Community Intervention & Educational Services Home of The COOL Program

DWI / DUI

1225 EAST 5TH STREET, WS NC 27101 | 336-776-0322

DWI/DUI PARTICIPANT SIGN-IN SHEET

Start Date: _____ Group _____ Time: _____

Client Name: _____ Phone: _____

Email Address: _____

☐ BAC ☐ No Diagnoses ☐ Active Diagnoses ☐ Remission _____

☐ PO ☐ CS ☐ DSS ☐ Attorney Name: _____

	Date of Session	Present / Absent	Amount Paid	Assignment Completed	Staff Initials
Assess. / ADETS		☐ Yes ☐ No			
1 (1.5 hours)		☐ Yes ☐ No			
2 (3 hours)		☐ Yes ☐ No			
3 (4.5 hours)		☐ Yes ☐ No			
4 (6 hours)		☐ Yes ☐ No			
5 (7.5 hours)		☐ Yes ☐ No			
6 (9 hours)		☐ Yes ☐ No			
7 (10.5 hours)		☐ Yes ☐ No			
8 (12hours)		☐ Yes ☐ No			
9 (13.5 hours)		☐ Yes ☐ No			
10 (15 hours)		☐ Yes ☐ No			
11 (16.5 hours)		☐ Yes ☐ No			
12 (18 hours)		☐ Yes ☐ No			
13 (19.5 hours)		☐ Yes ☐ No			
14 (21 hours)		☐ Yes ☐ No			
15 (22.5 hours)		☐ Yes ☐ No			
16 (24 hours)		☐ Yes ☐ No			
17 (25.5 hours)		☐ Yes ☐ No			
18 (27 hours)		☐ Yes ☐ No			
19 (28.5 hours)		☐ Yes ☐ No			
20 (30 hours)		☐ Yes ☐ No			

Program Requirement = Assessment / ADETS + Sessions Needed: _____

Program Name: DWI / DUI / SUBSTANCE Assessing Clinical Name: _____

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DUI CLASS RULES

Today's Date:_____ **YOUR COPY!!** *(Give to client)*

1. Must complete the required sessions of_____. **STATE RULES! NOT OURS!**
2. Only allowed to miss 3 Sessions (Please use this wisely!). **ALL SESSIONS MISSED MUST BE MADE UP.**
3. You have to complete at least one session a week Monday or Wednesday.
4. Please arrive at least 10 minutes prior to class time. If you arrive late, you will not be allowed to attend the group and will be marked absent.
5. Assessment fee is **$100. (It is non-refundable)**
6. **Driving record $10.75**
7. You must be caught up on payments before continuing to attend the group.
   We accept CASH, CREDIT/DEBIT, CHECK, SQUARE (sent weekly through email or text)
8. Each class lasts one hour and 30 minutes. **You must stay for the entire class.**
9. Cell phones must be turned off and put away. **NO TEXTING.**
10. Be respectful to staff and other participants.
11. Remember confidentiality! Anything said or done in class must stay in class!
12. ANY INDIVIDUAL CONVERSATIONS BETWEEN STAFF AND YOURSELF, DO NOT NEED TO BE SHARED WITH OTHERS IN THE GROUP!
13. If you have technical issues please contact 336-682-2331.

Main Office Line: 336-776-0322

Website www.ciescoolprogram.com

ADETS

16 hours	$160 + $25 WORKBOOK
20–29 hours	$400
30–40 hours or more	$800

Group Day(s): _____ Start Date: _____

Time: _____

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DWI- RELATED CLINICAL ASSESSMENT
DEMOGRAPHICS

Name: _____ Age: _____ Race: _____ Gender: _____

Marital Status (check): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Highest Grade Level of Education Completed (check)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Associates ☐ Bachelors or higher

Are you employed ☐ Yes ☐ No

Referral Source (Name/Contact info): _____

_____

Circumstances around DWI: _____

_____

_____

CURRENT LIVING SITUATION

Who lives with you? (check all that apply) ☐ Family ☐ Friends ☐ Partner ☐ Roommate

