* Please fill out all and only the information that has an X by it.

* Please stop where it says stop.

* The AUDIT, DUDIT and DAST questionnaire pertain to when you were drinking and/or using. So that is how you are to please answer those questions.

* If there is anything that you are unsure about or have a question about, please leave it blank and you can go over the information with the evaluator.

Thank You!

Price Counseling Center

2920 Marietta Hwy, Ste 132
Canton, GA 30114
770-479-5501

NEW CLIENT INFORMATION & REGISTRATION
CONFIDENTIAL

Please respond completely and accurately to the following items so that we might be better able to serve you. If an item does not apply to you, please place "N/A" in the space. Thank you for your time and cooperation. WELCOME TO OUR PRACTICE!

CLIENT'S NAME:_____ DATE: _____
(Last) (First) (Middle)

How would you like to receive your evaluation (circle one): **MAIL** **EMAIL** **PICK UP**

Address:_____ Email: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Driver's License No:_____

Date of Birth: _____ Current Age: _____ Social Security No: _____

Marital Status: _____ How long?_____ Race: _____

Client's Nearest Relative (in case of emergency):

Name: _____ Relation:_____

Address: _____

Home Phone: _____ Work Phone: _____

Please list the names **and ages** of any children or other persons residing in client's household:

_____

Probation Officer: _____ Phone No. _____

Address: _____ City_____ State ____ Zip _____

Attorney: _____ Phone No: _____

Address: _____ City_____ State ____ Zip _____

DFCS Caseworker: _____ Phone No. _____

ALCOHOL/DRUG QUESTIONNAIRE
ADAPTED MAST
To be filled out if <u>at any point</u> in your life this information has been true.

1. Please list any drugs you have ever used besides alcohol:

			Last use
Yes	No	Marijuana	_____
Yes	No	Cocaine (crack, powdered, freebase)	_____
Yes	No	Methamphetamine or Amphetamines (Crank, Ice, "Nazi dope")	_____
Yes	No	Tranquilizers (Xanax, Ativan, Valium, etc)	_____
Yes	No	Ecstacy (MDMA)	_____
Yes	No	Pain pills (Oxycontin, Demerol, Dilaudid, etc)	_____
Yes	No	LSD, PCP, "K", peyote	_____
Yes	No	Steroids	
Yes	No	Research Chemicals	_____
Yes	No	Other _____	_____

2. The day after using any substance, have you ever experienced agitation, tremors, headache, nausea, hallucinations, skin crawling, or seizures? (Please circle those that apply.)

3. What is your <u>most</u> preferred drug? Include alcohol _____
How do you use your drug of choice? _____

Yes No 4. Have you ever awakened the morning after alcohol or drug use the night before and found that you could not remember a part of the evening before?

Yes No 5. Does your spouse (or do your parents) ever worry or complain about your alcohol or drug use?

Yes No 6. Can you stop drinking or taking drugs without a struggle after one or two drinks, hits, pills, etc?

Yes No 7. Do you ever feel bad about your use of alcohol or drugs?

Yes No 8. Do you ever try to limit your use to certain times of the day or to certain places?

Yes No 9. Are you always able to stop using or drinking when you want to?

Yes No 10. Have you ever attended a meeting of Alcoholics Anonymous (AA), NA, CA?

Yes No 11. Have you gotten into fights when using or drinking?

Yes No 12. Has using/drinking ever created problems with you and your wife, girlfriend, boyfriend, etc.?

Yes No 13. Has your spouse (or other family member) ever gone to anyone about your use of alcohol or drugs?

Yes No 14. Have you ever lost friends or girlfriends/boyfriends because of alcohol or drug use?

Yes No 15. Have you ever gotten into trouble at work because of drinking?

Yes No 16. Have you ever lost a job because of drug or alcohol use?

Yes No 17. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking or drugging, or recovering?

Yes No 18. Do you ever drink before noon, or use drugs in the a.m.?

Yes No 19. Have you ever been told that you have liver trouble? Cirrhosis, lung problems or stomach problems? Skin problems, tooth decay due to drug use?

Yes No 20. Have you ever gone to anyone for help about your use of alcohol and/or drugs?

Yes No 21. Have you ever been in a hospital because of physical injuries you suffered from alcohol and drug use?

Yes No 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where substance abuse was part of the problem?

Yes No 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drugs or alcohol played a part?

Yes No 24. Have you ever been arrested, even for a few hours, because of behavior induced by substance abuse, such as public intoxication, fighting, BUI, etc?

Yes No 25. Have you ever been arrested for driving after using alcohol?

Yes No 26. Have you ever been arrested for DUI after using drugs?

Yes No 27. Have you ever failed a drug screen at work?

Yes No 28. Have you ever used alcohol or drugs while on probation?

Yes No 29. Have you ever passed up a job because you didn't want to be drug screened?

Yes No 30. Have you ever sold drugs?

Yes No 31. Have you ever had an open case with a local DFCS agency which involved drug use?

Yes No 32. Have your children ever been removed from your home because of drugs?

Yes No 33. Have you ever had a meth lab in your home, car, storage facility, out building?

Yes No 34. Have you ever failed a drug screen as part of a DFCS investigation?

