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MENTAL HEALTH
Do you have any mental health concerns?
Have you ever been given a mental health-related diagnosis?
Have you ever been hospitalized for mental health-related issues?
Family Mental Health History:
Have you ever had thoughts of harming yourself or someone else?
Do you currently have thoughts of harming yourself or someone else?
If yes, do you have a suicidal/homicidal plan?
If yes, do you currently have the means to carry out this plan?

NUTRITION/DIET
Do you have any food allergies: (Please list)
Do you have any special diet needs/requests:
Do you have any problems chewing, swallowing, binging, restricting calories, etc.:
Have you had any significant weight gain or loss in the last 6 months:
Dental Provider: Last dental exam:
Dental Concerns:

Please complete the following by filling in every single field or cell. An answer to each question is required.

	Age Started	**Last Use**	**Method** *(smoke, snort, IV, etc.)*	**Acquired** *(streets, doctor, family, internet, etc.)*	**Frequency of use**	**Amount**
Alcohol						
Heroin						
Other opiates/pills						
Methamphetamine						
Amphetamines/Speed						
Cocaine/Crack						
Xanax/Anxiolytics/Benzos						
MDMA/Molly/Ecstasy						
Cannabis/Marijuana						
Spice						
Bath salts/designer drugs						
Inhalants						
Hallucinogens/LSD						
Other						

Do you us tobacco? If yes, what kind? How much?

Have you ever been arrested?	
Legal issues in the last 12 months?	
Do you have a probation officer? (name/number if yes)	
Do you have an attorney? (name/number if yes)	
Do you have any children?	
Do you have any custody concerns?	
Do you have any OCS involvement? (name/number if yes)	
Brief description of the problem that you hope we can help you with:	

Brief description of the improvements that you want to see in your life:
Client Signature: _____ Date: _____

Staff Member receiving application and verifying that all information is complete: _____

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A. MILITARY FAMILY AND DEPLOYMENT

1. **Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?** ***[IF SERVED]*** **In which area, the Armed Forces, Reserves, or National Guard did you serve?**

- ○ NO
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. **Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard?** ***[IF ACTIVE]*** **In which area, the Armed Forces, Reserves, or National Guard?**

- ○ NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

5b. **Have you ever been deployed to a combat zone?** ***[CHECK ALL THAT APPLY.]***

- ○ NEVER DEPLOYED
- ○ IRAQ OR AFGHANISTAN (E.G., Operation Enduring Freedom [OEF]/ Operation Iraqi Freedom [OIF] Operation New Dawn [OND])
- ○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ○ VIETNAM/SOUTHEAST ASIA
- ○ KOREA
- ○ WWII
- ○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ○ REFUSED
- ○ DON'T KNOW

[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]

A. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)

2. **Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?**

- ○ NO
- ○ YES, ONLY ONE
- ○ YES, MORE THAN ONE
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE.] **What is the relationship of that person (Service Member) to you?** ***[WRITE RELATIONSHIP IN COLUMN HEADING.]***

1 = Mother 2 = Father
3 = Brother 4 = Sister
5 = Spouse 6 = Partner
7 = Child 8 = Other (Specify) _____

Has the Service Member experienced any of the following? ***[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]***	_____ **(Relationship) 1.**	_____ **(Relationship) 2.**	_____ **(Relationship) 3.**	_____ **(Relationship) 4.**	_____ **(Relationship) 5.**	_____ **(Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6b. Was physically injured during combat operations?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6c. Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6d. Died or was killed?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW

E. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. **How would you rate your overall health right now?**

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. **During the past 30 days, did you receive:**

a. Inpatient treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	○	_____nights	○	○	○
ii. Mental or emotional difficulties	○	_____nights	○	○	○
iii. Alcohol or substance abuse	○	_____nights	○	○	○

b. Outpatient treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____times	○	○	○
ii. Mental or emotional difficulties	○	_____times	○	○	○
iii. Alcohol or substance abuse	○	_____times	○	○	○

c. Emergency room treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____times	○	○	○
ii. Mental or emotional difficulties	○	_____times	○	○	○
iii. Alcohol or substance abuse	○	_____times	○	○	○

3. **During the past 30 days, did you engage in sexual activity?**

- ○ Yes
- ○ No *[SKIP TO F4.]*
- ○ NOT PERMITTED TO ASK *[SKIP TO F4.]*
- ○ REFUSED *[SKIP TO F4.]*
- ○ DON'T KNOW *[SKIP TO F4.]*