Are the people you live with demonstrating positive changes and are they a good support system? ☐ Yes ☐ No

Briefly explain _____

Do you feel safe where you live? ☐ Yes ☐ No

Do you have any issues with transportation? ☐ Yes ☐ No

Do you have issues with childcare? ☐ Yes ☐ No

Do you have any religious affiliations? ☐ Yes ☐ No

Are you homeless or in danger of becoming homeless? ☐ Yes ☐ No

ADDICTIVE BEHAVIORS

Have you used Alcohol? ☐ Yes ☐ No

When was the last time? ☐ Today ☐ Yesterday ☐ Last week ☐ A month ago ☐ Other; when? _____

Types of substance used now or in the past (check all that apply)

☐ Marijuana ☐ Cocaine ☐ Crack Cocaine ☐ Alcohol ☐ Meth ☐ Speed ☐ Painkillers ☐ Other: _____

Briefly explain how long, and when you started using? _____

_____

How has using this substance(s) affected your work, family, and friends, relationship? _____

_____

Do you have or have had a problem with gambling? ☐ Yes ☐ No

If yes, since when and how long? _____

How has gambling affected your financial situation? _____

_____

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MILITARY HISTORY

Have you ever served in the military? ☐ Yes ☐ No

How long and when discharged? _____

Did you suffer any trauma due to your military experience? ☐ Yes ☐ No

LEGAL HISTORY

What are your current charges? _____

Have you been arrested before? ☐ Yes ☐ No

If yes, please explain (convictions, arrests, citations) _____

_____

_____

_____

MENTAL HEALTH HISTORY

Do you have a past mental health diagnosis? ☐ Yes ☐ No (If applicable, check all that apply)

☐ Depression AND Anxiety ☐ Audiovisual Hallucinations ☐ Delusions ☐ Intellectual, Cognitive or Developmental delays ☐ Physical, Emotional or Sexual abuse ☐ Other _____

Are you currently being treated for such diagnoses? ☐ Yes ☐ No

Are you planning to hurt yourself? ☐ Yes ☐ No Are you planning to hurt someone else? ☐ Yes ☐ No

PHYSICAL HEALTH

Do you have any of the following health conditions? ☐ Broken bones ☐ Head Injuries ☐ Allergies ☐ Diabetes ☐ High blood pressure ☐ Pancreatitis ☐ Liver Disease ☐ Cancer ☐ HIV ☐ TB ☐ Function Impairment

Are you taking any Medications? ☐ Yes ☐ No

If so, list the name & dosage:

Name:	Dosage:

Clinician notes and recommendations (include level of care education/treatment recommendations AA/NA, other mutual help. Psychiatric services, vocational rehabilitation, health department of, social services, primary care, problem gambling hotline 1-877-718-5543.)

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ACUTE INTOXICATION/WITHDRAWAL AND RELAPSE, CONTINUED USE OR PROBLEM POTENTIAL

Complete Substance Use History:

Thorough history for all substances (check all that apply)

☐ Alcohol ☐ Nicotine ☐ Illicit (☐ Heroin ☐ Marijuana ☐ Meth ☐ Cocaine ☐ Crack Cocaine ☐ Hallucinogens AND Inhalants)

☐ Over-the-Counter ☐ Prescribed ☐ Other:

Pattern(s) of Substance Use:

☐ First use

☐ Regular use

☐ Binging

When in the last 12 months: _____

Typical amount/frequency: _____

Maximum amount used: _____

Last date used and amount: _____

Perceived problem(s) with use: _____

Current level of risk for intoxication or withdrawal: _____

Eye Openers:

Physical discomfort from use/not using/withdrawal (CIWA.COWS): _____

_____

Any high risk behaviors that may interfere with your recovery? (i.e. problems gambling) ☐ Yes ☐ No