Yes No 35. Have you ever refused a drug screen which was part of a DFCS investigation?

Yes No 36. Have you ever stayed up for 24 hours or more using drugs?

Yes No 37. Have you ever "overdosed"? If so, on what? _____

What is the longest period of time that you have been under the influence? _____
If so, on what?_____?

Have you ever been administered Narcan?_____ If so, how many times?_____?

List your arrests - lifetime (include dates): _____
_____
_____
_____
_____

I understand that if I am untruthful on any part of my evaluation, the evaluation will be invalid. I may have to repeat the evaluation and pay another fee.

I understand that if I see someone I know in the office or in a group session, I will honor their confidentiality as they will honor mine.

***I understand that evaluations and counseling as part of a court ordered, court referred, or probationary program are not covered under insurance and the balance due is my responsibility to pay at the time of service.

***** I also understand that this evaluation is only valid for six months. If treatment is recommended, I must begin and complete treatment before six months of the date of my evaluation, or sooner if required by the court, counselor, or probation officer.**

_____ _____
Client Signature Date

BEHAVIOR IN SESSION

I understand that I am being referred to an introductory counseling program as part of my probation or legal situation. This program does not claim to treat underlying psychological problems or severe depression. If I have other issues, it is my responsibility to speak to my therapist about them and an additional program will be outlined for me.

_____ _____

Client's Signature Date

APPOINTMENTS AND CANCELLATIONS

Our appointments are generally 30-50 minutes. It is not our policy to "double book" appointments so our time is exclusively committed to your appointment. When an appointment is missed, own schedule is seriously disrupted as I am unable to make this time available to other clients. For this reason we require that you give me 24 hours notice of your intent to cancel or reschedule an appointment. **If you cancel an appointment without 24 hours notice, or if you miss an appointment, you will be charged for the session.** These charges are not covered by insurance and are due at the next scheduled appointment, or within two weeks of the cancellation. My signature below indicates that I have read and understand the information regarding appointments and cancellations. If you elect to pay by credit card, if the credit card is not in your name, we reserve the right to communicate with the owner of the credit card for matters of finance only.

_____ _____

Client's Signature Date

THE PRICE COUNSELING CENTER

Grace Riley Price, L.C.S.W.

RELEASE OF INFORMATION

NAME OF PATIENT: _____

The Price Counseling Center is hereby authorized to release to and/or receive from:

Name: _____

Contact Information (address, email, etc.): _____

_____

the following documents and/or information (please **initial** all that apply):

Notification of Initial Contact	_____
General Treatment Information	_____
Periodic Progress and Evaluation Reports	_____
Attendance Reports	_____
Other: _____	_____

I hereby release The Price Counseling Center from any and all liabilities, responsibilities, damages and claims which might arise from the release of the information authorized above. I acknowledge that this consent is valid for **6 months**. I further understand that I can withdraw this consent for release of information at any time prior to the expiration date by giving written notice to The Price Counseling Center.

Patient's Signature: _____ Date _____

Patient's Representative: _____ Date _____

Witnessed: _____ Date _____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

AUDIT

Client _____

Date _____

Score _____

1. How often do you have a drink containing alcohol (Score)

Never	(0)
Monthly or less	(1)
Two to four times a month	(2)
Two to three times a week	(3)
Four or more times a week	(4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	(0)
3 or 4	(1)
5 or 6	(2)
7 to 9	(3)
10 or more	(4)

3. How often do you have six or more drinks on one occasion?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	(0)
Less than monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

9. Have you or someone else been injured as a result of your drinking? (0)

No	(0)
Yes, but not in the last year	(2)
Yes, during the last year	(4)

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?

No	(0)
Yes, but not in the last year	(2)
Yes, during the last year	(4)

X

DUDIT

For each question in the chart below, please **X** in one box your answer based upon when you were actively using. Please be honest

	0	1	2	3	4	Score
1. How often do you use drugs other than alcohol?	Never	Once a month or less often	2-4 times a month	2-3 times a week	4 times a week or more	
2. Do you use more than one type of drug on the same occasion?	Never	Once a month or less often	2-4 times a month	2-3 times a week	4 times a week or more	
3. How many times do you take drugs on a typical day when you use drugs?	0	1-2	3-4	5-6	7 or more	
4. How often are you heavily influenced by drugs?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
6. Over the past year, have you have not been able to stop taking drugs once you started?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
7. How often over the past year have you taken drugs and then not done something that you should have done?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
9. How often over the past year have you had feelings of guilt or a bad conscience because you used drugs?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
	0	2	4			
10. Have you or anyone else been mentally or physically hurt because you used drugs?	No	Yes, but not over the last year.	Yes, in the last year.			
11. Has a relative or a friend, a doctor/nurse or anyone else, been worried about your drug use o said to you that you should stop using drugs?	No	Yes, but not over the last year.	Yes, in the last year.			