[IF YES] **Altogether, how many:**

	Contacts	RF	DK
a. Unprotected sexual contacts were with an individual who is or was *[NONE OF THE VALUES IN F3c1–F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]*			
1. HIV positive or has AIDS	|___|___|___|	○	○
2. An injection drug user	|___|___|___|	○	○
3. High on some substance	|___|___|___|	○	○

4. **Have you ever been tested for HIV?**

- ○ Yes *[GO TO F4a.]*
- ○ No *[SKIP TO F5.]*
- ○ REFUSED *[SKIP TO F5.]*
- ○ DON'T KNOW *[SKIP TO F5.]*

a. **Do you know the results of your HIV testing?**

- ○ Yes
- ○ No

5. **How would you rate your quality of life?**

- ○ Very poor
- ○ Poor
- ○ Neither poor nor good
- ○ Good
- ○ Very good
- ○ REFUSED
- ○ DON'T KNOW

1. **In the past 30 days, have you injected drugs?** *[IF ANY ROUTE OF ADMINISTRATION IN B2a–B2i = 4 or 5, THEN B3 MUST = YES.]*

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

2. **In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?**

- ○ Always
- ○ More than half the time
- ○ Half the time
- ○ Less than half the time
- ○ Never
- ○ REFUSED
- ○ DON'T KNOW

F. VIOLENCE AND TRAUMA

10. **Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F13.]

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

12a. **Have had nightmares about it or thought about it when you did not want to?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

12b. **Tried hard not to think about it or went out of your way to avoid situations that remind you of it?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

12c. **Were constantly on guard, watchful, or easily startled?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

12d. **Felt numb and detached from others, activities, or your surroundings?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

DON'T KNOW

11. **In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?**

- Never
- A few times
- More than a few times
- REFUSED
- DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

6. **How satisfied are you with your health?**

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

7. **Do you have enough energy for everyday life?**

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ Mostly
- ○ Completely
- ○ REFUSED
- ○ DON'T KNOW

8. **How satisfied are you with your ability to perform your daily activities?**

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

9. **How satisfied are you with yourself?**

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. **In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a nonprofessional, peer-operated organization that is devoted to helping individuals who have addiction-related problems, such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?**

   ○ YES *[IF YES]* SPECIFY HOW MANY TIMES |___|___| ○ REFUSED ○ DON'T KNOW
   ○ NO
   ○ REFUSED
   ○ DON'T KNOW

2. **In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?**

   ○ YES *[IF YES]* SPECIFY HOW MANY TIMES |___|___| ○ REFUSED ○ DON'T KNOW
   ○ NO
   ○ REFUSED
   ○ DON'T KNOW

3. **In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?**

   ○ YES *[IF YES]* SPECIFY HOW MANY TIMES |___|___| ○ REFUSED ○ DON'T KNOW
   ○ NO
   ○ REFUSED
   ○ DON'T KNOW

4. **In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?**

   ○ YES
   ○ NO
   ○ REFUSED
   ○ DON'T KNOW

5. **To whom do you turn when you are having trouble?** ***[SELECT ONLY ONE.]***

   ○ NO ONE
   ○ CLERGY MEMBER
   ○ FAMILY MEMBER
   ○ FRIENDS
   ○ REFUSED
   ○ DON'T KNOW
   ○ OTHER (SPECIFY) _____

6. **How satisfied are you with your personal relationships?**

   ○ Very dissatisfied
   ○ Dissatisfied
   ○ Neither satisfied nor dissatisfied
   ○ Satisfied
   ○ Very satisfied
   ○ REFUSED
   ○ DON'T KNOW

BEHAVIORAL HEALTH: CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

CPH Behavioral Health supports and protects the fundamental human, civil, constitutional, and statutory rights of each client.

CPH Care Transitions detox program has been designed with the intention of meeting the client's individual needs that may be conducive to their recovery process. We view the client's individual needs as priority of this program. The client has a voice in the modification of their treatment services. Client program evaluation forms and suggestion boxes are available. Completed evaluation forms may be given to any staff member.