If yes list: _____

What influences your substance use? _____

_____

_____

What are the negative consequences related to your use? _____

_____

_____

SUBSTANCE USE EDUCATION, TREATMENT, AND RELAPSE HISTORY

Substance use education ☐ Yes ☐ No

If yes, list name of program and date/year: _____

_____

Interventions or treatments? (obtain the release forms when applicable) ☐ Yes ☐ No

If yes: _____

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List Interventions/treatments (Include dates, agency name, level of care, & outcome(s))

_____

_____

Problem gambling education? ☐ Yes ☐ No

If yes, list name and date: _____

Any periods without symptoms/reduction of use? ☐ Yes ☐ No List when: _____

Periods of Sobriety? ☐ Yes ☐ No If yes, Include duration, motivation(s), and reason(s) for continued use. Also include relapse triggers – history and severity _____

_____

_____

I have filled out this assessment with Community Intervention. I state that everything filled out by me is true to the best of my knowledge

Client Print: _____ Client Signiture_____

Staff Print: _____ Staff Signiture_____

Clinician Notes and recommendations:

Barriers to treatment?_____

Barriers: _____

Strengths: _____

Needs:_____

Abilities: _____

Preferences: _____

Additional Notes:_____

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YOUR INFORMATION

Name:_____ Date of birth:_____ Age:_____

Address: _____ Apt#: _____ Driver's License: _____

City: _____ Social Security #: _____

State:_____ Zip:_____

Race (check): ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Multi Racial ☐ Native American

Cell phone #: _____ Work phone #: _____

Employer: _____ Employer phone #: _____

Person to contact for emergency: _____

Relationship to you: _____ Phone #: _____

Referral Source: (check) ☐ Criminal Court ☐ Civil Court ☐ Probation/Parole ☐ DSS ☐ Voluntary ☐ Other

County: (check) ☐ Forsyth ☐ Davie ☐ Davidson ☐ Guilford ☐ Montgomery ☐ Stokes ☐ Surry ☐ Other

Probation: (check) ☐ Supervised ☐ Unsupervised ☐ PJC ☐ Deferred Prosecution ☐ Not Applicable

Probation/Court Officer:_____ DSS Case Worker: _____

Email Address: _____

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FINANCIAL RESPOSIBILITY

I understand that if I carry a balance greater then $100 I will not be allowed to continue classes until my account is caught up. _____

I understand I have the option to have an automatic draft from my account through Square. _____

I understand that I will not receive a certificate and or no papers will be filed on my behalf with the DMV until I pay off my entire balance. _____

I understand that payments must be made weekly or every two weeks according to my work schedule. _____

Payments will go as follows:

30 hours or more	$80 a week	or	$160 every 2 weeks	for 10 weeks total
20 hours	$66.67 a week	or	$133.34 every 2 weeks	for 6 weeks total
16 hours	$37 a week	or	$74.00 every 2 weeks	for 5 weeks total

Client Signature:_____

Staff Signature: _____

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DMV REQUIREMENTS

I understand upon completion of the number of sessions required of me that the North Carolina Department of Vehicles will only accept 508 forms 30 day after the first day I start the program regardless of how soon I finish. This information has been explained to me by CIES Staff. _____

Time Frame for DMV to process: Once we have submitted the information over to the DMV, which is right after you finish paying and completing the group. DMV has been behind and there are only two people processing all of the 508 for the state. As we know the environment in the world has changed and so we have to wait longer for things. We will do our best to get the applications sent to them, but please know once we submit it to them, its up to them on how fast they process, usually two to three weeks. _____

Client Signature:_____

Date: _____

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NOTICE OF PRIVACY POLICIES AND COMMUNICATIONS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Community Intervention & Educational Services discloses patient information relating to treatment, payment, and health care operations. This information is shared with other health care providers, insurance companies, managed care companies, and other professionals.

Your health care information may be used to obtain an explanation of your health benefits and to obtain authorization to continue treatment. Insurance/managed care companies receive treatment reports and clinical information upon request. Patient information may be disclosed for utilization reviews and for quality assurances.

