

ADMISSION REPORT

SAMIS # _____

Admission Date: _____ Presenting Problem: DWI DUI Other

Soc. Sec. #: _____ Drivers License #: _____ Age: _____ DOB: _____

Name: _____
Last First MIDDLE

Address: _____
Street City State Zip

Phone #: (H) _____ Phone #: (W) _____

Marital Status: M S W D Sep Sex: M F Education: (0-20, CED) Race:

Living Arrangements: Alone Family Friends Other

Employer: _____ Occupation: _____ Years: _____ Income: \$ _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Address: _____
Street City State Zip

Referral Source DDMP Monitor Parole and Probation: _____

Client Payment Agreement SAMIS

1. Before any services may be rendered to clients at Allied Counseling Group, clients are required to read and discuss with their therapist/counselor this document which includes a _____ payment contract and rules for clients who cancel, miss, or fail to pay for services. Only three (3) absences are allowed for clients attending the program longer than 12 weeks; only two (2) absences are allowed for clients attending the program 12 weeks or less. Client(s) Initials _____

2. Payment must be made in full at the contracted fee **each time services are rendered**, which begins at the time of client arrival and sign-in at the clinic for a group or individual appointment. Missed appointments will result in clients being placed on a pre-paid status only with no future appointments set until the missed appointment is paid. Clients in groups are issued receipts in payment envelopes the following week. It is the client's responsibility to maintain receipts as proof of attendance for supervising probation officers. A \$5 charge will be made to clients requesting duplicate copies of receipts. **CLIENTS WILL NOT BE ADMITTED TO GROUPS UNLESS PAYMENT FOR THAT GROUP IS MADE THAT DAY OR EVENING, OR UNLESS ANY PREVIOUS BALANCE DUE HAS BEEN PAID.** Client initials _____

3. Allied Counseling Group does offer sliding scale fees which are contracted on an individual basis between the client and his/her therapist. Proof of income and debt may be required in order to qualify for sliding scale fees. **At no time will individual counseling be offered for less than \$40 per session, nor will group sessions be offered for less than \$30 per group session** Client initials _____

4. Clients may not cancel appointments and/or group session less than 24 hours before a scheduled appointment. **Cancellations made less than 24 hours before a scheduled appointment will be charged at the contracted full fee.** Only emergencies may qualify as waiver to this requirement. The clinical director retains the right to determine on a case by case basis whether or not this requirement may be waived. An advance agreement between the client and therapist about what does and does not qualify as an emergency is recommended to prevent any misinterpretations. **If appointments must be cancelled, the client is required to make the cancellation, not a friend, or a family member, due to confidentiality law.** Client initials _____

5. A client will not be seen if not paying for group or individual appointment at the time client signs in for group or appointment. Client will be charged a cancellation fee in the event that payment is not made at the time of sign-in, and clients shall be placed on suspended status for non-payment. No future groups or appointments shall be attended until this cancellation fee is paid. Clients may then be placed on a pre-paid basis for individual appointments thereafter, upon the discretion of the clinical director. **CLIENTS ARE ALLOWED ONLY TWO SUSPENSIONS FOR NON-PAYMENT. A THIRD NON-PAYMENT SHALL RESULT IN BEING DISCHARGED FROM THE PROGRAM.** Clients placed on suspended status shall be discharged after 30 consecutive days' absence from the program per COMAR regulations, and must complete a new evaluation to be readmitted. Client initials _____

6. Payment for the evaluation is accepted as cash, money order or approved credit card Payment only. Returned checks shall result in a \$25 fee, with clients placed thereafter On a cash payment basis only. **NO THIRD PARTY CHECKS ARE ACCEPTED.**

Client(s) initials _____

8. Telephone conference time with therapists at the office will not exceed 50 minutes total time. Office telephone conferences will be billed at the agreed upon full fee. Telephone conference time with therapist at their homes may accrue up to 50 minutes at no charge; after 50 minutes' accrued time, therapists may charge one and one-half times the agreed fee per quarter hour of telephone conference time.