X

Name:_____ Date:_____

The Drug Abuse Screening Test (DAST)

Please answer the questions below honestly regarding your past drug use by circling Yes or No

Yes	No	1. Have you used drugs other than those required for medical reasons?
Yes	No	2. Have you abused prescription drugs?
Yes	No	3. Do you abuse more than one drug at a time?
Yes	No	4. Can you get through the week without using drugs (other than those required for medical reason)?
Yes	No	5. Are you always able to stop using drugs when you want to?
Yes	No	6. Do you abuse drugs on a continuous basis?
Yes	No	7. Do you try to limit your drug use to certain situations?
Yes	No	8. Have you had "blackouts" or "flashbacks" as a result of drug use?
Yes	No	9. Do you ever feel bad about your drug use?
Yes	No	10. Does your spouse (or parents) ever complain about your involvement with drugs?
Yes	No	11. Do your friends or relatives know or suspect you abuse drugs?
Yes	No	12. Has drug abuse ever created problems between you and your spouse?
Yes	No	13. Has any family member ever sought help for problems related to your drug use?
Yes	No	14. Have you ever lost friends because of your use of drugs?
Yes	No	15. Have you ever neglected your family or missed work because of your use of drugs?
Yes	No	16. Have you ever been in trouble at work because of drug abuse?
Yes	No	17. Have you ever lost a job because of drug abuse?
Yes	No	18. Have you gotten into fights when under the influence of drugs?
Yes	No	19. Have you ever been arrested because of unusual behavior while under the influence of drugs?
Yes	No	20. Have you ever been arrested for driving while under the influence of drugs?
Yes	No	21. Have you engaged in illegal activities in order to obtain drugs?
Yes	No	22. Have you ever been arrested for possession of illegal drugs?
Yes	No	23. Have you experienced withdrawal symptoms as a result of heavy drug intake?
Yes	No	24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?
Yes	No	25. Have you ever gone to anyone for help for a drug problem?
Yes	No	26. Have you ever been in a hospital for medical problems related to your drug use?
Yes	No	27. Have you ever been involved in a treatment program specifically related to drug use?
Yes	No	28. Have you been treated as an outpatient for problems related to drug abuse?

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____ hereby authorize the disclosure of records/information:

From: _____ (Name of DBHDD-approved **Clinical Evaluator** - releasing agency)

To: Dept. of Behavioral Health and Developmental Disabilities, Division of Addictive Diseases, **DUI Intervention Program**
2 Peachtree Street, Suite 22.286, Atlanta, GA 30303
FAX: 404-657-6417

_____ Initials I authorize the following information from my records (and any specific portion thereof): All results of my clinical evaluation as shown on the DUI Offender Case Presentation form, including alcohol and drug abuse information, the NEEDS assessment and any other information about my clinical evaluation requester by the DUI Intervention Program. **AND**

_____ Initials If I am a minor, my parent/guardian/court-ordered custodian and I both must initial here in order for this information to be released.

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

The above information is for the purpose of: ____*Enabling the professional staff of the DBHDD Division of Addictive Diseases, DUI Intervention Program, and its agents to review and approve the recommendation of my Clinical Evaluator.*

_____

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* ____six (6) months after the completion of my clinical evaluation which occurred on _____(date).

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.

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

_____
Signature of (check one) **Date**

☐ **Patient** ☐ **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.

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

AUTHORIZATION FOR RELEASE OF INFORMATION

X I, _____ DOB _____ hereby authorize the disclosure of records/information

From: _____
(Name of DBHDD-approved **Clinical Evaluator** - releasing agency)

To: _____
(Name of DBHDD-approved DUI Intervention Program **Treatment Provider**)

_____ (Address) (Phone/Fax)

X ____ Initials I authorize the following information from my records (and any specific portion thereof): *All results of my clinical evaluation as shown on the DUI Offender Case Presentation form, including alcohol and drug abuse information, the NEEDS assessment and any other reports, test results, or documents used by the evaluator to complete my evaluation. AND*

X ____ Initials If I am a minor, my parent/guardian/court-ordered custodian and I both must initial here in order for this information to be released.

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

The above information is for the purpose of:

____*To permit transfer of my clinical evaluation record to the DUI Intervention Program Treatment Provider of my choice, for the purpose of my treatment.*

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*

____Six (6) months after the completion of my clinical evaluation which occurred on _____ (date).

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.

X _____ **Date**

X _____ **Signature of Individual/Consumer/Patient/Applicant**

_____

_____ **Signature of (check one)** **Date**

☐**Patient** ☐**Guardian** ☐ **Court-appointed Custodian of Minor**
☐**Agent designated by Individual's Advanced 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.

_____ **Date this authorization is revoked by Individual**

_____ **Signature of Individual or legally authorized Representative**

Price Counseling Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our Commitment to Protect Your Mental Health and Medical Information

You have a right to privacy with respect to your past, present, and future mental health and medical information. Price Counseling Center is required by law to protect your information and to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information. You have the right to receive a paper copy of this Notice.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. In the event this Notice is revised, you may request a paper copy of the revised notice.

How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. In general, our use and disclosures fall within the following three categories: treatment, payment, and healthcare operations.

Treatment - We will use your protected health information and disclose it to others as necessary to provide treatment to you. For example, members of our clinical staff may access your record in the course of your care, or share information in the process of coordinating your care. Additionally, disclosure to another facility, community health center, or private practitioner may become necessary for your continued treatment, with a written or oral release of information from you.

Payment - We will use or disclose your protected health information as necessary to arrange for payment of services provided to you. For example, information about your diagnosis and the services we provide to you may be included in a bill that we sent to a third-party payer.