A. **YOU HAVE THE RIGHT** to quality care and to treatment with dignity and respect as a person.
B. **YOU HAVE THE RIGHT** to reasonably expect to obtain from nursing staff your complete and current information about your assessment, treatment and detox process in terms and language that you can understand.
C. **YOU HAVE THE RIGHT** to know by name and responsibility, the staff member(s) involved in your treatment process.
D. **YOU HAVE THE RIGHT** to consideration of your privacy and individuality as it relates to physical, social, religious, and psychological well-being within the constraints of the program setting.
E. **YOU HAVE THE RIGHT** to expect nursing staff to make reasonable response to your requests within the framework of the therapeutic policies of the treatment program.
F. **YOU HAVE THE RIGHT** to information about the relationship to other health care institutions and agencies so far as your care or referral is concerned.
G. **YOU HAVE THE RIGHT** to expect reasonable continuity of care in your treatment, which shall include, but not limited to, the appointment times that staff is available.
H. **YOU HAVE THE RIGHT** to confidentiality as it relates to your treatment program. Case consultation and treatment issues may be reviewed with the staff and will be discussed discretely.
I. **YOU HAVE THE RIGHT** to the confidentiality of your treatment record. Information from the treatment record can be released to other persons and agencies only when you complete a "Release of Information" form specifying the person or agency.
J. **YOU HAVE THE RIGHT**, when significant alternatives for your care and treatment exist, to information concerning alternatives, such information shall be provided without risk to your confidentiality.
K. **YOU HAVE THE RIGHT** to discuss any non-disciplinary discharge planning.
L. **YOU HAVE THE RIGHT** to refuse treatment to the extent permitted by law and to be informed of the potential consequences of this treatment refusal.
M. **YOU HAVE THE RIGHT** to examine and receive an explanation of your bill regardless of sources of the payment.
N. **YOU HAE THE RIGHT** to express a grievance or a complaint that you may have relating to your treatment. Every effort will be made to resolve complaints with the person with whom they occur.

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CLIENT RESPONSIBILITIES

A. **YOU HAVE THE RESPONSIBILITY** provide information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health.
B. **YOU HAVE THE RESPONSIBILITY** to share expectations of and satisfaction with the program.
C. **YOU HAVE THE RESPONSIBILITY** to ask questions when you do not understand your care, treatment, or services or what you are expected to do.

D. **YOU HAVE THE RESPONSIBILITY** to follow instructions for your plan of care, treatment, or services, and expressing concerns about your ability to follow the proposed plan of care, treatment, or services.
E. **YOU HAVE THE RESPONSIBILITY** to accept consequences for the outcome of care, treatment, or services if you do not follow the planned care, treatment or services.
F. **YOU HAVE THE RESPONSIBILITY** to follow the program's polices and procedures.
G. **YOU HAVE THE RESPONSIBILITY** to show respect and consideration of program's staff and property, as well as other individuals and their property.
H. **YOU HAVE THE RESPONSIBILITY** to meet financial commitments.
I. **YOU HAVE THE RESPONSIBILITY** to provide the program the signed written acknowledgement confirming that your responsibilities were explained.

I have read and understand the CLIENT BBILL OF RIGHTS and CLIENT RESPONSIBILITIES.

Client Signature Date

Staff Witness Signature Date

(Original copy to client's chart, second copy for client records.)

NOTICE OF CONFIDENTIALITY LIMITS RELATED TO ALCOHOL AND DRUG ABUSE RECORDS

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to any person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser unless:

1. The client consents in writing; or
2. The disclosure is allowed by a court order; or
3. The disclosure is mad eto a medical personnel in a medical emergency or to qualified personnel or research, audit, or program evaluation; or
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

While these broad protections are applied to all Behavioral Health Department records, in some circumstances counseling records are afforded more stringent protections under Federal Law (42 CFR Part 2 for Federal Regulations). Notably medical services delivered in our Behavioral Health Department are not subject to this extended protection. No regulations protect any information about suspected child abuse or neglect from being reported.

