More to Life Counseling, LLC

THC Expungement Short Form Assessment/Intake

Name: _____ Maiden/Other Name: _____ Gender: _____(M) _____(F)

Birthdate: _____/_____/_____ Age: _____ Place of Birth: _____ Ethnicity: _____

Address (Number & Street): _____ City: _____ State: _____

Phone: _____SS#:_____ Referral Source: _____

Attorney: _____ Phone: _____ Judge: _____

Emergency Contact: _____ Phone: _____

Driver's License #: _____ Suspended or No U.S. License?

History of Treatment (Substance Abuse)

Provider/Facility	When and for how long?	For What?	Helpful? Why or Why Not?

Substance History

	Substance	First use age	Last use age	Current use (Y/N)	Frequency	Amount
	Alcohol					
	Amphetamines/speed					
	Barbiturates/downers					
	Cocaine, Crack					
	Hallucinogens (e.g., LSD)					
	Inhalants (e.g. glue)					
	Marijuana or Hashish					
	PCP					
	Ecstasy/MDMA					
	Prescription - _____ _____					
	Other: _____					

Legal History (past 2 years)

Date(s)	Charge	Drug Related?	Time Incarcerated	Clean Time After Release
Notes: _____				
Pending Charges/Court Dates:		**Parole/Probation?** **NO** **YES** If yes, until when:		

_____

Client Signature Date

_____

Provider Signature Date

MORE TO LIFE COUNSELING, LLC

351 Pascoe Blvd. Ste. 102
Bowling Green, KY 42104
201 W. Main St. 3rd Floor
Scottsville, KY 42164
Phone: 270-904-4945 Fax: 270-721-0988

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____

Phone: _____ Alternate #: _____ Soc. Sec. No.: _____

I _____ **authorize** *More to Life Counseling* **to release information to:**

Name: _**COURT -**_____

Address: _____

Phone: _____

Information to be _____ mailed _____ picked up. Date: _____

Type of Information to be Released: __Marijuana Expungement Certificate of Completion_____

_____

Purpose of Disclosure: Notify the court of completion of Marijuana Education Class_____

_____

This information may be communicated in the following manner: ☐ Oral ☐ Written

This authorization shall be in effect for 12 months or _____ following the date of signature.

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that the action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand Alcohol and Drug client records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

_____ Relationship to client if unable to sign _____
Signature of Client or Guardian Date

Witness: _____

I authorize the release of the indicated sensitive records also (client to initial):
Mental Health Records ..... _____ (initial)
HIV or AIDS ..... _____ (initial)
Chemical Dependency ..... _____ (initial)
DUI Records ..... _____ (initial)

MORE TO LIFE COUNSELING, LLC

351 Pascoe Blvd. Ste. 102
Bowling Green, KY 42104
201 W. Main St. 3rd Floor
Scottsville, KY 42164
Phone: 270-904-4945 Fax: 270-721-0988

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____

Phone: _____ Alternate #: _____ Soc. Sec. No.: _____

I _____ authorize *More to Life Counseling* **to release information to:**

Name: _**ATTORNEY -**_____

Address: _____

Phone: _____

Information to be _____ mailed _____ picked up. Date: _____

Type of Information to be Released: __Marijuana Expungement Certificate of Completion_____

_____

Purpose of Disclosure: Notify your Attorney of completion of Marijuana Education Class_____

_____

This information may be communicated in the following manner: ☐ Oral ☐ Written

This authorization shall be in effect for 12 months or _____ following the date of signature.

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that the action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand Alcohol and Drug client records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

_____ Relationship to client if unable to sign _____
Signature of Client or Guardian Date

Witness: _____

I authorize the release of the indicated sensitive records also (client to initial):
Mental Health Records ..... _____ (initial)
HIV or AIDS ..... _____ (initial)
Chemical Dependency ..... _____ (initial)
DUI Records ..... _____ (initial)

NAME:_____

MORE TO LIFE COUNSELING, LLC

351 Pascoe Blvd. Ste. 102
Bowling Green, KY 42104
210 W. Main St. 3rd Floor
Scottsville, KY 42164
Phone: 270-904-4945 Fax: 270-721-0988

As a client being served by the behavioral health agency above, I acknowledge that I received a copy of the Notice of Privacy, policies and practices for medical records, effective April 14, 2003 as mandated by the HIPAA law of 1996 P.L. 104-191. HIPAA only applies to a covered entity or covered provider. It ***does not apply to the other participants*** in a group therapy session or to a group leader who is not a covered provider. In general, participants in group therapy are not required by HIPAA or other federal law to keep matters discussed in the group counseling session confidential.

I have read and understood the above limitations of HIPAA when it pertains to group participation.

_____
Signature of Client Date

_____
Witness Signature Date

The person who explained this to me was, _____ and I was able to ask any questions concerning the HIPAA laws and the person answered my questions.

This form expires one year from the date of the signature above.