Healthcare Operations - We will use or disclose your protected health information in the course of operating Price Counseling Center or for the healthcare operations of another organization that has a relationship with you. Unless you instruct us otherwise, we may use and disclose information to contact you as a reminder that you have an appointment at our office.

Uses and Disclosures Requiring Your Authorization

We are generally prohibited from using or disclosing your protected health information for purposes other than treatment, payment, and health care operations without your written authorization, unless the use or disclosure is within one of the categories described below. In addition, we generally may not use or disclose psychotherapy notes written by your mental health provider without your written authorization, even for treatment, payment and healthcare operations. You have the right to revoke your authorization in writing at any time, except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures Not Requiring an Authorization

By law, we may use or disclose certain protected health information without an authorization in the following circumstances:

When required by law - We may disclose protected health information when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to certain criminal activity, or in response to a court order. We must also disclose protected health information to authorities that monitor our compliance with these privacy requirements.

Judicial and Administrative Proceedings - We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information in certain cases in response to a subpoena, discovery request, or other lawful process, subject to your notice and opportunity to object.

Law Enforcement - We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a subject, fugitive, material witness, or missing person;
- About the victim of a crime, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at Price Counseling Center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Relating to deceased individuals - We may disclose certain protected health information related to death pursuant to a valid subpoena of a coroner or medical examiner.

To avert a serious threat to health or safety - We may disclose protected health information, in order to avoid a serious threat to your health or safety and the health and safety of the public or another person.

For specific government functions - We may disclose protected health information as required by military authorities, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security and intelligence reasons, such as protection of the President.

Uses and Disclosures to Which You May Object

In the following situations, we may disclose a limited amount of your protected health information if we inform you in advance and you do not object, as long as the disclosure if not otherwise prohibited by law:

To families, friends, or others involved in your care - We may share with these people certain information directly related to their involvement in your care, or payment for your care with your permission. We may share certain protected health information with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information

You have the following rights with respect to your protected health information:

To obtain access to your protected health information - You generally have the right to see and obtain copies of your protected health information upon written request. We may deny you access to review or copy your protected health information. If your request is denied, we must provide you with a reason for the denial and explain any right to have the denial reviewed. If we grant your written request for copies of your protected health information, we will advise you in advance of any fees we may impose for the costs of copying and mailing.

To request restrictions on uses and disclosures - You have the right to ask that we limit how we use or disclose your protected health information. We will consider your request, but are not legally bound to agree to the restriction. If we do agree to any restriction, we will put the agreement in writing and abide by it except in the case of emergency situations. We cannot agree to limit uses and disclosures that are required by law.

To receive confidential communications - You have the right to request that we communicate with you by using an alternative address or by alternative means. We must agree to your request as long as it is reasonable for us to comply.

To request an amendment - If you believe that your protected health information is incorrect or incomplete, you have the right to request in writing that we amend the information. Your request must include the reason you are seeking a change. We may deny your request if (1) we did not create the information or the information is not part of our records; (2) the information is not permitted to be disclosed; or (3) the information is correct and complete. Any denial must be in writing and must state the reasons for the denial and explain your right to submit a statement of disagreement and to have your statement (and any rebuttal), along with your request and the denial, appended to your record.

ALL MULTIPLE DUI OFFENDER CLIENTS - PLEASE READ CAREFULLY

Revised October 2019

Multiple DUI offenders who get two or more DUI offenses within a 10-year period are required, as a condition of license reinstatement, to get a clinical evaluation, and if indicated by the evaluation, complete a substance abuse treatment program. These requirements, effective July 1, 2008, are in addition to all other existing requirements for license reinstatement. Under this law, the Department of Behavioral Health & Developmental Disabilities (DBHDD) is responsible for approving clinical evaluators and treatment providers and establishing regulations for implementing these requirements.

DUI RISK REDUCTION PROGRAM

- ☐ It is best that you complete the DUI Risk Reduction program (DUI School of 20 hours of classroom instruction before getting the clinical evaluation.

CLINICAL EVALUATION

- ☐ The clinical evaluation consists of a clinical interview, a review of your NEEDS Assessment results from the DUI school, and any other assessment instruments deemed appropriate by the evaluator to complete a thorough evaluation. Only an approved evaluator from the DBHDD Registry of Clinical Evaluators can complete your clinical evaluation.
- ☐ You will be given a Clinical Evaluation Agreement / Contract that informs you of the services you are entitled to as part of the evaluation process, including a free copy of your evaluation.
- ☐ If the evaluation results in a treatment recommendation, the clinical evaluator must show you a list of approved providers (DBHDD Registry of Treatment Providers).
- ☐ The evaluator can only recommend a specific level of care.
- ☐ The evaluator cannot tell you to go to a specific treatment provider.
- ☐ The evaluator cannot determine the number of weeks you have to attend treatment.
- ☐ If the evaluator determines there is no need for treatment, the evaluator will submit a case presentation to DBHDD for review.
- ☐ If approved, DBHDD will provide the client with a "Requirements Met" certificate, which can be submitted to the Department of Driver Services (DDS) for license reinstatement.