I have read and understand these limits of CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS

_____

Client Signature Date

_____

Staff Witness Signature Date

CPH BEHAVIORAL HEALTH
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CLIENTS RULES AND REGULATIONS

1. No phone contact privileges unless it's a treatment task and under the direct supervision for CT staff member. Telephone calls will be restricted to 10 minutes. We will only accept emergency incoming calls.
2. There are no pass privileges off campus. Clients may also NOT visit each other's rooms.
3. No smoking, vaping, or chewing tobacco allowed on facility property.
4. Patients must be fully and appropriately dressed when in common area including footwear. Clothing must cover entire stomach, buttocks, and shoulders at all times. You will be asked to change if attire is deemed inappropriate by staff. No hats are to worn in the treatment center.
5. Meals and treatment activities are strongly encouraged. Meals will be eaten in common area, or in a location at the direction of the medical staff.
6. When patient are physically able, they are required to maintain the cleanliness of their room including; making a bed, changing out linens and towels and wiping bedside table.
7. No use of any mood- altering medications or chemicals will be permitted while at CT. A urinalysis test may be done randomly. **Compliance is mandatory.**
8. Quiet time is 10:30 PM. Turing lights out and staying in your room is encouraged and using quiet voices is mandatory for the respect of others.
9. Patients are not allowed to bring outside reading material including newspapers into CT. Faith based materials are allowed with prior approval. No CDs, tapes, headphones or unrelated treatment materials will be allowed on the premises. Television privileges are at the discrepancy of the staff and will be limited.
10. No cussing or intimidation of counselors or peers. Threatening behavior will result in dismissal from Care Transitions. Sexually harassing behavior will not be tolerated, this includes but is not limited to: touching, sexual innuendos, sexual humor, and stories of sexual content.

FAILURE TO COMPLY WITH RULES AND REGULATIONS MAY RESULT IN EARLY DISCHARGE

I have read and understand the CLIENT RULES AND REGULATIONS.

_____

Client Signature Date

_____

Staff Witness Signature Date

(Original copy to clients chart, second copy for client records)

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Serenity House | Diamond Willow | Outpatient Services
245 North Binkley St. Suite 202 Soldotna, AK 99669
Intake Office: 907.714.4521 | Fax Number: 907.260.4063

FINANCIAL POLICY

Thank you for choosing us as your treatment provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Services will be billed and submitted to insurances as appropriate. We will offer an extended payment plan if need is documented. All charges are your responsibility.

Insurance

We may accept assignment of insurance benefits at the time of your assessment or intake appointment. The balance is your responsibility whether the insurance company pays or not. We can only bill your insurance company if you give us your insurance information, a copy of your insurance care and/or an original claim form are requested when you are admitted.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our Utilization Review Team will comply with all necessary clinical reviews as required by your insurance company. If, however, your insurance company has not paid your account within 45 days, the balance will become your responsibility. Our agency is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please let us know if you have questions or concerns regarding our Financial Policy.

I have read, understand, and agree to this Financial Policy

Client Name _____ Client Number _____

Client Signature _____ Date _____

OTHER: CARE TRANSITIONS-BEHAVIORAL HEALTH: WHAT TO BRING TO TREATMENT

We want your stay during detox treatment to be as comfortable as possible and we expect that you will bring some personal items that will help to enable your comfort. We would prefer, however, that all your personal belongings fit into one carry size bag. We also provide plenty of food and healthy snacks, so there is no need to bring outside food items to detox.

Acceptable items to bring:

- Appropriate clothing for 3-4 days. We will provide flannel pants and T-shirts for sleeping. No spaghetti strap tank tops or low cut tops. You may bring flip-flops or slippers if preferred, but footwear is required. Also bring a coat, jacket, or sweatshirt, depending on the season. NO inappropriate logos or wording. Please do bring several pairs of underwear and socks for your stay.
- Any prescription medications you are taking **NEED** to be in original bottle with original label that includes doctor's name, name of medication, and dosage schedule.
- Stamps, envelopes, and writing paper if you wish to write letters (outgoing mail will be reviewed).
- Your own personal recovery associated books and materials. Faith-based materials if wanted.
- Picture identification. (ID or Driver's License, etc.)
- Personal hygiene products will be provided, but special hygiene products will be accepted on case-by-case basis (examples: ethnic specific shampoos and conditioners, etc.)
- A smile and positive attitude, to prepare for a better life that you deserve.

Unacceptable items to bring:

- **ANYTHING** containing alcohol or food items that contain sugar as a primary ingredient (first 5 ingredients in an item).
- No personal snacks.
- No colognes, perfumes, or body sprays. Most people become sensitive or nauseous to these products while in treatment.
- **NO TOBACCO PRODUCTS. THIS INCLUDES VAPING, CHEWING TOBACCO, CIGARETTES, ETC.** No zippo or butane lighter fuels or other flammable liquids.
- No cell phones or MP3/CD/radio players.

Any unlabeled medications without an active prescription or not in original container; contraband such as cigarettes, loose tobacco, vapes or vape juice, or other drug paraphernalia brought into the facility will be destroyed upon admission.

