

# *Loaves and Fishes of Beaufort*

"Serving our community in Jesus' name"

## Addictions Treatment Application

1730 Live Oak Street  
Beaufort, NC 28516  
252.838.9035 Fax: 252.838.1156  
[www.loavesandfishesnc.org](http://www.loavesandfishesnc.org)

Mailing Address: PO Box 2535  
Beaufort, NC 2851

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance (For doctor's visits): \_\_\_\_\_

Policy #: \_\_\_\_\_

Upcoming Court Dates and County:

\_\_\_\_\_  
Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Probation: Yes / No Officer's Name and County: \_\_\_\_\_

Are you court ordered to treatment? Yes / No

If "Yes" ... Which County? \_\_\_\_\_

Duration of Treatment Ordered? \_\_\_\_\_ Charge: \_\_\_\_\_

Have you completed detox: Yes / No

Name of Detox: \_\_\_\_\_

Date Completed: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Briefly explain why you are seeking treatment at Loaves and Fishes Counseling:

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## **Patient History**

Please list all current and past mental and physical diagnoses/conditions:

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Please list all current medications:

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Do you have any food or drug allergies: Yes / No Please list below if you answered "yes"

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Have you ever attempted to harm yourself or someone else? Yes / No If you answered "yes", please explain:

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Have you ever been Involuntarily Committed? Yes / No

If you answered "yes", please explain and give name and address of where you were treated:

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Do you have any physical limitations: Yes / No If you answered "yes", please explain:

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Have you been tested for HIV, Hep-C, or TB? Yes / No Results: \_\_\_\_\_

Date of last use: \_\_\_\_\_ What was your drug of choice? \_\_\_\_\_

List all substances used/abused:

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Have you ever been discharged from another treatment facility and for what reason(s):

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## Financial Policies and Agreement

We currently do not charge a monthly fee for admission into our treatment program. However, it is the client's responsibility to cover the following expenses if applicable:

- Medications (From Beaufort Drug Co.)
- Attorney Fees
- Dental Care
- Any medical care outside of our primary medical provider, Open Water Medical
- Other non-covered expenses

If a resident would like to have a card on file for petty cash, he or she will need to make the proper arrangements with the benefactor. The resident may only receive a maximum of \$10.00 per day. Please note that Loaves and Fishes does not provide funds for residents to purchase incidentals. If the resident has a debit/credit card, it will be held in the financial office as well. If you wish to leave card information on file to be used for the items beyond the monthly fee, please fill out the section below.

Financially Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Address: (No PO Box)

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Credit Card # \_\_\_\_\_ Sec. Code \_\_\_\_\_ Exp. Date \_\_\_\_\_

Zip Code \_\_\_\_\_ Would you like us to call prior to using your card? Yes/No

*By signing below, I authorize Loaves and Fishes Counseling to utilize this authorization for incidental charges, petty cash, or any other charge needed for the good of the patient. I understand and agree that my card will not only be charged, but that there are no refunds of fees of charges under any circumstances. I also understand that my information may be given to third parties for the continued care of the patient.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **General Informed Consent**

*This general informed consent applies to all licensed, provisionally licensed, registered and intern status clinicians with Loaves and Fishes of Beaufort Counseling. This consent also serves as a general consent for pastors, Peer Support Specialists, support staff, interns, and other individuals that may be involved in the treatment process. Treatment will be provided in individual sessions and group sessions.*

### **Counseling Background:**

Each individual provides services to a diverse population to include: men, women, couples, and families. Theoretical orientations are evidence based when applicable. Each clinician, when required, is under clinical supervision by a licensed supervisor with the NCSAPPB.

### **Services Offered/Staff**

We provide inpatient, outpatient, individual, family and group counseling. At Loaves and Fishes Counseling, we have adopted a team approach to treatment and counseling. Our treatment team is made up of paraprofessionals, volunteers, provisionally licensed counselors, licensed counselors, interns, peer support specialists, and pastors. Due to the nature of many of our groups, this team may change without notice. Although some patients will require weekly individual treatment, this is not the case for all patients. A person-centered treatment plan will be put in place for all patients.

### **Confidentiality**

All members of our treatment team have signed confidentiality agreements which both educate them and bind them to hold all information in the strictest confidence per HIPAA Privacy Rule, 45 C.F.R. § 164.508(c)(2)). It is our desire to keep each patient safe and make decisions that are both beneficial for the individual and the other patients. Group therapy and individual therapy is provided for each patient. The guidelines and limitations of confidentiality apply to group counseling as well.

All patient records are kept on an electronic database which is secure and only accessible by staff. We will keep confidential anything clients say as part of our counseling relationship with the following exceptions: (a) a patient directs us in writing to disclose information to someone else, (b) it is determined that a patient is a danger to themselves or others, (c) our agency is ordered by a court to disclose information, and (d) if a patient discloses abuse to a child, elder, or handicapped individual.

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## **Referral/Termination**

In the event that the counseling relationship must terminate or if the counselor becomes incapacitated, all clients will be referred to another provider within the agency. Prior to terminating the counseling relationship, the client will be notified of said termination. In the event that a referral is necessary, the counselor will take the proper steps to help the client through this transitional period.

## **The Counseling Relationship**

The relationship between client and counselor will develop over time. Although this relationship may become a powerful tool in the life of the client, the client must understand that this relationship is strictly professional.

## **Complaints**

Although clients are encouraged to discuss any concerns with the counselor, a client may file a complaint against the provider with the organization(s) below should the client feel that the counselor is in violation of any of these codes of ethics.

## **Consent to Treat**

By signing below, I give consent for Loaves and Fishes to treat me for any substance abuse and mental health diagnoses.

North Carolina Substance Abuse Professional Practice Board  
PO Box 10126  
Raleigh, NC 27605

I/We agree to these terms and will abide by these guidelines.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

# Loaves and Fishes of Beaufort

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## CONSENT FOR RELEASE OF INFORMATION

Loaves and Fishes Counseling Ministries

1730 Live Oak Street ▪ Beaufort, NC 28516

(252) 838-9035 fax: (252) 838-1156

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

I hereby authorize the release and/or exchange of specified information regarding my medical and psychological condition, history, and treatment *between Loaves and Fishes Counseling Ministries* and the person/provider(s) listed below per Privacy Rule, 45 C.F.R. § 164.508(c)(2):

- **Carteret Health Care**\_\_\_\_\_
- **Beaufort Drug Company** \_\_\_\_\_
- **Open Water Medical**\_\_\_\_\_
- **Carteret County Department of Social Services**\_\_\_\_\_
- **North Carolina Courts** \_\_\_\_\_
- **All law enforcement/DPS agencies** \_\_\_\_
- **Vocational Rehabilitation** \_\_\_\_\_
- **Emergency Contacts (As listed on Residential Application)**\_\_\_\_\_
- **Financial Responsible Party (As listed on Residential Application)**\_\_\_\_\_

This information shall include only that of the nature and to the extent which is specified below:

### INFORMATION TO BE RELEASED:

### PURPOSE FOR RELEASE:

- |   |   |
|---|---|
| <input type="checkbox"/> All Admission and Discharge                        | <input type="checkbox"/> For Diagnostic Purposes  |
| <input type="checkbox"/> Summary of Prior Treatment                         | <input type="checkbox"/> For Continuity of Care   |
| <input type="checkbox"/> Verbal/Written Updates as Needed                   | <input type="checkbox"/> For Coordination of Care |
| <input type="checkbox"/> Current Medications                                | <input type="checkbox"/> Date Range _____         |
| <input type="checkbox"/> All Dates of Treatment                             |   |
| <input type="checkbox"/> Medical/ Psychiatric/ Psychotherapy Progress Notes |   |
| <input type="checkbox"/> Laboratory and Radiology Reports                   |   |
| <input type="checkbox"/> _____  |   |

I understand that information to be released, may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions. I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be disclosed without my further written consent unless provided for by state and federal law. I understand I may revoke this authorization at any time, except to the extent that action has already been taken. Unless otherwise revoked, this consent will expire one year from the date of consent.

\_\_\_\_\_  
Patient Signature

OR

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date of Consent

**I hereby revoke this authorization effective** \_\_\_\_\_ **Patient Signature** \_\_\_\_\_

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INFORMATION TO BE RELEASED:

PURPOSE FOR RELEASE:

- |   |   |
|---|---|
| <input type="checkbox"/> All Admission and Discharge                        | <input type="checkbox"/> For Diagnostic Purposes  |
| <input type="checkbox"/> Summary of Prior Treatment                         | <input type="checkbox"/> For Continuity of Care   |
| <input type="checkbox"/> Verbal/Written Updates as Needed                   | <input type="checkbox"/> For Coordination of Care |
| <input type="checkbox"/> Current Medications                                | <input type="checkbox"/> Date Range _____         |
| <input type="checkbox"/> History of Psychotropic Drugs                      | <input type="checkbox"/> All Dates of Treatment   |
| <input type="checkbox"/> Medical/ Psychiatric/ Psychotherapy Progress Notes |   |
| <input type="checkbox"/> Laboratory and Radiology Reports                   |   |
| <input type="checkbox"/> _____  |   |

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\_\_\_\_\_ OR \_\_\_\_\_  
Patient Signature Parent / Guardian Signature