TREATMENT:

- ☐ You must choose a treatment provider from the DBHDD Registry of Treatment Providers who is permitted to deliver the ASAM level of care recommended by the clinical evaluator.
  NOTE: As part of a court order, only a judge can tell you to go to a particular treatment program.
- ☐ However, if a judge orders you to go to a treatment program not on the DBHDD Registry, completion of that treatment may not count toward driver's license reinstatement.
- ☐ DBHDD requires that Level I services include three to nine hours of treatment services per week. The length of treatment is up to one year. A treatment review occurs when 4 months has been completed. A decision will then be made for you to continue with more counseling or complete the treatment program.
- ☐ You will be given a Treatment Agreement / Contract that informs you all requirements for successful completion of the program.
- ☐ It is the responsibility of the treatment provider to determine the length of treatment and the number of hours you must attend. You may be expected to attend more than the minimum number of hours and weeks of treatment.
- ☐ The treatment program may have additional requirements to be met before you are considered as having completed treatment. Each individual treatment provider or agency determines additional services.
- ☐ Finally, you must have satisfied all fees to the treatment provider in order to receive your "Treatment Completion" form, which can be submitted to DDS for license reinstatement.

X _____ X _____

Client Signature *Date*

THE PRICE COUNSELING CENTER

Grace Riley Price, L.C.S.W.

Clinical Evaluation Contract

Anyone who gets a DUI in Georgia is required to attend DUI School, have a clinical evaluation from a State approved Clinical Evaluator, and complete any treatment recommendations with a State approved Treatment Provider. These requirements, effective 7-1-1997 and 7-1-2008, are State law. The State approved evaluators and treatment providers can be found on the web at https://dbhddapps.dbhdd.ga.gov/MOPAS/ProviderSearch/SearchDUIIPProvider.aspx Other conditions may be required for license reinstatement fees. Call the Department of Drivers Services at 678-413-8400 for information on your case.

- It is best that the client complete DUI School before having a clinical evaluation.
- The client will select a clinical evaluator from the State Registry and have the DUI School forward the NEEDS assessment to that evaluator.
- The client may select any evaluator they wish from the Registry.
- The client is entitled to a second opinion.
- The client will select a treatment provider from the State Registry. If this is not done within 60 days of the evaluation, the evaluator may conduct another evaluation.
- The client will pay the clinical evaluation fee of $125 in full at the time of service.

- The Clinical Evaluator (CE) attests that they are currently on the State Registry of approved clinical evaluators.
- The CE will complete the report within 7 business days of the completion of the interview unless waiting on documents from client.
- The CE will determine the level of treatment recommended not the place or length of treatment.
- The CE will show the client the list of State approved treatment providers on the Registry.
- The CE will forward the necessary forms and information to the selected treatment provider after the client signs the necessary release of information form.

I have read and understood the terms of this agreement. I have received a copy of the contract.

X _____ Date

Client Signature

_____

Clinical Evaluator Signature CE# Date

2920 MARIETTA HWY • STE 132 • CANTON, GA 30114 • 770-479-5501 • FAX 770-479-5502

Georgia Department of Behavioral Health & Development Disabilities Office of Addictive Diseases. DUI Intervention Program (DUIIP)	DUI Intervention Program 2 Peachtree Street NW. 22nd Floor Atlanta , GA 30303 Phone: 404-657-6433 Fax: 404-657-6417

Treatment Selection Form

Georgia law requires all DUI offenders to have a Clinical Evaluation and, if required, complete treatment at a provider of your choice. As your Clinical Evaluator, I am recommending that you complete the following ASAM level of treatment:

☐ **Level I: 6 – 12 Weeks** ☐ **Level I: 4 – 12 Months** ☐ **Level II and Above:**

The statewide providers of this level of treatment can be located on the DUI Intervention Program website http: https://gaduiintervention.dbhdd.ga.gov/home.aspx. In this general area, the Treatment Providers are listed below or attached to this page. Circle the Provider you wish to use for treatment sign & date below.

Provider/ID	Prime Solutions Certified	Service Name	Region	County	City	Contact Info
Cushing, Christy ID:2081	No	Price Counseling Center	1	CHEROKEE	Canton	Emma Price 2920 Marietta Hwy. Ste 132. Canton 30114 770-479-5501 770-479-5501
Payne, Rebecca ID:1852	No	Choice Counseling and Evaluation Services	1	CHEROKEE	Canton	Rebecca Payne 3753 Marietta Hwy, Ste 150, Canton 30114 770-594-5317 404-414-8289
Price, Emma ID:3254	No	Price Counseling Center	1	CHEROKEE	Canton	Kathy Gardynski 2920 Marietta Highway Suite 132. Canton 30114 770-479-5501 770-479-5501
Price, Grace ID:1196	No	The Price Counseling Center	1	CHEROKEE	Canton	Emma Price 2920 Marietta Hwy . Sui #132#122. Canton 30114 770-479-5501 770-479-5501
Tzortzinakis, Christina ID:3164	No	Price Counseling Center	1	CHEROKEE	Canton	Christina Tzortzinakis 2920 Marietta Hwy Suite 132. Canton 30114 770-479-5501 770-479-5501

https://dbhddapps.dbhdd.ga.gov/MOPAS/ProviderSearch/SearchDUIIPProvider.aspx

X _____ **Client Signature**

X _____ **Date**

Initial Treatment Plan

ASAM Level of treatment:

