Coastal Horizons Center, Inc. Client Information Form

Page 1 of 3

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes.

LAST Name:

FIRST Name:

MIDDLE Name:

(MAIDEN) Name:

Today's Date:

Date of Birth : **Age:** **Gender:** M F **SSN:** **No SSN**

Home phone + area code:

Cell phone + area code:

Work phone + area code: Email (telehealth services):

CHC offers automated voice & text reminders for upcoming individual and/or doctor visits.

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required and standard text rates apply.)

I would like automated reminders using my primary phone: (choose only ***one***) Home Cell Work

I do **NOT** want automated reminders

Do you have any of the following? (please mark all that apply)

Medicaid? **No** ** **Yes** **If Yes**, type?

Medicare? **No** ** **Yes** **If Yes**, type? **A only** **B only** **A and B**

Health Choice? **No** **Yes**

Private Health Insurance? **No** ** **Yes** Name:

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required to contact third parties for billing, a copy of your card is required and all services may not be covered by your insurance.)

Who referred you to Coastal Horizons Center? (***please mark all that apply)***

Self | DSS | TASC | Judge/Court | Court Counselor

Family / Friend | Voc Rehab | State P.O. | Private physician | School

Inpatient Facility | VA | Federal P.O. | Other:

Address:

P.O. Box (if applicable):

City: **Zip:** **County:**

Mailing Address:

Is **English** your preferred language? ** **No** **Yes** ****If No,** list preferred language:

Race:

Alaskan Native
American Indian/
Native American
Asian
Black/
African American
Multiracial
Pacific Islander
White
Unknown
Other:

Ethnicity:

Cuban
Mexican American
Puerto Rican
None Above

Marital Status:

Domestic Partners
Divorced
Married
Never Married
Separated
Widowed

FOR FRONT DESK OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete: If Insured, did client sign consents to bill? No Yes

If insured, was a copy of the card obtained? No Yes

Printed verification of Medicaid coverage/no coverage attached to CI packet - No Yes Eligible? No Yes

Time arrived:

Coastal Horizons Center, Inc. **Client Information Form** **Page 2 of 3**

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes

Print your name:

FEMALES ONLY:

Are you currently pregnant? **No** **Unsure** ** **Yes**

**If yes, name of Dr. or Office following your care:

Highest education grade completed: *If less than 12th*, do you have your GED? **No** **Yes**

Are you currently enrolled in school? **No** ** **Yes**

****If yes**, what grade are you currently in? Name of the school:

Employment Status:

- Unemployed - looking
- Receiving Disability Benefits
- Seasonal work
- Full-time
- Unemployed - not looking
- Receiving Unemployment
- Home-maker
- Part-time
- Currently a student
- Benefits
- Retired

When employed, what is your **usual** occupation?

What best describes your current living arrangements?

- Alone
- With child(ren)
- Other relatives
- With Parents
- Other:
- With Spouse
- Homeless
- Others not related
- HARRTS

Are you a Veteran or prior service member? **No** **Yes**

Have you had a past head trauma or Traumatic Brain Injury? **No** **Yes**

Are you in the Reserves, active military or Guard? **No** **Yes**

Who served in Active Duty? N/A Self Family Member

How many people live in your household?

What is your **annual household** income?

Who is your Primary Medical Care Provider?

Please mark the number of times you have attended any AA, NA or other self-help mutual support groups focused on recovery from substance abuse and dependence in the last 30 days.

- No attendance in past month
- 4-7 times (about 1x wk)
- 16-30 times (4x's or more a wk)
- 1-3 times (less than 1x a wk)
- 8-15 times (2-3x's wk)
- Sporadic, frequency unknown

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete:

Coastal Horizons Center, Inc. **Client Information Form** **Page 3 of 3**

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes

Print your name:

In case of an emergency, who should we contact on your behalf?

Name: Relationship of emergency contact:

Number (**include area code**): City/State:

Are you your own legal guardian? ** **No** **Yes**

****If NO, please write the name of your legal guardian:**

How is this person related to you?

What is their primary phone number (include area code)?

What is their address (include city, state & zip)?

What brings you to us today and what services are you looking for? DWI Services

List the arrest year & offense type (DWI or DWLR) for each offense you must resolve ($100 per E508 Form):

Have you lived outside of NC within the past 20 years? **No** **Yes** *If yes, driving record from that state is required.