Patient information is exchanged among health care providers. For example, patient information regarding diagnosis, symptoms, treatment recommendations, medication, family history, medical conditions, drug or alcohol use, and other clinical information provided by the patient is discussed among the clinician, medical doctor, psychologist, and/or other health care professionals who are involved in the patient's treatment.

GIES may call your home or work to discuss treatment or scheduling of appointments. We may leave a message on your answering machine to remind you of your appointment or request that you return our call. The clinician's name, phone number, the office of affiliation, and the time of your appointment may be left on the answering machine. If any individual other than you answer the home telephone, the information will be given to that individual. If we call your work and you are not the individual taking the call, we will state the name of our company and our phone number to the individual answering the phone and request that you return our call.

Federal and state laws obligate CIES to protect and safeguard all patient information. Protected health information consists of but is not limited to client's name, address, phone number, and medical treatment information. The law states that our clients have the right to confidentiality, and therefore, we are obligated to ensure that their protected health information remains private and confidential. If you become aware of the inappropriate disclosure of your or another client's protected health information, please report the disclosure to Community Intervention & Educational Services, LLC

Upon request you may receive an accounting of all disclosures regarding your health care information. You have the right to place restrictions on the patient information that is released by CCI. Furthermore, CIES is required to maintain a designated record set, which includes patient medical information and billing information. You have the right to inspect, copy, and amend the patient health care information maintained in your designated record set. In order to inspect, copy, amend, or request restrictions on our health care information, please call your clinician at our office at 336-768-2331.

There are exceptions regarding your right to amend, copy, inspect, and restrict the release of protected health information. Information that is accurate and complete cannot be amended. Documents that are not created by GIES may not be amended, copied, or inspected. Documents that are included in litigation may not be inspected, copied, amended, or restricted from release. Psychotherapy notes are not a part of the designated record set and, therefore, are excluded. Furthermore, other states, federal, or governmental laws may overrule your right to inspect, amend, and restrict the release of your protected health information.

Signature of Client/Guardian:_____ Date:_____

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EDUCATIONAL SERVICES: STATEMENT OF CLIENTS' RIGHTS

Community Intervention & Educational Services provides services to all clients without regard to **race, color, religion, national origin, gender, sexual orientation, age, disability, veteran status, or any other discriminatory factor** recognized by law.

When you receive services from Community Intervention you also have certain rights. Listed below is a summary of those rights. If you would like more detailed information about these rights, please ask your primary service provider. At Eliza's Helping Hands and Community Intervention, we strive to provide the highest quality of services possible while striving to protect and enhance the rights and quality of life of all of our clients.

You have the right to know the basic expectations for use of the organization's services.
The main offices of Community Intervention & Educational Services are located at
1225 East 5th Street Winston-Salem, NC and are open

Monday & Wednesday from 8 a.m. to 5 p.m.
Tuesday through Thursday from 9 a.m. to 7:30 p.m.
Friday from 8 a.m. to 1 p.m.
Saturday 8:30 a.m. to 1 p.m.

You will be given written information explaining the various services that we offer, the specific locations and hours of operation for each service, and the expectations required to receive those services. You will also be notified in writing of any rules, behavioral expectations, and other factors that could result in discharge or termination of services. Termination of services may result if you violate one or more of the conditions as specified in your individual service agreement.

You have the right to a treatment plan or a plan for your services. You have the right to participate in the development of your plan. A written plan of services or treatment, based on your individual needs, must be implemented within 30 days of admission to services. For Medicaid recipients of mental health services, a treatment plan will be developed upon admission to services.

You have the right to refuse services or treatment. You have the right to consent to treatment or services and may withdraw your consent at any time. If you refuse a recommended service, treatment, or medication, the organization will attempt to inform you of the consequences for such refusal. The only time that you can be treated without your consent is in an emergency situation, when it has been court-ordered, or if you are a minor and your parent or guardian has given consent.