☐ L1 Short Term (6-12 wks) ☐ L1 Long Term (4-12 mo) ☐ L2 ☐ Other_____

☐ Obtain my driver's license/Permit

☐ Individual counseling

☐ Random Drug Testing

☐ Attend Support Group Sessions

☐ Complete Treatment - Completion of treatment requires full attendance and participation at all sessions, completion of initial and/or revised treatment plan, abstinence from alcohol and other impairing illicit and non-indicated medications. If medication is required, coordination of care is required. Other requirements are completion of first step, identify triggers for use, attendance at support group – one for every group attending, completion of relapse plan, and pay all required fees.

Short Term objectives:

1) Assess history and current patterns of alcohol/drug abuse.
2) Engage in ASAM level 1 treatment as directed by the legal system and comply with all requirements of the program as outlined in the treatment contract.
3) Demonstrate knowledge of what changes in attitude and behavior need to occur in order to maintain sobriety and avoid re-offending.
4) Make necessary social and environmental adjustments to maintain an ongoing sober, healthy lifestyle.
5) Make progress towards re-establishing driving privileges.
6) Demonstrate use of available resources of support and extend support system.

Long Term Goals:

1) Eliminate Driving while under the influence of mood altering substances.
2) Gain support and knowledge to make a reality-based decision about the need for abstinence, or at least for low-risk use of alcohol.
3) Self-assess honestly the negative consequences resulting from alcohol/drug abuse.
4) Learn and practice the life skills necessary to implement healthy behaviors.
5) Establish a healthy, alcohol and drug-free lifestyle, and a reliable healthy social network.
6) Work toward re-establishing driving privileges (if necessary) and avoid jeopardizing this privilege.

Client: _____ Date _____

Therapist: _____ Date_____

Contract for Treatment Services

Counseling/treatment services: You are agreeing to attend individual or group therapy at the Price Counseling Center. You are responsible for your treatment and recovery; our responsibility is to facilitate your personal program. The goal is to provide high quality health care in a manner that clearly recognizes individual needs and rights. We also recognize in order to be effective, the client and counselor must develop treatment plans and keep an open dialogue. We agree to help you meet your goals and encourage you to move forward to protect your values and health needs.

Required Fee Payment: I, _____, request the agency named above to provide professional services. I agree to pay all required fee(s): Fees are due at time of services unless otherwise arranged.

$ __30.00 per session for Level I ASAM group counseling

Treatment fees: Group sessions payments may not be more than 1 session behind. Advance payment is for minimum sessions paid for in advance. The session fee will be $30 per group session. If any alternative arrangements are made, you guarantee payment will be made in accordance to payment schedule arranged. You agree to have your wages garnished if necessary.

Rules: Persons receiving a DUI are required to attend DUI School, have a clinical evaluation from a DBH approved provider, and complete any treatment recommendations with a DBH approved treatment provider. These requirements, effective 7-1-1997 or 7-1-2008, are State law. Other conditions may be required for license reinstatement such as: ignition interlock, proof of insurance, and reinstatement fees. Call the Department of Drivers Services at 678-413-8400 for information regarding your case.

The client will select a treatment provider from the DUI Intervention Registry. The treatment provider attests that they are currently on the DBH Registry of approved treatment providers. To obtain a certificate of completion, client must complete treatment plan, required sessions, and pay full amount due. If client is absent for more than 3 times, client may be required to start the program over. If client arrives late or leaves early, this will count as an absence. If client misses a session, client will be required to make it up plus one more session. If client tests positive for non-required drugs or medication, client will be required to complete a new treatment/behavioral plan. Client will be required to attend support groups for every session of group. Clients are required to treat all members with respect. Information shared by members in the group is to remain strictly confidential. We cannot guarantee confidentiality between all members; however, all members will be asked to keep information private and within the group setting. I understand leaving treatment or being dismissed may require starting treatment over and losing my driving permit.

Confidentiality: The law protects the privacy of communications between a client and a clinical evaluator/treatment provider or counselor. In most situations, we can only release information about your treatment to others with a written authorization form that meets certain legal requirements imposed by HIPPA (Health Insurance Privacy Act of 1996). Your information will remain confidential with your provider and staff on an as needed basis for processing under strict business protocols. Your information will be transmitted and filed using electronic secure means. Electronic transmissions cannot always be guaranteed; however, secure methods and protocols will be used. The release can be voided by the client unless action has already been taken. Disclosures without your consent include: mandated reporting of physical or sexual abuse of children, threats of suicide or homicide, information necessary for supervision or consultation, client files a complaint, client files workers compensation claim, collection of fees, government agency requests information for health oversight, if court ordered by law, information released as outlined in the HIPPA Notice of Privacy Practice, and those required by law.

I have read this contract and reviewed the fee schedule. By signing this form, I understand my rights as a client at this agency and responsibilities for payment.

