(Please Print)

TODAY'S DATE:

PATIENT INFORMATION

Patient's Last name:	First:	M. I.	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Contact Email Address: Can we contact you by this address: ❑ Yes ❑ No	Birth Date: / /	Age:	Gender: ❑ M ❑ F

Street Address:	Social Security #: -- --	Home #: ( ) -- -- Cell #: ( ) -- --

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #:

Referred by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Web site	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Is this person a patient here?	❑ Yes	❑ No		

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.: - -	Birth date: / /	Group #:	Policy #:	Co-payment: $ .00

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )- -	Work phone no.: ( )- -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Recovery Center & or My Insurance Company to release any information required to process my claims.

Patient/Guardian signature:	***Date:***

Coastal Recovery Center

CONFIDENTIALITY OF CLIENT RECORDS

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by ***Costal Recovery Ctr..*** (**42U.S.C. 290dd-3 and 42 U.S.C. 290ee for Federal laws and 42CRF Part 2)** for Federal regulations: approved by the Office of Management and Budget under Control No. o930-0099.) Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuse client unless: (1) the client 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 laws and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal laws and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under South Carolina State law to appropriate State or local authorities.

PATIENT BILL of RIGHTS

Coastal Recovery Center takes pride in its ability to provide the best quality of services to its clients in the community of Horry County. When you receive services from the staff of ***Coastal Recovery Ctr***. your rights are protected. You also have certain responsibilities associated with the use of these services.

1. You have **the right** to receive services suited to your needs and you consent to treatment.
   1a. You have **the responsibility** to provide accurate information about your needs and your ability to pay for services.
2. You have **the right** to receive services that respect your dignity and protect your health and safety and for your records to be maintained with adequate safeguards in accordance with State and Federal regulations.
   2a. You have **the responsibility** to respect the dignity, health and safety of others, to comply with ***Coastal Recovery Ctr.*** program rules established to protect the dignity, health and safety of its clients, visitors, and staff and to cooperate with tests of this facility's emergency plans.
   2b. You have **the responsibility** to comply with contraband control policies that apply to this facility where you receive services. ***Coastal Recovery Ctr***. prohibits the presence of certain items or materials, which are defined as contraband.
   2c. Contraband is defined as alcoholic beverages, illicit drugs, potential weapons, and other items or materials that are potentially harmful or offensive to others.
3. You have **the right** to an individualized treatment plan and the right to participate in planning the services you request and need.
   3a. You have **the responsibility** to work on your service plan goals and objectives to the best of your ability.
4. You have **the right** to refuse services, unless a physician or a licensed psychologist feels refusal is unsafe for you or others; you have freedom from abuse, neglect and exploitation.
   4a. You have **the responsibility** to use the services needed.
5. You have **the right** to receive prompt services.
   5a. You have **the responsibility** to pay for services received at the time of the service delivery.
6. You have **the right** to receive services on a confidential basis and review your record with the approval and assistance of the ***Medical Director of Coastal Recovery***. You have **the right** to privacy in visits unless contraindicated in the recovery and treatment process or as ordered by a physician or other authorized healthcare provider.
   6a. You have **the responsibility** for making reasonable requests to review, obtain copies, and request amendment of your records, and for making appropriate use of the information contained in your records.
7. You have **the right** to exercise all civil, political, personal, and property rights to which you are entitled as a citizen of the State of South Carolina and the United States of America.
   7a. You have **the responsibility** to respect the rights of others to include not only their privacy, but, property as well.
8. You have **the right** to file a complaint, without incurring any retaliation by contacting our HIPPA Compliance Officer, Mr. William Mobley, Executive Director, at ***Coastal Recovery Center***, 1113 44th Avenue North, Suite 100, Myrtle Beach, SC 29577, Phone#: (843) 449-6261.
   8a. You have **the responsibility** for attempting to resolve complaints directly with the person involved.
   If your complaint is not resolved to your satisfaction you can contact:
   Bureau of Health Facilities Licensing, SC DHEC, 2600 Bull Street, Columbia SC 29201-1708. Phone#: (803) 898-3432.