I have read and understand the WHAT TO BRING TO TREATMENT.

_____

Client signature Date

_____

Staff Signature

(Original copy to client's chart, second copy for client records)

Central Peninsula Behavioral Health
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DRUG USE GUIDELINES

Please read the following expectations regarding recreational, over the counter, and prescription drug use while in CPH Behavioral Health Substance Use Treatment Programs.

Treatment plans for substance use disorders are individualized for each and every client in consultation with CPH Behavioral Health Department Counselors and Medical Providers. Our shared expectations are for our clients to be fully engaged in decision making regarding their treatment plan. This includes the decision to discontinue and avoid using legal or illicit drugs, prescription medications, or over the counter products that will likely interfere with recovery from substance abuse.

Some examples of medications/substances that must be avoided includes cannabis, alcohol, and herbal products with psychoactive effects such as kratom or valerian root. Examples of over the counter medications that should be avoided include Benadryl/diphenhydramine and Imodium/loperamide. Examples of prescription medications that are problematic for recovery include benzodiazepines (lorazepam/valium, Klonopin/clonazepam, alprazolam/Xanax), drugs used as sedatives (ambien/zolpidem, sonata/zaleplon, and lunesta/eszopiclone), and many muscle relaxants (flexeril/cyclobenzaprine, soma/carisoprodol, robaxin/methocarbamol, and baclofen). Also all drugs that fall into the opioid drug class (codeine, hydrocodone, oxycodone, tramadol, morphine, fentanyl, and hydromorphone), as well as all stimulants (Adderall/dextroamphetamine, Ritalin/methylphenidate, and vyvanse/lisdexamfetamine).

All clients that enter into our treatment programs with these drugs will be required to properly dispose of them in a designated charcoal disposal container before admission. We will not hold onto or store these types of durgs for our clients. Oour goal is to eliminate your long term need to take addictive substances as part of your recovery plan. Expectations are made only in the event that the medications brought into the facility have been recently prescribed and are acceptable by the admitting medical provider to use as part of your tapering detox protocol.

While at Care Transitions detox facility, the medications prescribed and utilized are for use only while under the direct care of our team of providers. Individuals who leave against medical advice (AMA), will not be discharged with detox medications for ongoing use.

Please ask our staff nurse or medical provider during your admission process if you have any questions or concerns regarding this practice guideline.

I understand that above practice guideline and authorize the disposal of any unauthorized or prohibited substances or paraphernalia at the time of admission, as well as disposal of all detox medications at time of discharge.

I have read and understand the DRUG USE GUIDELINES.

_____

Client Signature Date

central peninsula behavioral health

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Intake Office (907) 714-4521 Fax (907) 260-4063
245 N. Binkley St. Suite 202
Soldotna, AK 99669

Consent for Release of Confidential Information

Client Name:_____ **Date of Birth:**___/___/_____
authorize the mutual exchange of information and communication between Central Peninsula Behavioral Health & _____.
Phone # _____ fax # _____ and I authorize the information to be exchanged verbally, in writing, and/or by fax.

I am aware that disclosure information may include alcohol/drug abuse information, and/or psychological/ psychiatric information. I authorize the following information to be exchanged:

(**Please initial which information will be released**)

_____ Acknowledge presence in treatment/attendance
_____ History pertinent to this referral
_____ Diagnosis
_____ Urinalysis results
_____ Treatment plan
_____ Treatment records
_____ Discharge Summary, status
_____ Treatment recommendations
_____ Substance abuse assessment
_____ Program compliance
_____ Prognosis
_____ Psychological/Psychiatric assessment
_____ Psychological/Psychiatric reports
_____ Medical records
_____ Other_____

The above information is to be exchanged for the purpose of:_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written or verbal consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it previous to written revocation of this document and that in any event this consent expires: **(Specify event, date[s], or condition)**
If left blank, this specific authorization will expire 6 months from the date of my signature

_____

Signature of Client _____ Date: _____

Signature of Witness_____ Date: _____

Records from which this information has been disclosed are confidential and protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom the information pertains or as permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for release of alcohol and drug abuse client records. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(Revised June 2012)

Place ID
Sticker Here

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If left blank, this specific authorization will expire 6 months from the date of my signature.

Signature of Client: _____ Date: _____

Signature of Witness: _____ Date: _____

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