X Client Name: _____ Agency/Therapist _____

Signature: _____ Date_____ Signature _____ Date _____

DUI INTERVENTION PROGRAM

ALL CLIENTS

Revised October 2017

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The purpose of the Risk Reduction Program is to help people who have experienced a problem because of their use of alcohol or other drugs. Your DUI, drug possession, or other charge may not be the first time you have had a problem because of your use of alcohol or drugs. The program will teach you how to reduce your chances of having future alcohol or drug related problems.

COMPLETION OF THE DUI, ALCOHOL OR DRUG RISK REDUCTION PROGRAM

Some offenses that require completion of the DUI, Alcohol or Drug Risk Reduction Program (DUI SCHOOL) are DUI, Drug Possession, and Underage Alcohol Possession While Operating a Vehicle. Judges will sometimes order people to attend the Risk Reduction Program for other offenses. At the Risk Reduction Program you will take an assessment, and attend a 20-hour Intervention course. The results of your assessment are confidential, and will not appear on your driving record. You will learn about your assessment results during class. If you have questions, please talk to your Instructor after you begin class.

It is against the law for anyone to tell you that you have to attend a particular DUI Risk Reduction Program (DUI school). A Judge or Probation Officer may require you to bring proof that you completed the DUI School, but they cannot tell you which school you have to attend.

IF YOU HAVE RECEIVED 2 OR MORE DUI'S IN THE PAST 10 YEARS

If you have a DUI arrest after 7-1-08, the law requires persons who have received 2 or more DUI in a ten-year period to get a substance abuse clinical evaluation and if necessary, complete a treatment program in order to regain their driver's license. For arrests prior to 6-30-08, the period is five years.

IF YOU ARE FIRST TIME DUI OFFENDER

For DUI arrests after 7-1-08, all first DUI offenders are required to have a clinical evaluation and complete treatment if recommended as a standard condition of probation unless specifically waived by the judge for first offenders.

FOR ALL DUI'S

You must get a clinical evaluation before or after you complete DUI School. This clinical evaluation is different from the assessment questionnaire you completed at the Risk Reduction Program. The Evaluator is a substance abuse professional who will interview you in person. If available, he/she will have the results of your assessment survey from the DUI School to review before meeting with you. The Risk Reduction Program will provide you with the registry from the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) listing all approved Evaluators in your area. You may choose any Evaluator on the registry. After you choose an Evaluator, you will need to sign a Release of Information form and pay up to a $25.00 transfer fee so that the Risk Reduction Program can send a copy of your assessment to the Evaluator. The costs for each Evaluator are listed on the registry, and start at $110.00. Some Risk Reduction Programs may have a Clinical Evaluator available, but you are not required to get your clinical evaluation at their facility.

After completing the clinical evaluation, the Evaluator may recommend that you attend a Treatment Program. The Clinical Evaluator will make a recommendation for the level of service you need and give you a DBHDD -approved registry of treatment providers in your area. The Evaluator and the Risk Reduction Program cannot refer you to a particular Treatment Provider; that is your responsibility. In addition, you cannot receive treatment services from the person who does your clinical evaluation. If you have someone in mind for treatment, do not select that person for your clinical evaluation.

NOTE: To be eligible for driver's license reinstatement, you have to go to a Clinical Evaluator and Treatment Provider that are on the DBHDD-approved registry.

I have read the above information, or the program has read it to me. I have received a copy of this form.

X _____ _____

Student Signature Date

Georgia Department of Human Resources
Mental Health, Mental Retardation and Substance Abuse

MULTIPLE DUI OFFENDER PROGRAM

CLINICAL REFERRAL TRANSFER FORM

To:_____ **T-**_____
(Selected Treatment Provider) *(Provider ID #)*

Attached are the Case Presentation format and the release of information for clinical evaluation on the client listed below:

Client's Full Name:_____ _____
(Last, First, Middle) *(Date of Birth)*

Address:_____
(Include: City, State, Zip)

Driver's License #:_____

DHR ID#:_____ **RRP Course Completion Date:**_____
(RRP Certificate of Completion #)

Evaluator's Name:_____

Address:_____
(Include: City, State, Zip)

Telephone #: (_____)_____ **Provider ID#: C-**_____

Date Evaluation Completed:_____

ASAM Level of Treatment Referred to:

Level I: ☐	**Level II.1:** ☐	**Level II.5:** ☐
Level III.1: ☐	**Level III.3:** ☐	**Level III.5:** ☐
Level III.7: ☐	**Level IV:** ☐	**OMT:** ☐

I hereby swear (or affirm) that this clinical evaluation was conducted by the undersigned in accordance with the rules of the Department of Human Resources, Chapter 290-4-13, and Georgia law, O.C.G.A. Section 37-7-2.

