

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

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 and who diagnosed you:

Please list all current medications, prescription and over the counter:

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

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

Have you ever been Involuntarily Committed? Yes / No

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

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

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:

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

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Financial Policies and Agreement (Cont.)

This form is for payment of services not covered under the resident's monthly fee, such as:

- Medications (From Beaufort Drug Co.)
- Legal 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: _____

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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, staff member or customer
 - Leaving the property without permission and/or supervision
 - Behavior that is considered dangerous to self or other individuals
 - Sexual misconduct including to but not limited to the use of words, gestures, or written materials
 - 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 will work at the thrift stores Monday through Saturday, after group sessions. Residents must check in with Brenda or Jessie when leaving the thrift store(s) for any reason. Breaks will be taken behind the housewares store only. Residents are not allowed to take a break or loiter in front of either thrift store.
- Residents will not take any item, paid or unpaid, from the thrift store without **prior approval** from PB, Gabbie or Shannon.
- Designated grocery days are on Mondays and Thursdays. Only under extreme weather conditions will this be deviated from.
- 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 an overnight visit. Visitors must be interviewed by staff before visitation and will sign out the resident upon each visit. Visits are on Saturday from 10am to 4pm.
- After 30 days, residents may use the office phone, however calls will be limited to 5-minute durations and will be logged in by staff. These calls may be made in the morning before group or between groups. The thrift store phone may **not** be used.
- 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.

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- 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.**
- If residents do not take their medications as prescribed, they will return all untaken medications to staff at the first moment possible. Storing up medication or taking over-the-counter medication without discussing it with staff and/or a medical provider **prior to using it** is grounds for dismissal.
- Residents may NOT have a vehicle while staying at Loaves and Fishes.
- Residents may not smoke in front of the thrift stores. Smoking is allowed in front of the counseling office and behind the housewares store only.
- Residents may not go into Subway for any reason.
- 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. Mail will be held for one week. After 7 days, mail will be returned to sender. It is the patient's responsibility to update all parties of a forwarding address.
- 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.
- This list is not inclusive and should not be deemed so. Failure to comply with program rules are considered non-compliance and grounds for dismissal.

Signature _____

Date _____

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LOAVES AND FISHES OF BEAUFORT

AUTHORIZATION FOR USE/DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. By signing this Authorization, I understand that I am giving my authorization to **LOAVES AND FISHES OF BEAUFORT**, to use and/or disclose my protected health information ("PHI") as specified in this Authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize _____ to disclose or obtain the following information from the medical records of:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Information to be disclosed:

Complete health record(s), including radiology and lab reports (but excluding actual images of film, x-rays, etc.)

Complete health record(s), including all images (x-rays, photographs, etc.)

or

Select from the following (check as many as apply):

Discharge Summary Progress Notes

History and Physical Examination Nursing Notes

Consultation Reports Laboratory Tests

Mental Health Care Reports, (except Physiotherapy notes)

X-ray Reports

Treatment for alcohol and/or drug abuse

Photographs, videotapes, digital or other images

Other (please specify)

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AUTHORIZATION FOR USE/DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION

This information is to be disclosed to LOAVES AND FISHES OF BEAUFORT for the purpose of documenting and providing treatment for _____.

Loaves and Fishes of Beaufort
PO Box 2535
Beaufort, NC 28516
P: (252) 838-9035
F: (252) 838-1156

The patient or the patient's representative must read and initial the following statements:

- a. I understand that unless earlier revoked, this authorization will expire six months from date of signature.

Initials: _____

- b. I understand that I may revoke this authorization at any time by notifying the Health Care Provider in writing, but if I do, it won't have any effect on any actions the Health Care Provider took before it received revocation.

Initials: _____

- c. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits, except under special circumstances as specified by law.

Initials: _____

Signature of Patient or Representative

Date

Printed Name

Relationship of Representative
to Patient

Sworn to and subscribed before me
this the ____ day of _____, 20____.

NOTARY PUBLIC

My Commission Expires: _____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****