New PROGRESSIONS LLC

Confidential

ADSS

Consumer Orientation

I hereby acknowledge that I have received and have been given an opportunity to read a copy of New Progressions legal documentation and policies listed below. I hereby give my consent to receive and participate in treatment services at New Progressions. I understand that if I have any questions regarding any of the following policies and procedures: I can contact New Progressions at 404-565-2249.

☐ Substance Abuse Outpatient Consent for Treatment
☐ Consent for Release of Information

Notices Provided to Individual & Family:

☐ Access to emergency services, 24/7 On Call Service (Left with Individual)
☐ Consent for Treatment and Verification of Diagnosis
☐ Rights and grievance and appeal procedures (Left with Individual)
☐ Policy on weapons brought into the program (Left with Individual)
☐ Policy on Seclusion and Restraint (Left with Individual)
☐ Policy on Alcohol and Drugs (Left with Individual)

DATEP Orientation Packet Needed Diagnosis:_____

- _____ Co-Occurring Mental Health and Substance Abuse Disorder Yes/No (Circle One)
  - If yes, Referral for Medical Assessment Yes/No (Circle One)
  - Complete ROI for outside Medical Provider Yes/No (Circle One)
  - Attending Group Enrollment Date:_____ Yes/No (Circle One)
  - Fee Schedule Agreement Yes/No (Circle One)

Leave Client/Guardian with the following
_____ Orientation Letter
_____ Privacy Notice
_____ Grievance Policy
_____ Consumer Rights

Individual Printed Name: _____ Date: _____

Individual Signature: _____ Date: _____

Staff Member Printed Name & Credentials: _____ Date: _____

Staff Member Signature & Credentials: _____ Date: _____

☐ Individual/Parent Refuses to Acknowledge Receipt:

Staff Member Signature & Credentials: _____ Date: _____

Substance Abuse Outpatient Consent for Treatment

Individual Name: _____
Please put your initials beside each statement after reading.

1. REQUEST FOR TREATMENT

_____ I consent to be admitted to the New Progressions, LLC Outpatient program for the provision of substance abuse intervention/treatment services. I am aware and informed of the nature and purpose of the services, possible alternative options and approximate length of care. I understand that, while there are clear benefits to receiving services, desired outcomes are not guaranteed.

2. COOPERATION WITH TREATMENT

_____I understand that my status as a Individual of New Progressions, LLC is dependent upon my willingness to cooperate with staff and other Individuals, as well as to comply with the program rules. I understand that my failure to cooperate and comply may result in an alternative placement for me.

3. TRANSFER OF SERVICES

_____I understand that there may be a need to transfer me to some other location for substance abuse treatment and intervention services, medical and mental health needs, depending on the situation. I give the staff of New Progressions, LLC permission to make such recommendations.

4. COMMUNICABLE DISEASES

_____I understand that New Progressions, LLC is responsible for informing the County Health Department of any communicable diseases that I may self-report, in accordance with 381.23 and 384.06 F.S.

5. CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

_____I understand the importance of confidentiality and the right to privacy of fellow program Individuals. I am aware of Federal confidentiality laws and regulations governing alcohol and drug treatment programs. I agree to maintain confidentiality but am aware that there are some legal exceptions or limits to confidentiality.

6. PROGRAM RULES

_____ I understand that I am expected to abide by the rules of the program. As a part of our substance abuse program I understand that I am subject to random drug screens and agree to this program rule.

7. INDIVIDUAL RIGHTS

_____ I understand that I have basic rights afforded to me and that if I believe my rights have been violated I have recourse (see your handbook for a detailed explanation of my rights.

8. FEES

_____ I understand that I am responsible for any fees associated with services I receive. The program operated by New Progressions, LLC is made available to you without discrimination based on your ability to pay. If you are unable to pay the assessed fee, a sliding fee scale or payment arrangements can be negotiated with you.

☐**I attest that substance abuse treatment is not needed for me at this time.**

_____

Individual Signature/Date

Georgia Department of Behavioral Health & Developmental Disabilities

_____
Name of Individual/Individual/Patient/Applicant

_____
Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize:

New Progressions LLC
(Name of Person or Agency to whom information should be given - requesting agency)

5526 Old National Hwy. Ste B, Atlanta, GA 30349 404-565-2249 (O) 678-732-0173 (F)
Address) (Phone/Fax)

to obtain from:

_____
(Name of Person or Agency to whom information should be given - releasing agency)

_____
(Address) (Phone/Fax)

the following type(s) of information from my records (and any specific portion thereof):

_____ I authorize the disclosure of alcohol or drug abuse information, if any.(Please see paragraph 2 below)
Initials

_____ I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus)
Initials and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

for the purpose of:

*1. I understand that the information disclosed pursuant to this Authorization **may** be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*

2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.

3. I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.

4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

___ one (1) year.
___ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.

_____ _____
Signature of Individual/Individual/Patient/Applicant Date

_____ _____
Signature of Witness/Staff (Title or Relationship to Individual) Signature of (check one): Date
☐Parent ☐Guardian ☐Court-appointed Custodian of Minor
☐ Agent designated by Individual's Advance Directive

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142. Fax: 404-657-2173.

_____ _____
Date this authorization is revoked by Individual Signature of Individual or legally authorized Representative

Counselor/Clinician Name

Parent/Guardian Name (s)

Staff Responsible for the Coordination/Integration of this plan

Client Signature **Signature Date**

Parent Signature **Signature Date**

Clinician/Case Worker Signature **Signature Date**

Licensed Clinician Signature **Signature Date**

Psychiatrist Signature **Signature Date**

Psychiatric NP Signature **Signature Date**

Counselor/Clinician Name

Parent/Guardian Name (s)

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