_____ _____
Clinical Evaluator Signature **Date**

NOTE: Attach this original form to front of Case Presentation and include the release form and mail or fax to Treatment Provider. Place a photocopy of this form in the client's file. ***(or the original if faxed)***

Clinical Evaluation Form

Multiple

Client Name: _____ **Client RRP certificate #** _____

Client's full address: _____ **RRP Completion Date:** _____

_____

Client Phone: _____ **Client DL #** _____ **DOB:** _____

Evaluation Start Date: _____ **Completed:** _____

Clinical Evaluator's Name: _____

DBH CE Provider Number: _____ **Complete mailing address:** 2920 Marietta Hwy, Ste 122, Canton, GA 30114

___ **First Offender** ___ **Multiple Offender** ___ **Habitual Offender** ___ **3 Drug Possessions** ___ **Other** (specify)

Demographic summary: _____

_____

_____

_____

_____

_____

Legal Summary: _____

_____

_____

Past treatment summary: _____

_____

_____

Recommendations summary: _____

_____

_____

_____

DBHDD Clinical Evaluation: Client name:

Circle or check as applicable

Drug of Choice:

☐ Taking the substance in larger amounts or for longer than the you meant

☐ Wanting to cut down or stop using the substance but not managing to do so

☐ Spending a lot of time getting, using, or recovering from use of the substance

☐ Cravings and urges to use the substance

☐ Not managing to do what you should at work, home or school, because of substance use

☐ Continuing to use, even when it causes problems in relationships/school/social

☐ Giving up important social, occupational or recreational activities because of substance use

☐ Using substances again and again, even when it puts you in danger

☐ Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance

☐ Needing more of the substance to get the effect you want (Increased tolerance)

☐ Development of withdrawal symptoms, which can be relieved by taking more of the substance

☐ Early sustained remission _____ (how long)

☐ Current use is low risk ☐ Remission 1 year +

☐ Secondary drugs used in last 12 months:

More than 12 months ago:

Assessment Tool Scores/Results – interpretation in notes

☐ NEEDS Score _____

☐ MAST Score _____

☐ DAST Score _____

☐ SASSI Score _____

☐ Other Score _____

Criminal Record/number of DUI arrest/SA related:

Additional Drugs used or relevant DX:

Additional Risk Factors

☐ Criminal Record (List)

☐ Family History

☐ High BAC (Amount)

☐ More ≥ 2 DUIs lifetime with no treatment since last arrest

☐ Positive Drug Screen

☐ Hangovers

☐ Blackouts

☐ High Tolerance – drinks ≥ 4 drinks before feeling effects

☐ High Risk Driving Record (based on self-reports or MVR)

☐ Reckless driving

☐ 2 speeding tickets w/in 24 months

☐ Super-speeder

☐ Drinks High Risk amounts ≥ 3 xs ≥ 4 drinks in last 6 months

☐ Drinking with medication or with illicit drug use

☐ Less effective/Needs support to move forward with life

☐ Co-Occurring DX/Mental Health DX/Screening needed

☐ Other

Readiness to change:

Already doing	Willingness to go
☐ 12 step	☐
☐ Sponsor	☐
☐ Treatment/counseling	☐
☐ Mental Health Counseling	☐
☐ Other – provide details	☐

TX Recommendations

If any of the additional Risk Factors are noted, clinical evaluator will need to justify a release with collateral information collected and verified. This could include any of the following: MVR, BAC, criminal record, verification of behavior change from approved sources, treatment completion verification.

☐ **No Referral:**

☐ Does not meet criteria & no additional Risk Factors

☐ **Meets DSM V DX with remission ? 1 year:**

☐ Remission Verified: Abstinence, treatment, working a recovery program. Reliable sources.

☐ **Mild SUD and/or with ≥ 1 additional risk factor(s):**

☐ .5 ASAM Education: Prime for Life

☐ Short Term Level I ASAM

☐ Other:

☐ **Moderate SUD and/or ≥ 2 additional risk factors:**

☐ .5 ASAM Education: Prime for Life

☐ Short Term Level I ASAM

☐ Long Term Level I ASAM

☐ Mental Health Assessment/Counseling/Health Physical

☐ Drug Screening

☐ Other:

☐ **Severe SUD and/or ≥ 3 additional risk factors:**

☐ .5 ASAM Education: Prime for Life

☐ Long Term Level I ASAM

☐ Level _____ ASAM

☐ Mental Health Assessment/Counseling/Health Physical

☐ Drug Screening

☐ Other:

Client Assessment Criteria		Concern			Strength and Skills	Problem, Concern(s) and Priority Level
		Yes	No	Other		
1	Acute Intoxication and/or Withdrawal Potential: Assess for intoxication/withdrawal management.					
2	Biomedical Conditions and Complications: Assess/treat co-occurring, physical health, or complications.					
3	Emotional, Behavioral or Cognitive Conditions and Complications: Assess/treat co-occurring or sub-diagnostic mental conditions or through coordination of other professional services					
4	Readiness to Change: Assess stage of readiness and commitment level. Abstinence or harm reduction.					
5	Relapse, Continued Use or Continued Problem Potential. Assess level of readiness for relapse services, education or other					
6	Recovery Environment: Assess need for specific individualized family/significant other, housing financial vocational, educational legal, transportation and/or childcare services.					

Level	ASAM Criteria: Individualized, Clinically – Driven Treatment	Reason(s) for referral:
.5	Early Intervention: Assessment and education for at risk individual who do not meet diagnostic criteria for Substance use disorder. Individuals who have been making high risk choices but do not meet criteria for a higher level of care.	
1	Outpatient Services: Less than 9 hours of service per week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies. ☐ Short term ☐ Long term	
2+	Intensive Outpatient: 9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability 2.5 or greater: Refer client to a higher level of care.	

DBHDD Clinical Evaluator # Name:	Signature	Date