Client initials _____

9. No child custody matter shall be accepted until client signs the court testimony contract. Any client referred to this agency for chemical dependency evaluation and treatment and/or other psychotherapy by an attorney for a pending court case of any nature shall be required to sign the court testimony contract, with or without a subpoena from any party to the case, wherein the client agrees to pay \$100 per hour for expert witness fees, excluding travel time, travel expenses, lodging, meals and other incidental expenses required for clinical staff to attend court, including loss of wages from any other employment on the day(s) of court hearing(s). This fee shall be paid in advance to Allied Counseling and shall be held by Allied Counseling; in the event that no expert testimony is required in the client's case, all pre-paid expert testimony fees shall be refunded in full within seven (7) days of Allied Counseling receiving court documents stating that the case has been adjudicated, dropped or settled.

Client initials _____

10. No completion report for services rendered shall be issued to any client or supervisory agent Until all required service evaluations, homework, discharge summary sessions and accrued fees are paid in full.

Client initials _____

11. No client shall receive services at Allied Counseling if arriving under the influence of alcohol And/or drugs, or if verbally abusive or threat of abuse is observed. Local police shall be summoned in the event that clients refuse to render keys to personal vehicles if he/she has driven to the agency under the influence of alcohol and/or drugs. Clients shall forfeit paid fees for group and individual and family/marital sessions if the above-cited conditions are determined to be detrimental to therapy or group process.

Client initials _____

12. Unless otherwise agreed upon in advance and in writing, treatment sessions for individual And family/marital treatment are 50-minute sessions. Late arrival shall result in the client Receiving the remaining allotted time for that appointment, with no overlap into other Clients' appointments.

Client initials _____

Allied Counseling Group Rules and Regulations

This summary has been prepared in an effort to answer many standard questions which may arise during your treatment experience. Please feel free to ask the staff to clarify any point that you may not understand, or to answer any questions that may occur to you.

1. You are required to attend all regularly scheduled sessions unless an emergency situation arises which prohibits your attendance. It is your responsibility to notify our office of your pending non-attendance at least 24 hours in advance of the session to avoid being charged. We cannot acknowledge any scheduled session to a second party unless you have signed a release of information to that party. TARDINESS BY MORE THAN TEN MINUTES WILL RESULT IN YOUR BEING CHARGED FOR AN ABSENCE AS YOU WILL NOT BE ALLOWED INTO THE GROUP UNLESS YOU CONTACT US EN ROUTE TO REPORT TRAFFIC ACCIDENT OR SIGNIFICANT DELAYS THAT CAN BE CORROBORATED. BEING LATE OR ABSENT DUE TO WORK SCHEDULE PROBLEMS OR OTHER WORK-RELATED REASONS WILL NOT BE TOLERATED. IT IS YOUR RESPONSIBILITY TO ARRANGE EITHER YOUR WORK OR YOUR TREATMENT SCHEDULE TO ALLOW AMPLE TIME TO ATTEND ALL SESSIONS.

2. The treatment philosophy of Allied Counseling Group supports abstinence from all mood-altering substances except under medical supervision. You are required to remain drug/alcohol-free during your treatment experience with Allied Counseling Group that will hopefully support a drug/alcohol-free lifestyle after discharge. It has been our experience that patients cannot actively pursue resolutions to their problems while under the influence of a mood-altering substance. You must also review and sign the Random Testing Contract and abide by all conditions therein in order to remain active in this program.

3. You are required to actively participate in all phases of your treatment. This includes assisting in the development of treatment plans and after-care plans, completing homework assignments on time, and being open and honest in your disclosures. Refusing to sign your treatment plan may result in your being discharged if this conflict cannot be successfully resolved between you and the staff person writing the plan and clinical director. Refusing to participate in group discussions may also compromise your status in the program and may result in your being discharged. Any special needs, e.g. learning and other disabilities need to be made known to staff at the time of intake to more appropriately adjust your treatment plan.

4. NO DOCUMENTATION OF COMPLETION OF TREATMENT WILL BE ISSUED TO ANOTHER PARTY WITHOUT PAYMENT IN FULL OF ALL SERVICES RENDERED OR ASSESSED TO YOU AND WITHOUT COMPLETING THE SERVICE EVALUATION FORMS AND ANY OTHER OUTSTANDING ASSIGNMENTS AT THE END OF TREATMENT PROGRAM.

5. Allied Counseling Group operates on a fee-for-service basis. Some of the services you receive may be covered by your health insurance coverage. If you plan to utilize your insurance benefits, you will be

required to supply the necessary information and releases of information to accomplish this. If you do not have health insurance coverage or you choose not to utilize your benefits, you will be required to pay for services at the time they are rendered or under an alternative pre-approved plan of payment. Fee arrangements that must be renegotiated due to work layoffs or loss of employment must be done so with the director within the first 7 days' unemployment for any reason or else you will continue to be charged for each subsequent absence unless you request suspension status. If necessary, you will be suspended, with no additional charges accruing, for not more than 30 days until gainfully employed again, but you will be discharged after 30 days' absences due to state regulations. You must then seek readmission by paying for a new evaluation and any accrued unpaid balance on your account.

6. Confidentiality of patient identity and pertinent treatment information is strictly enforced. What you see and hear at Allied Counseling Group stays here.

7. Children cannot be brought to clinic or to sessions unless specifically requested by the counselor as part of treatment. No childcare is available for children and they cannot be left unsupervised by a parent or guardian.

8. Criteria regarding Involuntary Discharge are listed in the Patient Orientation Form.

9. Allied Counseling Group has a limited supply of reading materials available for your review. You will be required to sign out certain items and return them in the same condition of use. You will be assessed for any damages that occur while the material is in your possession.

10. It is your responsibility to follow through with commitments you make while in treatment. You will be given specific homework assignments and materials to do while in treatment. Failure to follow up on these objectives in your treatment plan may result in your being discharged or receiving unsuccessful status reports. It is particularly important to follow through with any and all medical treatment, psychiatric treatment and advise staff of any changes in medical status and medications, or to follow through with referrals for medical and/or psychiatric treatment or alternative treatment, e.g. inpatient treatment referrals.

11. Only 3 absences are allowed during this treatment program; others must be pre-approved by the clinical director by contacting the director at least seven days prior to requesting an absence. An un-approved absence results in discharge due to non-compliance and/or being charged for missing groups.

12. ABSOLUTELY NO SOCIALIZING OR DATING OR OUTSIDE RELATIONSHIP BETWEEN GROUP PEERS IS ALLOWED WHILE PARTICIPATING IN TREATMENT TOGETHER.

We hope that your treatment experience will be of benefit to you. We encourage feedback on our services. If you have a question regarding services rendered, you have the right to have your questions addressed. You are the important person in this treatment experience.

Signature: _____

Date: _____

Witness: _____

Date: _____

RELEASE OF INFORMATION
To Receive and Send Information

I, _____, hereby give permission to

Allied Counseling Group _____
(Name of Clinician)

TO RELEASE FROM MY FILES THE FOLLOWING INFORMATION:

- evaluation
- attendance
- recommendation _____
Extent or nature of information to be disclosed)

THIS INFORMATION IS TO BE RELEASED TO:

- Motor Vehicle Administration
- Medical Advisory Board
- Division of Parole and Probation
- Drinking Driver Monitor Program
- Other _____
(Name of agency to which disclosure is made)

THE PURPOSE OR NEED FOR SUCH DISCLOSURE IS:

- to inform of my status in treatment
- to inform of my progress in treatment
- Referral _____
(Reason for disclosure)

THIS CONSENT WILL EXPIRE:

- _____
(Date, event, or condition)

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE THEREON.

Signature of client or person authorized to give consent Date

Signature of witness Date