NOTICE OF PRIVACY POLICIES AND PRACTICES
FOR MORE TO LIFE COUNSELING, LLC

DEAR CLIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

More to Life Counseling, LLC is committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit a healthcare provider a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnoses, test results, treatment, a plan for future care or treatment as well as other pertinent health care data and billing-related information. This notice applies to all of the records of your care generated by the facility. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other professionals involved in your care
- Legal document outlining and describing the care you receive
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and client satisfaction.

Understanding what is in your record and how your health information is used helps you ensure accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive and accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

More to Life Counseling, LLC is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/or locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a notice on your next office visit. The revised policies and practices will be applied to all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

The following categories describe examples of the way we use and disclose medical information:

For Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical condition, and providing treatment

For Payment. We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your treatment so they we will pay us or reimburse you for treatment. We may also tell your health plan about treatment you are going to receive in order to determine whether your plan will cover it. If your account is sent for collection, non-medical contact and

credit information from that account will be made available to combine with and update non-medical accounts you may have that are with the same collection agency.

For Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of More to Life Counseling, LLC. For example: Information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality, as well as combine medical information about many clients to evaluate the need for new services or treatment We will remove information that identifies you from this set of medical information to protect your privacy.

Business Associates. In some instances, we have contracted separate entities to provide services to us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the agency when you do not wish a family member or other individual to have authorization to receive your information.

Victims of Abuse, Neglect or Domestic Violence. We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Appointment Reminders. The agency may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by a brief, non-specific message that may be left on your answering machine. If you don't approve of this method, or, if you prefer alternative methods please inform the agency.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Other uses and disclosures. Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of More to Life Counseling, LLC, please contact:

Cathy Gamm, More to Life Counseling, LLC, 351 Pascoe Blvd. Suite 103H, Bowling Green, KY 42104 (270) 904-4945

Jonathan Lee, More to Life Counseling, LLC, 351 Pascoe Blvd. Suite 103D, Bowling Green KY 42104 (270) 904-4945

If you believe that your privacy rights have been violated, please contact the aforementioned official, or, you may file a complaint with the Office for Civil Rights. There will be no retaliation for filing a complaint with either the agency's official or with the Office for Civil Rights. The address for the Office of Civil Rights is listed below:

Office for Civil Rights

U.S. Dept. of Health and Human Services

200 Independence Ave., S.W.

YOUR RIGHTS

EVERY CLIENT HAS THE RIGHT TO:

INFORMATION
Be informed of the rules of client conduct, including the consequences for the use of alcohol and other drugs or other infractions that may result in disciplinary action or discharge.

ACCESS
A client shall not be unlawfully discriminated against in determining eligibility for a treatment program.

Request a written statement of the charge for a service and be informed of the policy for the assessment and payment of fees.
Review client record in accordance with AODE policy.

Receive one (1) free copy of client record in accordance with KRS 422.317

CHOICE
To decide what provider to obtain services from.

CONFIDENTIALITY
That your personal information will be kept private according to HIPPA guidelines and in accordance with 908 KAR 1:320 or KRS 222.271(1).

INDIVIDUALALITY
To receive individualized treatment planning

DIGNITY
To be treated with consideration, respect, empathy, courtesy, and attentiveness.

COMFORT & SAFETY
To feel comfortable and safe when receiving services.

CONTINITY
To receive continued information and solution-focused support from program clinicians after completion of program

OPINION
To have input into your treatment and case management plans and be informed of their content.

To freely express views during program groups so much as it does not violate the rights of others in the group.

Right to file a grievance, recommendation or opinion regarding the services received.

I have been told of my rights as a client. I fully understand these rights and know that if I have questions or concerns in the future, that I am encouraged to speak to More to Life Counseling freely.

_____ _____

Client Signature Date Clinician Signature Date

INFORMED CONSENT DISCLOSURE

You are assured confidentiality. This is the foundation on which we build our trust with you and we value it highly. We will not share information about you (or those for whom you have responsibility) without your awareness. Whenever it is necessary to share information with anyone outside of the above entities, we will discuss that with you and have you give permission to release such information by signing an "Authorization for Release of Information" form indicating the specific information to be released and to whom it is to be released.

EXCEPTIONS: There are, however, some conditions when your staff member is required by law to release confidential information about you with or without your permission. They are as follows as they relate to you and others in your family/household involved with your families therapy process. Please initial each and then sign:

_____1. If your staff member has reasonable cause to believe that you intend to hurt yourself or someone else.

_____2. If your staff member has reasons to suspect that you are a perpetrator of abuse or victim of abuse.

_____3. If your staff member has reasonable cause to believe children in the home are being neglected.

_____4. If your staff member is subpoenaed to court and ordered by the judge to testify about you. The staff member will do his/her best to protect your right to confidentiality while complying with the court order.

My signature confirms that I have read, discussed, and understand the above information.

_____

Client (or guardian) Date

_____

Clinician Date