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 the NO TOBACCO POLCY.

Client signature:_____ Date:_____

Staff witness signature:_____

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

CARE TRANSITIONS BEHAVIORAL HEALTH

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

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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/SOCIAL HISTORY			
Employment status:		Occupation:	
Annual household income:		Is it enough to meet your needs?	
Primary income source:			
Did you receive current PFD?			
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) Other-Please Specify:	☐ Homeless ☐ Private residence w/o supportive services ☐ Other		
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

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:

SERENITY HOUSE TREATMENT CENTER-BEHAVIORAL HEALTH APPLICATION FOR

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

	Age Started	**Date of Last Use**	**Method** *(smoke, snort, IV, etc.)*	**Acquired** *(streets, doctor, family, internet, etc.)*	**Frequency of use**	**Amount**
Alcohol						
Heroin						
Fentanyl						
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 use tobacco?	If yes, what kind?	How much?

Have you ever been arrested?	
Have you been arrested in the last 30 days?	
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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D. EDUCATION, EMPLOYMENT, AND INCOME

1. **Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]***

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ REFUSED

2. **What is the highest level of education you have finished, whether or not you received a degree?**

- ○ LESS THAN 12TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- ○ VOCATIONAL/TECHNICAL (VOC/TECH) DIPLOMA
- ○ SOME COLLEGE OR UNIVERSITY
- ○ BACHELOR'S DEGREE (FOR EXAMPLE: BA, BS)
- ○ GRADUATE WORK/GRADUATE DEGREE
- ○ OTHER (SPECIFY)_____
- ○ REFUSED

3. **Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "NOT LOOKING FOR WORK."]***

- ○ EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD BE, IF NOT FOR LEAVE OR AN EXCUSED ABSENCE)
- ○ EMPLOYED, PART TIME
- ○ UNEMPLOYED—BUT LOOKING FOR WORK
- ○ NOT EMPLOYED, NOT LOOKING FOR WORK
- ○ NOT WORKING DUE TO A DISABILITY
- ○ RETIRED, NOT WORKING
- ○ OTHER (SPECIFY) _____
- ○ REFUSED

4. **Do you, individually, have enough money to pay for the following living expenses? Choose all that apply.**

- ○ Food
- ○ Clothing
- ○ Transportation
- ○ Rent/Housing
- ○ Utilities (Gas/Water/Electric)
- ○ Telephone Connection (Cell or Landline)
- ○ Childcare
- ○ Health Insurance
- ○ REFUSED

5. **What is your personal annual income, meaning the total pre-tax income from all sources, earned in the past year?**

- ○ $0 to $9,999
- ○ $10,000 to $14,999
- ○ $15,000 to $19,999
- ○ $20,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 to $199,999
- ○ $200,000 or more
- ○ REFUSED

5. **Do you speak a language other than English at home?**

- ○ Yes
- ○ No *[SKIP TO QUESTION 6]*
- ○ REFUSED *[SKIP TO QUESTION 6]*

5a. What is this language?

- ○ Spanish
- ○ Other (SPECIFY) _____

6. **Do you think of yourself as… [YOU MAY INDICATE MORE THAN ONE.]**

- ○ Straight Or Heterosexual
- ○ Homosexual (Gay Or Lesbian)
- ○ Bisexual
- ○ Queer, Pansexual, And/Or Questioning
- ○ Asexual
- ○ Other (SPECIFY) _____
- ○ REFUSED

7. **What is your relationship status?**

- ○ Married
- ○ Single
- ○ Divorced
- ○ Separated
- ○ Widowed
- ○ In a relationship
- ○ In multiple relationships
- ○ REFUSED

8. **Are you currently pregnant?**

- ○ Yes
- ○ No
- ○ Do not know
- ○ REFUSED

9. **Do you have children? [Refers to children both living and/or who may have died]**

- ○ Yes
- ○ No *[SKIP TO QUESTION 10]*
- ○ REFUSED *[SKIP TO QUESTION 10]*

9a. How many children under the age of 18 do you have?

|__|__| ○ REFUSED

9b. Are any of your children, who are under the age of 18, living with someone else due to a court's intervention? ***[THE VALUE IN ITEM A9b CANNOT EXCEED THE VALUE IN A9a.]***

- ○ Yes Number of children removed from client's care |__|__|
- ○ No *[SKIP TO QUESTION 10]*
- ○ REFUSED *[SKIP TO QUESTION 10]*

9c. Have you been reunited with any of your children, under the age of 18, who have been previously removed from your care? ***[THE VALUE IN ITEM A9c CANNOT EXCEED THE VALUE IN A9a.]***

- ○ Yes Number of children with whom the client has been reunited |__|__|
- ○ No
- ○ REFUSED