Patient Signature & Date: _____ CRC Representative:_____

Coastal Recovery Center

Consent for Treatment

1. I _____have been fully informed of my rights as a client of ***Coastal Recovery Center***, the extent and limits of Confidentiality in Counseling and the goals associated with this Counseling. With that knowledge, I request and consent to receive Treatment from qualified personnel of *Coastal Recovery Center*. Initials: _____

2. I understand that the staff of *Coastal Recovery Center* may not disclose information about my Treatment to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my Treatment to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. Initials: _____

3. I understand that my Counselor will work with me at 1113 44th Avenue North, Suite 100, Myrtle Beach SC.29577. I further understand that my therapy will involve my participation in Medical assessment/monitoring, individual, family, and group counseling, and may involve homework assignments for me to do outside of Counseling sessions. I agree to participate actively in my Counseling, to cooperate with Dr. Graham in the management of my health and Counselor, to complete required assignments or other activities included in my therapy. Initials: _____

4. I understand that when I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group. Initials: _____

5. I understand that my therapy will include my attendance at meetings of independent self-help support groups such as *Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery* and/or other programs. I agree to participate in such programs and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants. Initials: _____

Client Signature: _____ Date: _____

CRC Representative :_____ Date: _____

Consent for the Release of Confidential Information

Client Name: _____ ID#: _____

I, _____ , authorize
(name of client)

Coastal Recovery Center
(name of program making the disclosure)

to disclose to

_____
(Person or organization to whom disclosure is to be made: **Emergency Contact Name and Phone #**)

the following information: Emergency Information ONLY
(nature of information)

Purpose of the disclosure is to: Inform Contact of Patient Ambulatory/Medical/Emergency
(purpose of disclosure)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and drug Abuse Patient Records,42C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

One (1) Year From Date Signed

I understand that, generally, this agency may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Client Signature	Date
CRC Representative Signature	Date

Revocation of Consent

Client Signature	Date

Coastal Recovery Center

Payment for Services Agreement

I, _____, request that Coastal Recovery Center provide professional services to me.

FEES SET AT 100% FOR SERVICE AS FOLLOWS

$175.00 per session for Physician Evaluation

$100.00-$140.00 per Follow Up session with the Physician (varies with time)

$100.00 per session for Clinical Evaluation Psychosocial

$100.00 per session for Individual Counseling

$117.00 per day for Intensive Outpatient Group Counseling (also see sliding fee schedule (in office))

$100.00 per Family session

$45.00 per Drug Screen $7.00 Alcohol Breath Screening

I agree that I am responsible for the charges for services provided by Coastal Recovery Center to me, although 3rd party and insurance carriers may make payments on my account. I understand full-fees for services are generally due at time of services.

Initial_____

I further guarantee that charges for services provided will be paid upon receipt of billing statements from Coastal Recovery Center and that any balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, I guarantee that payment will be made in compliance with those arrangements.

Initial_____

I understand that Coastal Recovery Center cannot guarantee payments from 3rd party payers and is not responsible for collection of such payments from insurance or 3rd party payers.

Initial_____

I have read the "Client's Rights" form and reviewed the fee schedule. In signing this form, I understand my rights as a client at this agency and my responsibilities for payment.

Client Signature:_____ Date:____/____/_____

Coastal Recovery Representative:_____ Date:____/____/_____

Coastal Recovery Center

Health Information Form

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Name:_____ Birth Date: ____/____/____

Do you have a Primary Care Physician?: Yes____ No____
If yes please name:_____

List any health problems or concerns you now have:_____
_____
_____
How would you describe your general health at this time?
____Excellent, ____Good, ____Fair, ____Poor
When and where was your most recent physical exam?
_____
_____
Did the results show that you had any medical problems at that time?____Yes _____No
If yes, what were they?_____
_____
_____
Please list any times you have been hospitalized or had surgery:
_____
_____
_____
Please list other major illnesses or injuries you have had, especially injuries to head/neck/spine:
_____
_____
_____
Please list any current medications and also any medications you have taken in the past year (either prescribed or over the counter) and the reasons you are or were taking them:

Type of medication:	Reason taken:	Any complications or side effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you now have, or have you ever had seizures or convulsions? _____Yes _____No
If yes, when and what condition caused them?_____
_____
_____
Do you have any allergies? _____Yes _____No If yes, what are they?_____
_____
_____

Please describe your family history of illness or diseases (any major illness experienced by a parent or sibling and any illness that seems to run in your family):

Who Type of Illness:

_____
_____
_____
_____
_____
_____

FOR WOMEN ONLY:

At what age did you start to menstruate?_____
Do you now have, or have you had any problems with your menstrual period?_____
If yes, please describe these problems:_____
_____
_____

