NEW DAY CENTER
Intervention. Counseling. Recovery.

DEMOGRAPHIC SHEET

INTAKE DATE: _____

LAST NAME: _____

FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____ WORK: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: _____

INSURANCE: _____

ID #: _____ GROUP #: _____

NAME OF SPOUSE (PARENT OR GUARDIAN): _____

(2) EMERGENCY CONTACTS (SOMEONE THAT DOES NOT LIVE WITH YOU) NAME & PHONE NUMBER

_____

_____

REFERRED BY: _____

REFERRING PHYSICIAN'S TELEPHONE: _____

FREEDOM OF CHOICE STATEMENT

We appreciate your choosing New Day Recovery Center as your Mental Health/Substance Abuse Counseling service provider. However, we want you, the client, to know that there are other agencies in our local area (suck as Ridge Hospital; Recovery Works, etc.) that provide all services provided here at New Day Recovery Center. You have the right to withdraw from our services at any time. A New Day Recovery Center staff member will do all she/he can to answer any questions and provide any referral information to the best of their ability.

Printed Name (client): _____

Signature (client): _____ Date: _____

Staff Signature: _____ Date: _____

Consent to Treatment and Recipient's Rights

Client_____

I, _____ the undersigned, hereby attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at New Day Recovery Center, hereby referred to as the Center. Further, I consent to have treatment provided by a doctor, psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Nonvoluntarily Discharge from Treatment: A client may be terminated from the Center nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by federal and/or state law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with _____.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness Date

Patients Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

YOUR RIGHTS AS A PATIENT

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records. If so, we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/legal advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

YOUR RIGHTS TO RECEIVE INFORMATION

1. Medications used in your treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to - termination of services at our clinic.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used,
5. Policy changes.

OUR ETHICAL OBLIGATIONS

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.

PATIENT'S RESPONSIBILITIES

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

WHAT TO DO IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED

If you believe that your patient rights have been violated, contact our Clinic Director, Kay Hubbard, LCSW at 2647 Regency Road, Suite 101, Lexington, KY 40503. Tel: 859.277.4357.

Financial Policy

The staff at New Day Recovery Center (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services (i.e. letter for court, etc) as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or the following charge cards: Mastercard, Visa, and American express. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account; _____ Date:_____/_____/_____

Co-responsible party: _____ Date:_____/_____/_____

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Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No

Marital Status (more than one answer may apply)

____ Single

____ Divorce in process
Length of time: _____

____ Unmarried, living together
Length of time: _____

____ Legally married
Length of time: _____

____ Separated
Length of time: _____

____ Divorced
Length of time: _____

____ Widowed
Length of time: _____

____ Annulment
Length of time: _____

Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married

____ Parents have ever been separated

____ Parents ever divorced

____ Mother remarried: Number of times: _____

____ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

Comments re: childhood development: _____

_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? ____ Yes ____ No

If Yes, describe: _____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: _____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal, child protection)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

PAST HISTORY

Traffic violations: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No
Child Protection Involvement: ____ Yes ____ No

DWI, DUI, etc.: ____ Yes ____ No
Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

EMPLOYMENT

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): _____

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

MEDICAL/PHYSICAL HEALTH

____ AIDS ____ Dizziness ____ Nose bleeds

____ Alcoholism
____ Abdominal pain
____ Abortion
____ Allergies
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bronchitis
____ Bed-wetting
____ Cancer
____ Chest pain
____ Chronic pain
____ Colds/Coughs
____ Constipation
____ Chicken pox
____ Dental problems
____ Diabetes
____ Diarrhea
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Miscarriages
____ Neurological disorders
____ Nausea
____ Pneumonia
____ Rheumatic fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet fever
____ Sinusitis
____ Smallpox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting
____ Whooping cough
____ Other (describe): _____
_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____/week	_____	____No ____Low ____Med ____High
Lunch	____/week	_____	____No ____Low ____Med ____High
Dinner	____/week	_____	____No ____Low ____Med ____High
Snacks	____/week	_____	____No ____Low ____Med ____High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam			

Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin /Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

SUBSTANCE ABUSE QUESTIONS

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: _____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Name/address of treatment providers _____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

FOR STAFF USE

Therapist's signature/credentials: _____ Date: ___/___/_____

Supervisor's comments: _____

_____ Physical exam: ____ Required ____ Not required

Supervisor's signature/credentials: _____ Date: ___/___/_____
(Certifies case assignment, level of care and need for exam)

AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

Client Name _____ Address _____
City, St, Zip _____ Phone _____
DOB _____ SSN _____

I, _____ hereby give permission to New Day Recovery Center, or any clinician performing services on behalf of New Day Recovery Center in connection with my treatment to:

_____ Disclose Information to AND/OR _____ Obtain Information from

_____ _____
Name of agency, physician, attorney Name of agency, physician, attorney

_____ _____
Address, city, state, and zip code Address, city, state, and zip code

_____ _____
Phone _____ Phone _____

_____ MY ENTIRE RECORD; OR
_____ ONLY THE FOLLOWING INFORMATION (PT. MUST INITIAL EACH ITEM TO BE RELEASED)

_____ ATTENDANCE INFO _____ GENERAL PROGRESS
_____ TREATMENT RECS _____ LEVEL OF RISK TO SELF OF OTHERS INFO
_____ EXPECTED TX LENGTH _____ TREATMENT PLAN
_____ SUBST. ABUSE EVAL RESULTS _____ DIAGNOSIS/ASSESSMENT
---------- OTHER (SPECIFY) _____

FORM IN WHICH INFORMATION SHOULD BE RELEASED: _____ VERBAL
_____ WRITTEN
_____ OTHER

The purpose of this disclosure is:
_____ to permit continuity of care.
_____ to permit case management (including reimbursement determinations) and processing of benefit claims.
_____ Other (specify) _____

The timeframe within which this release of information is applicable is from _____ to _____.
The undersigned hereby authorizes and gives this consent voluntarily. I understand that I have a right to inspect the information be released as permitted under the Privacy Rules. I also understand that the provision of the services is not contingent on my decision concerning this release of information, unless I am receiving treatment/services solely for the purpose of creating information for disclosure to a third party or if I am receiving research related treatment.
I understand that New Day Recovery Center cannot guarantee that the Recipient will not re-disclose my health information to a third party. The recipient may not be subject to federal laws governing privacy of health information.

_____ _____
Signature of Client/Custodial Parent/Legal Guard Signature of Witness

_____ _____
Relationship (if applicable) Date

I understand that I may revoke this Authorization in writing at any time. To revoke this authorization, please sign.

_____ _____
Signature of Client/Custodial Parent/Legal Guard Signature of Witness
Date _____

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Case Management Checklist

Case management is an important part of recovery treatment. Through case management, we can provide you with assistance with a variety of things to help you as you work your recovery. Our Case Managers serve as advocates to provide resources within the community.

If you would like information on, or currently need assistance with, any of the following, please let us know.

Please check the areas you may be interested in:

- ❑ Housing
- ❑ Transportation
- ❑ Food
- ❑ Clothing
- ❑ Child custody issues
- ❑ Employment
- ❑ Legal problems
- ❑ Medical care
- ❑ Dental care
- ❑ Education assistance
- ❑ Financial issues
- ❑ Medication
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Client Name: _____

Date: _____

For Administrative Use:

Authorization number: _____

Case Manager: _____

Appointment Date/Time: _____