You have the right to confidentiality. Unless the law requires it, your records and other infonnation about you will not be released without your written pennission (or if you are a minor, the written permission of your parent or legal guardian). Circumstances under which we may be required by law to share information with another about the services you receive include:

- If you give written permission we may share information with any person or agency you name.
- If we believe that you are an imminent danger to yourself or to others, or if we believe you are likely to commit a crime, we may share information with law enforcement and with threatened individuals.
- The court may order us to release your records without your permission.
- If we suspect that you have neglected or abused a child or dependent adult, or you are being investigated for child abuse or neglect, we are required by law to share information with county protective services officials.
- If you are HIV positive and we are aware that you are not following proper control measures, we are required to report this to agents charged with the protection of public health.
- Our attorney may need to see your file because of legal proceedings.

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COMMUNITY INTERVENTION ACKNOWLEDGEMENT OF RECEIPT OF WRITTEN STATEMENT OF CLIENTS' RIGHTS

I have received and reviewed a copy of Community Intervention & Educational Services Inc Services Statement of Clients' Rights explaining my rights.

Client Name (please print): _____

Client Signature: _____ Date: _____
(OR LEGAL GUARDIAN IF A MINOR)

Staff (print): _____

Staff Signature: _____ Date: _____

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TWO WAY CONSENT FOR RELEASE

Information to be released by:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

Information to be released to:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

☐ I also give my permission for the exchange of information (oral and/or written) between the above named agencies/schools/persons.

Print Name: _____

Signature of Participant: _____ Date: _____

CIES Caseworker Name (print): _____

CIES Caseworker Name (signature): _____ Date: _____

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SERVICE AGREEMENT

Reinstatement of Driver's License

To have your license reinstated, you must obtain a certificate of completion by:

A. Completing a substance abuse assessment at an authorized NC DWI Services provider; and

B. Completing the recommended level of treatment or education at an authorized NC DWI Services provider.

Provider Choice:

____ I understand that I have the right to choose to complete my recommended level of substance abuse treatment or education at **any** authorized NC DWI Services provider.

The following resources are available to assist you in finding an authorized NC DWI Services provider in NC:
NC DWI Services Provider List by County: www.ncdwiservices.org
NC DWI Services Main Phone Number: 984-236-5250

Service Level Recommendations:

____ I understand that the following is required to be completed to clear my license.
Level: _____ Minimum# of hours: _____ Duration (Minimum# of days): _____
Additional requirements (i.e. UDS, BAC,etc): _____

Assessment Policy:

____ I understand that if I have **not** begun the recommended substance abuse education or treatment to resolve my DWI within 6 months from the assessment date a new assessment and assessment fee will be required.

Complete Driving History:

____ I understand that a complete driving history from NC DMV is required for the assessment; I may bring one in or obtain it from this facility **at the cost** I would have incurred if I obtained it myself online at: https://edmv.ncdot.gov/DrivingRecords

Program Requirements and Fees:

____ I understand that if I complete the recommended level of care at Community Intervention, these will be the program requirements and fees: (list your program requirements and fees.) Items to include: Drug testing, cost, attendance, substance use policy, etc. Each treatment client must be scheduled to attend services weekly (10A NCAC 27G.3813)

Certificate of Completion (E508) Processing:

____ I understand that the provider has two weeks to submit the E508 after completion of services and payment. If you are pre-trial at time of assessment, you MUST inform your Treatment Provider of your conviction date in order to submit the E508 to the state. An additional period of 5 days or more is required to complete the process with DMV. Contact your Treatment Provider with questions regarding the status of your E508.