Do you require any of the following?

A court ordered evaluation **No** **Yes** A DWI Assessment? **No** **Yes**

A one time assessment? **No** **Yes** Counseling specific to a DWI? **No** **Yes**

How many times in the last 30 days have you been arrested?

Legal issues:

Do you have any criminal charges pending? **No** ** **Yes** **Court Date:

Do you have any outstanding warrants? **No** ** **Yes** **Charge:

Are you on any kind of probation? **No** ** **Yes** ** Supervised ** Unsupervised

Is treatment required by your probation officer? **No** ** **Yes** **P.O. Name:

Is this treatment required by the courts? **No** ** **Yes** **Why:

Are you currently enrolled in TASC? **No** ** **Yes** **TASC Staff Name:

Information included on this document is true to the best of my knowledge:

Client Signature:

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete:

Time completed:

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

42 CFR Part 2 and HIPAA

I, _____ **authorize**, Coastal Horizons Center **and:**

(Name of Individual) *(Name or general designation of individual or entity making the disclosure)*

Mark All That Apply

_____ NC Department of Public Safety (Officer supervising my case) _____

_✓_ NC Division of Motor Vehicles (DMV)

_✓_ NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

_____ _____

(Name of the prosecuting District Attorney)

_____ _____

_____ _____

(Other)

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

☐ My diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or

☑ assessment results, record of participation in and completion of recommendation, UDS results, e508 form

For the purpose of: DWI Services Case Management/Care Coordination

(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 ("HIPAA") of 1996 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:

Choose One:

[◉] **This consent shall expire one (1) year from the date executed, or**

[◉] _____ _____

(Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Date: **Executed this** _____ **day of** _____ _____

Day *Month* *Year*

I understand that I might be denied services if I refuse to consent to a 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 a disclosure for other purposes.

I have been provided a copy of this form: _____ Date: _____

(Signature of Patient)

Signature of person signing form if not the patient: _____ Date: _____

(Signature/relationship to patient)

Witness/Staff Signature: _____ Date _____

Notice Prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.

Coastal Horizons

Margaret Weller-Stargell,
President and CEO

Corporate Headquarters
Willie Stargell Office Park
615 Shipyard Blvd.
Wilmington, NC 28412

Administration
910.790.0187
910.790.0189 Fax

Open House Youth Shelter
(910) 392-6936

Rape Crisis Center
(910) 392-7185 New Hanover
(910) 754-7949 Brunswick

Outpatient Treatment
(800) 672-2903
(910) 343-0145 New Hanover
(910) 754-4515 Brunswick
(910) 259-0668 Pender

Community Based
Family Services
(910) 202-3155

Horizons Health
Primary Care
(910) 202-3860

WHAT
(910) 790-0948

Continuum of Care
(910) 230-6080

Prevention Services
(910) 202-0840

Outdoor Adventure
(910) 392-7106

TASC
(910) 762-5333 New Hanover

TASC RCE
(252) 618-3909 Region 1
(910) 321-6791 Region 2

NC TASC Training
Institute
(910) 202-5500

Our Children's Place
(919) 904-4286

Recidivism Reduction Services
(910) 202-3125

RESET
(910) 762-5333

DWI Services Provider Choice Form

I , _____ have been given information of all available DWI providers in Pender County, New Hanover County, and Brunswick County. I choose to receive DWI services from Coastal Horizons Center, Inc.

Client's Signature **Date**

Legal Guardian's Signature (if necessary) **Date**

Pender County
Coastal Horizons Center, Inc.
803 S. Walker St.
Burgaw, NC 28425
Phone: (910) 259-0668
Email: DWI@coastalhorizons.org

New Hanover County
Coastal Horizons Center, Inc.
615 Shipyard Blvd.
Wilmington, NC 28412
Phone: (910) 259-0668
Email: DWI@coastalhorizons.org

Brunswick County
Coastal Horizons Center, Inc.
120 Coastal Horizons Dr.
Shallotte, NC 28470
Phone: (910) 754-4515
Email: DWI@coastalhorizons.org

Short Term Treatment (minimum of 20 contact hours over a minimum of 30 days)
Long Term Treatment (minimum of 40 contact hours over a minimum of 60 days)
SAIOP (minimum of 90 contact hours over a minimum of 90 days)

Coastal Horizons Center, Inc.