G. **SOCIAL CONNECTEDNESS**

1. **In the past 30 days, did you attend any voluntary mutual support groups for recovery? In other words, did you participate in a non-professional, peer-operated organization that assists individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Women for Sobriety, religious/faith-affiliated recovery mutual support groups, etc.? Attendance could have been in person or virtual.**

   - ○ Yes *[IF YES]* Specify How Many Times |__|__| ○ REFUSED
   - ○ No
   - ○ REFUSED

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

   - ○ Yes
   - ○ No
   - ○ REFUSED

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

   - ○ Very Dissatisfied
   - ○ Dissatisfied
   - ○ Neither Satisfied nor Dissatisfied
   - ○ Satisfied
   - ○ Very Satisfied
   - ○ REFUSED

4. **In the past 30 days did you realize that you need to change those social connections or places that negatively impact your recovery?**

   - ○ Yes
   - ○ No
   - ○ REFUSED

5. **Do you currently have medical/health insurance?**

   - ○ Yes
   - ○ No *[GO TO NEXT SECTION]*
   - ○ REFUSED *[GO TO NEXT SECTION]*

5a. What type of insurance do you have [CHECK ALL THAT APPLY]?

   - ○ Medicare
   - ○ Medicaid
   - ○ Private Insurance or Employer Provided
   - ○ TRICARE or other military health care
   - ○ An assistance program [for example, a medication assistance program]
   - ○ Any other type of health insurance or health coverage plan (SPECIFY)_____
   - ○ REFUSED

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your quality of life over the past 30 days?

- ○ Very poor
- ○ Poor
- ○ Neither poor nor good
- ○ Good
- ○ Very good
- ○ REFUSED

2. In the past 30 days, how many days have you *[ENTER '0' IN DAYS IF THE CLIENT REPORTS THAT THEY HAVE NOT EXPERIENCED THE CONDITION. SELECT REFUSED FOR NO RESPONSE]*:

		Days	REFUSED
2a.	Experienced serious depression	_____	○
2b.	Experienced serious anxiety or tension	_____	○
2c.	Experienced hallucinations	_____	○
2d.	Experienced trouble understanding, concentrating, or remembering	_____	○
2e.	Experienced trouble controlling violent behavior	_____	○
2f.	Attempted suicide	_____	○
2g.	Been prescribed medication for psychological/emotional problem	_____	○

[IF CLIENT REPORTS 1 OR MORE DAYS TO ANY QUESTION IN #2, PLEASE ENSURE THAT THEY ARE SEEN BY A LICENSED PROFESSIONAL AS SOON AS POSSIBLE.]

3. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ NO REPORTED MENTAL HEALTH COMPLAINTS IN THE PAST 30 DAYS
- ○ REFUSED _____

4. In the past 30 days, where have you gone to receive medical care? You may select more than one response.

- ○ Primary Care Provider
- ○ Urgent Care
- ○ The Emergency Department
- ○ A specialist doctor
- ○ No care was sought
- ○ Other (SPECIFY) _____

10. Have you ever served in the Armed Forces, in the Reserves, in the National Guard, or in other Uniformed Services? *[IF SERVED]* What area, the Armed Forces, Reserves, National Guard, or other did you serve?

- ○ No
- ○ Yes, In The Armed Forces
- ○ Yes, In The Reserves
- ○ Yes, In The National Guard
- ○ Yes, Other Uniformed Services *[Includes NOAA, USPHS]*
- ○ REFUSED

E. LEGAL

1. **In the past 30 days, how many times have you been arrested?** ***[IF THE CLIENT INDICATES NO ARRESTS IN THE PAST 30 DAYS, BUT IS INCARCERATED AT THE TIME OF THE INTERVIEW, MARK CURRENTLY INCARCERATED]***

   |___|___| TIMES ○ REFUSED ○ Currently Incarcerated

2. **Are you currently awaiting charges, trial, or sentencing?**

   ○ Yes
   ○ No
   ○ REFUSED

3. **Are you currently on parole or probation or intensive pretrial supervision?**

   ○ Probation
   ○ Parole
   ○ Intensive Pretrial Supervision
   ○ No
   ○ REFUSED

4. **Do you currently participate in a drug court program or are you in a deferred prosecution agreement?**

   ○ Drug court program
   ○ Deferred prosecution agreement
   ○ No, neither of these
   ○ REFUSED

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 a 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, services, or what you are expected to do.
D. **YOU HAVE THE RESPONSIBILITY** to follow instructions for your plan of care, treatment, or services. Also, 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 BILL 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 made to 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

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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 is physically able, they are required to maintain the cleanliness of their room including; making a bed, changing out linens and towels, and wiping bedside tables.
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, staff, 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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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 card, 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 Zippos, 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
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

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 drugs for our clients. Our 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