I certify that I have read, understand, and have received a copy of this Service Agreement.
Signed in acknowledgement at time of assessment:

Client's Signature:_____ Date: _____

Counselor's Signature:_____ Date: _____

Signed in acknowledgement at time of enrollment into education/treatment:

Client's Signature:_____ Date: _____

Counselor's Signature:_____ Date: _____

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RIGHTS/ GRIEVANCES DOCUMENT

Client Rights

I understand my basic rights as a client. These rights include:_____
(See attached client's rights)

Grievance Policy

I understand that if I have a complaint/grievance, I should:_____
(See attached policies)

I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

DWI Services, NC Mental Health/Developmental Disabilities/Substance Abuse Services

Donna Brown
donna.m.brown@dhhs.nc.gov
3008 Mail Service Center
Raleigh, NC 27699
984-236-5256
Fax: 919-508-0963

North Carolina Addictions Specialist Professional Practice Board

www.NCSAPPB.org
www.NCSAPPB.org/ethical-complaint-form
Katie Gilmore, Associate Executive Director katie@recanc.com
P.O. Box 10126
Raleigh, NC 27605

Disability Rights NC

www.DisabilityRightsNC.org
info@disabilityrightsnc.org
3724 National Drive, Suite 100
Raleigh, NC 27612
877-235-4210 or 919-856-2195

I certify that I have received a copy of this Client Rights/Grievance Policy

Client's Signature:_____ Date: _____

Counselor's Signature/Credential:_____ Date: _____

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INFORMED CONSENT FOR TELEHEALTH DWI SERVICES

Introduction:

Telehealth refers broadly to electronic and telecommunications technologies and services used to provide care and services with a provider in one location and you in another location. Due to the unprecedented circumstances of the COVID-19 Pandemic, the North Carolina Department of Health and Human Services, Division of Mental Health/ Developmental Disabilities and Substance Abuse Services has given temporary approval for DWI Services authorized agencies to utilize two-way, real-time interactive audio/video and telephonic communications (Telehealth Platform) to provide assessment and outpatient treatment services. Alcohol and Drug Education Traffic School (ADETS) may only be provided via a two-way, real-time interactive audio/video platform. (Agency name) is currently using (telehealth platform name(s)) to provide (description of services).

As part of a telehealth session, you and your provider will communicate and exchange confidential or protected health information via a Telehealth Platform. The information that is exchanged may be used for diagnosis, counseling, follow up, and/or education, and may include the following:

- Client health information
- Live, two-way audio and video
- Sound and video files

To the extent feasible, electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and protected health information and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Benefits and Risks of Telehealth and Telephonic Counseling:

Expected benefits of telehealth services include but are not limited to,

- Increased access to addiction and behavioral health services
- Health and safety protection for the client and the clinicians in keeping with recommended mitigation measures during the COVID-19 Pandemic
- Client convenience

Potential risks and limitations of telehealth services include but are not limited to,

- In unusual instances, failure of privacy or security protocols causing a breach of privacy or loss of confidential personal health information
- Unexpected technology problems with software compatibility, internet connection(s), and/or failure of equipment (i.e. computer, tablet, etc.) and related delays in evaluation and treatment
- Counselors may miss important non-verbal communication that is not visible or detectable during telehealth sessions

____ I understand that the above expected benefits and potential risks are associated with telehealth services, but no results can be guaranteed or assured.

Electronic Communications:

Necessary Equipment:

- A device through which to conduct telehealth, including a screen, microphone, video camera and speaker, such as, a computer (PC or Mac) or a tablet (Android or iOS) or
- A telephone (Android, iOS, or landline)
- Access to email address authorized by you for use on the device that you will use for access to hyperlinks to join videoconferences (when applicable) and transmission of intake and/or orientation paperwork (ex. authorization to release confidential information)

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____ I understand that by providing my telephone number and/or email address in the designated areas below, and by signing this Informed Consent, I am authorizing (agency name) to provide me information via phone, voicemail, and/or email regarding my assessment, treatment, payment information, scheduled sessions, links to videoconferences, E508 status and other information regarding the services I am receiving. Information that I provide through email will not be forwarded to independent third parties without having prior written consent from me to do so, except as authorized and/or required by law.

Phone number: _____

Email address: _____

Technology Issues

____ I understand that in the event that the session is interrupted because of technology issues, I will disconnect from the session. *(Agency may edit to include their own policy. Example policy.)* I will attempt to re-contact my counselor via the telehealth platform on which we agreed to conduct sessions. If do not reconnect within two (2) minutes, then my counselor will call me on the phone number I have provided (above).