TELEHEALTH INFORMED CONSENT

Record Number: _____

I, _____ (client name) hereby consent to participate in "*Telehealth*" with an approved telehealth provider from Coastal Horizons Center (CHC).

(client's initials) _____ A Coastal Horizons representative has explained, and I understand that *Telehealth* may include, but is not limited to, mental health care delivery, psychiatric care, minor or routine primary care needs, diagnosis, consultation, treatment, transfer of medical information, and education using interactive audio, video, or data communications (i.e. phone, cellular phone, internet).

(client's initials) _____ A Coastal Horizons representative has explained, and I understand that *Telehealth* is the use of electronic information and communication technologies by a treatment provider to deliver services to an individual when he/she is located at a different site than the treatment provider.

(client's initials) _____ A Coastal Horizons representative has explained, and I understand that *Telehealth* involves the communication of protected health information both orally and/or visually, to healthcare professionals that may or may not be located in my city.

(client's initials) _____ Only clients who have mental health, substance use, or primary care needs that can be safely managed to the same standard of care for an in-person visit will be seen through telehealth. It is my responsibility to follow through with additional instructions such as lab work or going to a higher level of care (e.g. Urgent Care, Outpatient therapy) to ensure that my clinical and/or medical needs are being managed appropriately.

(client's initials) _____ I the client will use the telephone and/or Internet service at the originating site to virtually meet with a treatment provider, and the treatment provider will thereby abide by the legal and ethical standards of their state of licensure of North Carolina.

(client's initials) _____ A safety plan will be implemented by the treatment provider. My provider and I will both know local crisis services, and routine psychiatric and medical providers (if needed). I agree to follow their recommendations as a provision to have on-going *Telehealth.* ***Clients should access 911 or the nearest hospital if an emergency occurs.***

(client's initials) _____ Treatment provider will ensure that all standards that apply to in-office session will be consistent with *Telehealth*, including the confidentiality of the client. I understand that a Coastal Horizons Center member of staff may be present to operate equipment or computer software. I can at anytime request this staff to leave, or request that my provider not share sensitive personal health information or medical information while they are present.

(client's initials) _____ It is CHC's responsibility to provide an appropriate environment to ensure that the transmission is as accurate as possible as well as the confidentiality and integrity of their health information

is verified. Such as ensuring lighting, sound quality, and verifying identification of the presenting client.

(client's initials) _____ There is a possibility that, despite the reasonable precautions taken by our organization, transmission of client's health information could be distorted or disrupted by technological failures or accessed by unauthorized individuals.

(client's initials) _____ I understand that the laws protecting privacy and the confidentiality of personal health information also apply to *Telehealth*.

(client's initials) _____ I understand that I will be responsible for any copayments or coinsurances that apply to my *Telehealth* visit. It is my responsibility to determine if *Telehealth* is covered by my insurance carrier.

(client's initials) _____ I understand that I have the right to withhold or withdraw my consent to the use of *Telehealth* at any time during my treatment without affecting my right to future services. I may revoke my consent orally or in writing at any time by contacting my provider at CHC.

(client's initials) _____ As long as this consent is in force (has not been revoked) CHC may provide me with treatment via *Telehealth* without the need for me to sign another consent form.

(client's initials) _____ I understand that if receiving telemedicine services through CHC and my treatment provider prescribes a psychotropic medication, it may take up to 72 hours for me to receive via the delivery method agreed with my treatment provider (closest pharmacy if possible or through secured chain-of-custody with CHC staff). Additionally, there may be limited hours that *Telehealth* is available. ***In the event of an emergency, I will contact 911 or the nearest hospital for assistance.***

(client's initials) _____ I have had the alternatives to telehealth services explained to me, and, I am choosing to participate in telehealth. I understand that if receiving telemedicine that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

(client's initials) _____ I have read and understand this document and will address any concerns or questions with my treatment provider and/or the other CHC treatment team members present for during my treatment sessions.

