

Cover Sheet

WEB CAM/ASEP

1. Payment must be paid in full before clients can begin the online classes.
2. Be sure to fully complete **ENTIRE** orientation packet with all appropriate signatures.
3. Client must provide a non-returnable picture of themselves to verify identity during web cam sessions.
4. Include a copy of **2** forms of official identification (Passport, Birth certificate, Social security card, State I.D., Driver's License).
5. Please read through everything that you are signing so that you can fully understand what is required. Clients will be held accountable for knowing all requirements of the program; therefore, clients should keep all receipts and make copies of all paperwork for their own records.
6. Make sure that the email address provided is active and able to receive web cam "invitations".

***Once your payment has posted, you will receive an email which will include your start date and further instructions.**

***If you have any additional questions please email:**

ASEP@obrienhouse.org or call France-Claire Hebert at 225.344-6345, ext 308.

Intake Interview

WEB CAM

Identifying Information

Name _____

Age _____ Date of Birth _____ Social Security # _____/_____/_____

Address: _____

Phone: (cell) _____ (home) _____

Email Address: _____

Contact in case of emergency:

Name: _____

Relationship: _____

Phone #: _____

Have you ever received any type of treatment before for substance abuse? ___NO ___YES

If yes, where/when? _____

Any family history of alcohol or drugs? ___No ___YES

If yes, please list: _____

Do you have an attorney? ___NO ___YES If yes, who: _____

When stopped, did you blow? ___NO ___YES If yes, what did you blow? _____

Circumstances that you were stopped for. (To/From-stopped for what?)

Who referred you to O'Brien House? _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Treatment Agreement Education Program (ASEP- WEB CAM)

This contract and agreement is between O'Brien House, 446 N 12th St, Baton Rouge, LA 70802, and _____, hereafter referred to as the Client.

O'Brien House shall provide a Substance Abuse Education Program, and will provide the following services:

-Provide (1) one-hour education class to be held online for six (6) continuous weeks at a cost of \$75.00 per session (total is \$450.00).

****All makeup / missed classes will be at \$75.00 per makeup / missed session****

The total payment for the Education Program is \$450. This amount of \$450 does not include an assessment screening or makeup/missed class fees. This total amount is due before you are allowed to start the online classes. Please be aware that it may take up to 3 business days for your payment to post. Once you payment is posted, you will receive an email with your start date.

Amount due: \$450.00

PAY ONLINE with a credit or debit card at **Obrienhouse.org** (Client Payment link) *If you choose to pay online be aware that a transaction fee will be applied to each payment.

This agreement shall be effective from date of acceptance and signature until completion of course. I have read this agreement and understand my obligations.

X _____ Date: _____
(Client)

X _____ Date: _____
(Witness)

Group Member Confidentiality Pledge

WEB CAM

I _____, make this my pledge of confidentiality. I will not reveal anything I see, hear, or experience here other than about myself. I will not discuss anything that relates to another member of this group with anyone outside this group, other than with that person, and then only with their permission.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

OAD Notification of Patient Rights, Authorizations

I understand the law and regulations governing licensure of alcohol and drug abuse programs assures me of certain rights, and these apply to me, as a patient, or to my minor child, if my child is in treatment. Copies of these rights are available to me, and also posted on the agency's bulletin board. Some of these rights, as set out in the STANDARDS MANUAL, are copied below:

1. I have the right to be served without discrimination as to sex, race, creed, color, religion, or national origin.
2. I have the right to have the nature of recommended treatment and any specific risks of such treatment carefully explained to me.
3. I have the right to help develop my own treatment plan to meet my own specific needs.
4. I have the right to confidentiality. Except as may be required by law, no information concerning me, or my treatment, may be given out without my consent in writing. I have the right to revoke any consent given.
5. I have the right to privacy: When the agency expects outside visitors, I have the right to be notified in advance of their arrival and to be shielded from such visitors. My case shall not be discussed by staff in front of visitors or other patients.
6. If the agency desires to use cameras or tape recorders to aid in diagnosis, evaluation or treatment, the personnel must have my written permission, and must fully explain to me how they plan to use the pictures or recordings. I understand that staff must obtain advance permission from the program manager before using such equipment. (OAD programs do not use cameras and recording devices routinely).
7. I have the right to be told if the program cannot provide the services that I need.
8. I have the right to uncensored communication with my family, my attorney, and my personal physician. I further understand that mail and packages delivered to me are to be opened in staff's presence to assure that nothing illegal for me to have has been sent to me.

I have read the above statements and understand them. I also understand that this is only a partial listing of my rights. I certify this understanding by signing below.

Client Signature: _____

Authorization for Treatment

I understand that my admission to the **O'Brien House Education Program** is on a voluntary basis and I understand and accept the consequences of treatment as it has been explained to me. If my admission is on a voluntary basis, I am free to accept or reject any special type of treatment, including diagnostic procedures and/or hospitalization which staff may recommend. If my admission is based on a commitment or court order, I do not have this right.

Client Signature: _____

O'BRIEN HOUSE

ZERO TOLERANCE FOR VIOLENCE POLICY

Please be advised that this in order to ensure a safe environment for our staff, clients, and visitors to our campus.

We strive to provide quality service, care, and treatment to all of our clients. If some aspect of your care concerns you, we want to know and will do our best to address any concerns you might have.

However, O'Brien House will not tolerate threatening behaviors of any kind in any of our facilities (including harassment, profanity, verbal or physical threats toward our staff, clients, or visitors).

If you choose to engage in threatening behaviors in any of our facilities (including on the telephone or on at any O'Brien House properties) you risk termination of services from O'Brien House and may be referred elsewhere.

If your threatening behaviors result in termination of services, O'Brien House cannot guarantee that another provider of services will be found, but a good faith effort will be made to identify such a provider.

Client: _____ Date: _____

Witness: _____ Date: _____

Education Program Rules and Regulations

WEB CAM

1. Total payment must be paid in full before you are able to start the online classes (\$450).
2. You must attend six online class sessions in order to cover the six different topics.
3. The web cam version of this class is only available on Tuesday night, each week you will receive an email from Tokbox to invite you to the online class.
4. Group starts at 6:00 pm; you must be logged in and ready by this time to receive credit for that class.
5. During the six week education program you are to not use any mood altering substances (any alcohol, drugs, etc.).
6. If you have to miss group or an emergency occurs, call and leave a voicemail explaining the situation. **Call France-Claire at 225-344-6345 ext. 308! You may also call the ASEP cell at: 225-315-7494!** There are certain circumstances which will be excused (illness, work related excuse, death of family, etc.). However, unexcused absences will have a fee of \$75.
7. Confidentiality is extremely important. You must agree and obey the confidentiality statement.
8. Please remember that there may be handouts or homework that is required for some of the classes. **PAY ATTENTION** to what is due to turn in!

Client Signature: _____ Date: _____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

- Further Medical Care Personal Legal Investigation or Action Changing Physicians
 Research related treatment Creating health information for disclosure to a third party
Other: (Specify)

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

- Entire Record** Medical History, Examination, Reports Surgical Reports
Treatment or Tests
 Prescriptions Immunizations Hospital Records including Reports
Laboratory Reports
 X-Ray Reports MR/DD Records Other: _

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

- Alcoholism Drug Abuse Mental Health Vocational Rehabilitation
 HIV (AIDS) Sexually Transmitted Diseases Genetics
Psychotherapy Notes
 Other: _

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both sides of this form.

X _____
Signature of Individual or Personal Representative Authorized by Law

X _____
Date

Signature of Witness (If signed with an "X" or mark)

Date

For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

Signature and Title of Agency Representative

Date

HIPAA 404P

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