\_\_\_\_\_ \_\_\_\_\_  
Therapist Signature Date of Consent

\*\*\*\*\*

I hereby revoke this authorization effective \_\_\_\_\_

Patient Signature \_\_\_\_\_

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<u>INFORMATION TO BE RELEASED:</u>	<u>PURPOSE FOR RELEASE:</u>
<input type="checkbox"/> All Admission and Discharge	<input type="checkbox"/> For Diagnostic Purposes
<input type="checkbox"/> Summary of Prior Treatment	<input type="checkbox"/> For Continuity of Care
<input type="checkbox"/> Verbal/Written Updates as Needed	<input type="checkbox"/> For Coordination of Care
<input type="checkbox"/> Current Medications	<input type="checkbox"/> Date Range _____
<input type="checkbox"/> History of Psychotropic Drugs	<input type="checkbox"/> All Dates of Treatment
<input type="checkbox"/> Medical/ Psychiatric/ Psychotherapy Progress Notes	
<input type="checkbox"/> Laboratory and Radiology Reports	
<input type="checkbox"/> _____	

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\_\_\_\_\_ OR \_\_\_\_\_  
Patient Signature Parent / Guardian Signature

\_\_\_\_\_ \_\_\_\_\_  
Therapist Signature Date of Consent

\*\*\*\*\*

I hereby revoke this authorization effective \_\_\_\_\_

Patient Signature \_\_\_\_\_



# *Loaves and Fishes of Beaufort*

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## **Loaves and Fishes Waiver of Liability and Assumption of Risk Agreement**

### **Waiver:**

In consideration of my involvement with Loaves and Fishes of Beaufort, I for myself, my heirs, personal representative or assigns, do hereby release, waive, discharge, and covenant not to sue Loaves and Fishes of Beaufort, its trustees, directors, officers, employees and agents from liability from any and all claims including negligence of resulting in personal injury, accidents, or illnesses (including death) and property loss arising from use of premises.

### **Assumption of Risk:**

Our inpatient treatment program carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I have read the previous paragraph and I know and understand and appreciate these and other risks are inherent in the activity I am participating in. **I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

### **Indemnification and Hold Harmless:**

I also agree to indemnify and hold harmless Loaves and Fishes of Beaufort, its trustees, directors, officers, employees and agents from any and all claims, actions, suits, costs, expenses, damages and liabilities including attorney fees as a result of this use of premises.

### **Acknowledgement of Understanding:**

I have read this waiver of liability, assumption of risk, and indemnity agreement, and fully understand its terms. I acknowledge that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## **MEDIA RELEASE FORM**

I, \_\_\_\_\_, grant permission to Loaves and Fishes of Beaufort, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

- Videos
- Social Media
- Recruiting Brochures
- Newsletters
- General Publications
- Website and/or affiliates

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Signature: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Date: \_\_\_\_\_

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## **Residential Treatment General Rules**

- No Visitors inside the house or on any of our properties without prior approval
- The following behaviors may result in disciplinary action and/or immediate dismissal from the program:
  - Possession/Use of an unauthorized substance
  - Positive Urinalysis for unauthorized substances
  - Fighting, disrespect/harassment of fellow resident or staff member
  - Leaving the property without permission and/or supervision
  - Behavior that is considered dangerous to self or other individuals
  - Non-compliance to therapeutic interventions
  - Manipulating staff.
  - Unauthorized use of a phone, the Internet, or any other electronic device
- Residents may not have any electronic devices for the first 90 days of treatment. After the first 90 days, they be allowed to have a phone at the discretion of staff. This, however, is not guaranteed.
- Church services are mandatory
- Residents may receive **approved visitors after their first 30 days in the program** if deemed appropriate by our staff. **Approved visitors would be: immediate family, legal spouse, and clergy.** Boyfriends, Girlfriends, or acquaintances are **NOT** permitted for visitation. Residents are **NOT** permitted to have overnight visits. Visitors must be interview by staff before visitation and will sign out the resident upon each visit. Visits are on Saturday from 10am to 4pm. The same person that picks up the client needs to be the same person to drop them back off.
- Residents will contribute to the house duties. Failure to comply may result in discharge.
- Residents agree to submit to a random drug test at any time and upon admission. This test is supervised by a staff member of the same sex.
- Medications will be dispensed by a staff member each morning. It is the responsibility of the residents to not lose their medication. A replacement dose will not be given. **We do not allow any controlled substances in this program or any other substance that we deem mind altering or a threat to a resident's health or recovery.**
- Residents may NOT have a vehicle while staying at Loaves and Fishes.
- Patients agree to a search of their person upon admission and random search and/or seizure while enrolled in this program.
- If a patient leaves the program against therapeutic advice or is discharged, their personal belongings will be held for a maximum of **48** hours and then donated to our thrift store. Medications will be held for **30**-days and will then be disposed of at the Carteret County Sheriff's Department.
- Any patient that leaves this program on negative terms is no longer allowed on any Loaves and Fishes property or on any property where patients may be involved in therapy or any other event including church. This includes contact via phone, letter, or social media.

Signature \_\_\_\_\_

Date \_\_\_\_\_