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:
____
____
____
____
____
____

Loaves and Fishes of Beaufort

"Serving our community in Jesus' name"

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, TB or any other sexually transmitted disease? 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):

____

____

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.

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

"Serving our community in Jesus' name"

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, it's 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

Loaves and Fishes of Beaufort

"Serving our community in Jesus' name"

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: ____

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 duration of treatment.
- Church services are mandatory.
- Residents will work at the thrift stores Monday through Saturday, after group sessions. Residents must check in with the thrift store manager 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 or Gabbie.
- 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 interview by staff before visitation and will sign out the resident upon each visit. Visits are on Saturday from 10am to 4pm OR Sunday between church services (to be approved by staff). Visits must be reported to staff by the Friday before.
- After 30 days, residents may use the office phone, however calls will be limited to 5-minute durations. 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.

- 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.**
- Loaves and Fishes **may** help with the cost of necessary medications within the first 90 days. However, if the resident has money in the safe, this will be used first to pay for medications. The program will pay for medications on a **case-by-case basis and should in no way be deemed an obligation by Loaves and Fishes. After the first 90-days, the resident will be obligated to pay for their own medications.**
- 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. E-cigarettes are not allowed.
- 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 ______________________

Loaves and Fishes of Beaufort

"Serving our community in Jesus' name"

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

__ History and Physical Examination

__ Consultation Reports

__ Progress Notes

__ Nursing Notes

__ 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)

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

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