Have you had any of the following?
Pregnancies? _____Yes _____No If yes, how many?_____
What was you age at your last pregnancy? _____
Miscarriages? _____Yes _____No If yes, how many?_____
What was your age at your last miscarriage?_____
Abortions? _____Yes _____No If yes, how many?_____
When was your age at your last abortion?_____
Menopausal symptoms or treatment? _____Yes _____No
If yes, when?_____
_____
_____

FOR MEN ONLY:

Do you now have, or have had problems with your prostate, difficult or painful urination, or impotence? _____Yes _____No
If yes, please describe these problems:_____
_____
_____

Lifestyle / Health Habits:
On average, how many hours of sleep do you get?_____
Do you have problems with sleep? _____Yes _____No
If yes, what kind of sleep problems do you have?_____
_____
_____
Do you exercise regularly? _____Yes _____No
If yes, what type of exercise?_____
_____

Have you recently gained or lost a significant amount of weight (for most adults, more than 20 pounds in 6 months --- If you are smaller than average, a lesser amount may be significant to you)?_____
If yes, please describe this weight gain/loss and what you believe is the reason:
_____
_____
_____
_____
How much coffee, tea, cola, or other substance containing caffeine do you consume each day?
_____None _____Very Little _____Moderate Amount _____Heavy Use

_____

Patient's Signature:

_____

The above is true and correct to the best of my belief.

Please indicate which of the following substances you have used in your history.

Alcohol _____
(Beer, Wine, Vodka etc.) Age of 1st use / How often used / How much used / Method of use / Last use

Amphetamine_____
_
(Diet Pills, etc) Age of 1st use / How often used / How much used / Method of use / Last use

Methamphetamine_____
(Ice, Crystal) Age of 1st use / How often used / How much used / Method of use / Last use

Barbiturates _____
(Nembutal, Phenobarb, etc) Age of 1st use / How often used / How much used / Method of use / Last use

Benzodiazepines _____
(Klonipin, Xanax, etc.) Age of 1st use / How often used / How much used / Method of use / Last use

Cocaine _____
(Powder, Injection, Crack) Age of 1st use / How often used / How much used / Method of use / Last use

Hallucinogens _____
(LSD, Ecstasy, etc) Age of 1st use / How often used / How much used / Method of use / Last use

Opiates _____
(Heroin, Morphine) Age of 1st use / How often used / How much used / Method of use / Last use

Rx Opioids _____
(Oxy, Lortab,Vicoden**)** Age of 1st use / How often used / How much used / Method of use / Last use

Inhalants _____
Age of 1st use / How often used / How much used / Method of use / Last use

Marijuana _____
Age of 1st use / How often used / How much used / Method of use / Last use

Tobacco _____
(Smoke, Chew, etc) Age of 1st use / How often used / How much used / Method of use / Last use

Steroids _____
Age of 1st use / How often used / How much used / Method of use / Last use

Other _____
Age of 1st use / How often used / How much used / Method of use / Last use

Client signature _____ **Date**_____

Consequences

Name:_____

Please identify the negative consequences you have experienced related to your alcohol, drug or compulsive behavior.

___ Spent money on drinking/using that you needed for something else

___ Been embarrassed by what you did while under the influence

___ Gotten sick and thrown up in public

___ Driven while under the influence

___ Experienced physical withdrawal

___ Experienced increased tolerance

___ Drunk/used more than you meant to

___ Been asked to quit by others

___ Lied about your drinking/drug use

___ Experienced an overdose

___ Gone to work under the influence

___ Embarrassed members of your family

___ Passed out due to drinking/using

___ Experienced blackouts (memory gaps)

___ Been arrested for DUI/DWI

___ Lost a job due to drinking/using

___ Alienated yourself from friends/ relatives

___ Been divorced due to drinking/using

___ Gotten in a fight while under the influence

___ Had a car accident while drinking/using

___ Hurt someone else due to drinking/ using

___ Hoarded alcohol or other drugs

___ Gotten hurt in a sports/recreational accident while drinking/using

___ Been unfaithful to your partner while drinking/using

___ Hidden your alcohol or other drugs from family or friends

___ Sold or traded possessions to get alcohol or other drugs

___ Avoided an activity because it interfered with drinking/using

___ Committed a crime while drinking/ using

___ Committed a crime to get alcohol or another drug

___ Been in jail or prison due to drinking/using

___ Traded sex for alcohol or drugs

___ Sold illegal drugs to buy more

___ Considered suicide while drinking/ using or due to consequences of drinking/using

___ Attempted suicide while drinking/ using

___ Accidentally killed someone while drinking/using

___ Intentionally killed someone while drinking/using