Confidentiality

The laws that protect the confidentiality of clients' health information also apply to telehealth. Your counselor has a legal and ethical responsibility to make the best efforts to protect all communications that are a part of telehealth and telephonic counseling. However, electronic communications technologies are not 100% guaranteed. Additionally, every client utilizing telehealth and telephonic services should take reasonable steps to ensure the security of communications, including, but not limited to: secure networks, password-protected devices, and private space/room where others cannot see participants, overhear or interrupt sessions.

____ I understand the risks to confidentiality and will make every effort to protect telehealth and telephonic communications for my own protection and for the protection of confidentiality of others.

Records

Telehealth sessions will not be recorded in any way unless agreed to in writing by mutual consent. (Agency Name) will maintain a record of our session in the same way that in-person sessions are maintained in accordance with State and Federal laws, as well as, agency policy. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.

Fees

Telehealth fees: *(Include agency fees for telehealth and telephonic services provided including $100 for DWI-Related Clinical Assessment and $160 ADETS)*

Client Consent to Use of Telehealth:

This telehealth consent is intended as a supplement to the Service Agreement signed at the onset of clinical services and does not amend any of the terms of that Service Agreement. I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to participate in telehealth services under the terms described in this document.

Your counselor's signature indicates that this document has been reviewed with you to ensure that the terms described in this document are understood and agreed upon.

I hereby authorize (Agency Name) to use telehealth in the course of providing services to me.

Client's Signature:_____ Date: _____

Counselor's Signature:_____ Date: _____

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL
42 CFR PART 2 AND HIPAA

I, _____ [Patient's Name]

authorize to disclose to one another _____ the following information:
[Name or general designation of individual or entity making the disclosure]

Initial all that apply:

____ NC Department of Community Corrections (PO): _____
NC DMV NC Division of MH/DD/SAS

____ _____
[Name of the Criminal Defense Attorney]

____ _____
[Name of the prosecuting District Attorney]

____ _____
[Name of the appropriate court]

____ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or
[describe how much/what kind of information may be disclosed, including & explicit description of what substance use disorder information may be disclosed; as limited as possible]

____ for the purpose of _____
[describe the purpose of the disclosure; as specific as possible]

____ I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts & 104, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

____ I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:
[describe date/event/ ondition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]

____ I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.

____ I have been provided a copy of this form.

Signature of Patient:_____ Date: _____

Signature of Witness/Staff:_____ Date: _____

Notice Prohibiting re-disclosure of Substance Use Disorder Information: 42 CFR part 2 prohibits unauthorized disclosure of these records.

Revocation (if applicable):_____ Date: _____
Date Revoked:_____ Reason for Revocation:_____Staff Initials:_____

Community Intervention & Educational Services Home of The COOL Program

DWI / DUI

1225 EAST 5TH STREET, WS NC 27101 | 336-776-0322

DUI FORMAT & INFORMATION SHEET

CHECK LIST

Date of Intake: _____

☐ Information Sheet

☐ Driving Record

☐ Copy of Citation

Court Docket #: _____

CR#: _____

DL#: _____

Date Arrested: _____

County Arrested: _____

Date Convicted: _____

# of Prior DUI: _____

# of Classes Needed: _____

Last Date of Usage: _____

Breathalyzer Test Results: _____

(or check) ☐ Refused or ☐ Don't Know

FEES PAID

Assessment Fee Paid: _____

Driving Record
Amount Paid: _____

Amount of Classes Paid: _____

Paid DMV: _____

Client Name:	DOB:
Client Phone Number:	Client Email:
Race: Ethnicity:	Language:
Marital Status:	Employment Status:
Highest Level of Education:	Health Insurance:
ADETS or DUI:	Hours Needed:
START Date:	Group Day:
Attorney:	Virtual or in Person:
Date Completed Class:	
Intake Assessment completed by:	on date: