Client Name:____
Last   First   M.I.

Address:____

Home Phone____________________Cell:____________________Email Address:___________________________

☐ Messages Ok   ☐Please don't leave messages

D.O.B:________________Age_______Sex______Race:_______Marital Status________S.S.#________________
MM/DD/YYYY

Highest Grade Completed________Number of arrests in the last 30 days:________Are you a Veteran?__________

PLEASE CHECK THE APPROPRIATE OPTION:

☐ Unemployed   ☐Receiving Disability   ☐Looking for Work

☐Employed (Circle one) F/T or P/T Employer:

*Primary Care Physician:____

*Allergies:____

CURRENT MEDICATIONS CURRENTLY PRESCRIBED (please include dosage):

List TWO INDIVIDUALS TO BE CONTACTED IN THE CASE OF EMERGENCY:

1. Name ______________________________Tel: ________________ Relation: __________

2.Name____________________________Tel:_________________Relation:__________

Insurance Information

Insurance/Medical Assistance Number: ______________________________________MCO:____________________

*I request the payment of authorized Medicaid/Medicare/Other Insurance Company benefits be made to me on my behalf to Gateway Treatment Services LLC, for any services rendered to me by the party who accepts assignment/physician. Regulations pertaining to Medicaid/Medicare assignment of benefits apply. I understand my signature request that payment be made and authorizes release of medical information necessary to reimburse the claim. Item 9 of the HCFE-1500 claim form is completed; my signature authorizes releasing of the information to the insurance agency shown. In Medicaid/Medicare/Other Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid/Medicare/Other Insurance Company charged, the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicaid/Medicare/Other Insurance Company. I authorize the release of information to OPTUM and the local Core Service Agency if I am a medical Assistance client for the purpose of coordinating appropriate services.

__________________________________   _______________________________
Signature   Date

CONSENT FOR TREATMENT

Client's Name: ____

I am the _______Patient ________Parent ___________legally appointed guardian (court order

required) Other (Explain) ____

I voluntarily consent or give my consent to receive treatment and/or related services by Gateway Treatment Services LLC. Outpatient Substance Abuse Counseling Center (GTS) which may be advised and/or recommended by the attending physician.
I hereby request GTS and its qualified clinicians, physicians, employees and agents (collectively Gateway Treatment Services) to provide such as patient mental health and related medical services as are deemed medically necessary and appropriate.

_____ I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for GTS to render such emergency treatment and/or transfer myself or my child to a hospital for evaluation and/or treatment.

____ I understand that all information concerning the participation of myself/my child is confidential and that no information will be given without written consent from me.

_____ I agree that I have been fully oriented to the program's services and the treatment that is being provided to me. I have reviewed my rights and responsibilities as a patient and I am aware of the grievance process and the discharge/termination policy of this agency.

______ In agreeing to receive services at GTS, I understand I shall assist in following the individualized treatment plan that has been developed or will be followed by GTS and shall ensure that all the scheduled appointments are kept.

______ I am aware that an agent of my insurance company or other third-party payer may be given information about services such as, cost, dates, and providers of services or treatments I have received.

______ I understand it is my responsibility to cancel appointments within 24 hours if I am unable to keep the scheduled time allotted.

_______ I am aware that I may stop treatment with GTS at any time.

______ I understand that no promises have been made to me as to the results of treatment or of any procedure provided by this agency

____ I understand that if I am paying for services "out of pocket" that I am responsible for balances due

_________________________________ _____________________________

Signature Date

RISKS AND BENEFITS OF SUBSTANCE ABUSE TREATMENT

Receiving substance abuse services can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and/or helplessness. On the other hand, receiving substance abuse health services has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific challenges and significant reduction in feelings of distress. However, there are no guarantees of what will be experienced while participating in substance abuse counseling. In either situation you will have the support of your therapist throughout the process.

CONFIDENTIALITY

All information given to or obtained by program therapist/ counselor/physician will be used only for your treatment/rehabilitation and administration of the program. Information may be released for the purpose of your treatment or rehabilitation services or if required by Federal Law or in response to legal investigations and court order. Information requested about you for any other purpose can only be released by your written consent.

By signing this document, I am acknowledging that I have full knowledge and understanding of the program, its requirements, and my rights, and agree to participate according to the standards that have been set forth. I agree and understanding the intake process, program responsibilities, my responsibilities, and the termination process. I am also aware that I can choose to discontinue participation at any time. I have received A New Client Orientation session that included policies and procedures and I authorize the Gateway Treatment Services LLC. to bill on my behalf for services.

Consent to Services:

❏parent/guardian ❏minor (16 years or older) ❏adult consents to services

____________________	____________________
Print Name	Date
____________________	____________________
Signature	Relationship to Patient

____

Witness

Client: ____

Name:________________________________ DOB __________________

5 DAY FACE TO FACE SCREENING ASSESSMENT

Treatment Needs:

❏Activities of Daily Living
❏Anger/Temper/Conflict Resolution
❏Assertiveness/Self-esteem
❏Community Living
❏Family/Marriage
❏Finances
❏Home/Housing Trauma
❏Independent Living Skills
❏Safety to Self/Others
❏School Performance
❏Sexual Issues
❏Social Skills/Peer Interaction
❏Substance Abuse Issues
❏Coping Skills
❏Crisis Management Skills
❏Medication Compliance Skills
❏ Vocational Skills
❏ Leisure Skills
❏Work/Job Performance
❏ Legal Issues
❏Money Management
❏Dietary/Food Preparation
❏Physical Health

Available Resources:

____

____

Goals for Recovery:

____

____

Strengths:

____

Entitlements:

❏Client currently receiving entitlement benefits
❏Client has independently completed application on __________
❏Staff will assist the minor's parent or guardian to apply for entitlements by: __________
❏ Client refuses to disclose

Review of Somatic Status: Does the client have any significant past or current medical problems?
❏ Yes (Document details in Assessment) ❏ No
Does the client's medical condition require somatic care follow-up?
❏Yes (How often____________________❏
No Does the client have a primary care provider?
❏ Yes ❏No (Indicate time frame for referral to a primary care provider)

Authorization to Use and Disclose Protected Health Information

NOTICE – PLEASE READ: I understand that each authorization signed below will remain in effect for **365** days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized Gateway Treatment Services LLC, (GTS) to disclose my information to persons who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to others without my consent or authorization. GTS will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit the recipient of the protected health information from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name:________________________________Date of Birth:___________/___________/________

I hereby authorize the Gateway Treatment Services to:

❏ Disclose information ❏ Request Information ❏ Exchange

Information With Name of Person or Entity:____

Address____

Telephone/ Fax:____

INFORMATION TO BE USED/DISCLOSED/REQUESTED

Check the boxes of items needed:

	Diagnostic Assessment		Psychological Evaluation Reports		Treatment Plan/ISP
	Progress Notes		Psychiatric Evaluation		Other Social History
	Physician's Orders		Court Reports/Records		Medication Records
	School/Consultation		Laboratory Reports		Employment/Records / Reports
	HIV/AIDS Status		Drug and Alcohol Addiction Records		Recent Physical Exam

Other (CLEARLY SPECIFY)____

Purpose for Disclosure ❏ Assist in Treatment Planning ❏ Continuity of Care ❏ Other

I understand that I may withdraw this consent at any time in the future as explained above and that this consent will expire in 365 days from the dates signed below, unless otherwise specified.

This consent will expire on ______/_____/_____ OR Upon discharge from service

Signature: ______________________________ Relationship: ____________________Date: _______________

Notice: A mental Health Advance Directive is a legal document. Before signing any legal document, please read material carefully and seek legal counsel as needed.

Mental Health Advance Directive

Under Maryland law, it is the right of anyone sixteen (16) years of age or older to be involved in decisions about their mental health treatment.

The Advance Directive is designed to assist with the pre-planning process should an individual become incapacitated in making informed cognitive decisions.

(Initial Appropriate Responses)

I am sixteen (16) years of age or older

__________Yes __________No

__________ (Initials)

I currently have a Mental Health Advance Directive

____ Yes _______ No _______ Unsure

____
(Initials)

I have provided a copy of my Health Advance Directive to GTS LLC. Yes No (Initials)

I was offered a Health Advance Directive

__________Accepted __________Declined

(Initials) ____________

Client Name____Date____

❏ I have signed the 5-day face to face screening assessment
❏ I have been given a program orientation of GTS's Client Handbook and Program Rules.
❏ I have received an explanation of and signed the Client's Rights form.
❏I have received the complaint and grievance policy procedures.

❏ I received a description of different ways I can provide input into my services and provide feedback.
❏ I understand and have been given a copy of GTS's Notice of Privacy Practices.
❏ I have reviewed client HIPAA agreements.
❏ I have been provided with an explanation of GTS's confidentiality policies.

❏I have been provided with an explanation of and signed the Consent for Treatment.
❏ I have been provided information about behavioral expectations of clients and am aware that this information is also contained in the Client Handbook
❏ I have been provided with the criteria to be admitted for services, the processes and being discharged.
❏ I have been informed about GTS's staff response if they identify potential risks to my well-being.

❏ I understand GTS's hours of operation and how to access after-hour-services.
❏ I have received information about GTS's standards of professional conduct.
❏ I have been informed about possible reporting and follow-up requirements for clients who are mandated (court ordered) to services, regardless of discharge status.
❏ I have been assigned to my primary therapist and have been given their contact information.

❏ I understand and have signed forms with description and explanation of financial obligations, fees, and any financial arrangements for services performed by GTS.
❏ I understand GTS's health and safety policies regarding: restraint/seclusion, use of tobacco products, legal and illegal drugs, prescriptions medication and weapons brought into any GTS facility, program or activity.
❏ I understand the Program Rules and understand that the program may place restrictions on my customary rights and privileges, possible consequences of attitudes and behaviors, and that there will be ways to regain rights or privileges that have been restricted.
❏ I have been given a tour of the facility including: emergency exits, fire suppression equipment, first aid kits, emergency shelters, bathrooms, group therapy rooms.

❏ I have been asked if I have an advance directive, and have been offered education about this if I desire.
❏ I have been informed about the purpose and process of the screening and assessment.
❏ I have been informed about how my Treatment Plan will be developed; how I am expected to participate in the development of the plan and the achievement of my goals; the expected course of my treatment; how motivational incentives may be used; and expectations for legally required appointments, sanctions, or court notifications.
❏ I have been informed of the name of the person responsible for coordinating my services.

Assigned Individual Therapist ____

Assigned SUD Counselor: ____

Client Printed Name: ____

Client Signature: ____