(client's initials) _____ I have been offered a copy of this consent form.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

Executed this date: _____ Client Signature: _____

Guardian/Legal Representative Signature: _____

Relationship to Client: _____

CHC Staff Signature: _____

Informed Consent for Telehealth DWI Services

Fees

Coastal Horizons Center, Inc. is a private non-profit agency, licensed by the Division of MH/D/DAS, providing substance abuse and mental health services is required to prepare fees schedules for services and shall make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals able to pay..."[N.C. MH?DD?SAS Laws, 1990 edition, 122C-146]

DWI Assessment- $100.00; Multiple DWI Convictions-$100 for each E508

- *Administrative/Treatment Fee $75*

  DWI Treatment Level II (Short Term Treatment) $350

  DWI Treatment Level III (Long Term Treatment) $700
- *DWI Treatment Level IV (Substance Abuse Intensive Outpatient Program) $1,500* *Some individuals may qualify for state funding*

  ****E508s may be held by the provider until all fees are paid*

Fees are paid at the Front Desk or by calling (910)259-0668. Payment is collected Monday thru Friday, excluding holidays. We accept Cash, Check, and/or Visa/MasterCard.

(Initial) _____ I acknowledge that fees charged for DWI Services offered by Coastal Horizons Center, Inc. were discussed with me. I agree to pay the appropriate fees & understand that refusal to make payment as stipulated may result in denial or adjustment of services.

Client Consent to Use Telehealth Services

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. I hereby authorize Coastal Horizons Center to use telehealth in the course of providing services to me.

Client's Signature: _____ Date: _____

Legal Guardian Signature (if necessary) _____ Date: _____

Counselor's Signature & Credentials: _____ Date: _____

COASTAL HORIZONS CENTER, INC
Outpatient Mental Health / Substance Abuse Services
Assignment of Benefits & Financial Responsibility

I have requested mental health and/or substance abuse treatment services from Coastal Horizons Center, Inc. on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I understand that I will be responsible for any court costs or collection of fees should it become necessary to take action to collect for services rendered. I understand that it is my responsibility to notify Coastal Horizons Center, Inc. of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill or co-pays as determined by Coastal Horizons Center, Inc. and/or my health care insurer if the submitted claims or any part of them, which are denied for payment. I understand by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Coastal Horizons Center, Inc.

I understand that my health care benefit plan, with limitations, may include coverage by the State of North Carolina and/or North Carolina Medicaid and in such case a Business Associates Agreement with Trillium Health Resources has been contractually established for which I am not required to authorize release/disclosure of protected health information if I reside within Trillium's catchment area.

I understand that an authorization for the release of protected health information is necessary when my health care plan is with private insurance, Medicare, or a local managing entity/managed care organization other than Trillium.

DWI Self Pay	NA
Primary Insurance (please print)	Policy Number
DWI Self Pay	NA
Policy Holder's Name (please print)	Relationship to Consumer
DWI Self Pay	NA
Secondary Insurance (please print)	Policy Number
DWI Self Pay	NA
Policy Holder's Name (please print)	Relationship to Consumer
PATIENT'S Name (please print)	DATE

PATIENT'S Signature **or RESPONSIBLE Party's** Signature (if patient is a minor)

I, _____, authorize Coastal Horizons Center, Inc. to:
(Name of Individual)

Send Authorization For Use And Disclosure Of Protected Health Information
Client Contact Guidelines

Choose One: (Staff Contact)

_____ CHC Staff may leave a message on my primary phone with **detailed information**
(Initial)

_____ CHC Staff may leave a message on my primary phone with a **call back number only**
(Initial)

Choose One: (Automated Notices)

_____ Send **both** automated **calls and text message** appointment reminders to the number listed in CHC records (Initial) and any number forwarded or transferred to that number.

_____ Send **only** automated **text message** appointment reminders to the number listed in CHC records and any number forwarded or transferred to that number.
(Initial)

_____ Send **only** automated **call** appointment reminders to the number listed in CHC records and any number forwarded or transferred to that number.
(Initial)

_____ I am choosing to **NOT** participate with receiving appointment reminders
(Initial)

_____ Send **emails** notifying me of a missed appointment. Email: _____
(Initial) (Private Email address)

_____ **Mail** written communication to my residence with agency name on return envelope.
(Initial) (Written correspondence may be mailed to your residence without agency name for collection of fees.)

_____ **Other:** _____
(Initial)

The following protected information: **that I am a client of Coastal Horizons Center and appointment date(s) and time(s)** for the purpose of: **appointment scheduling/notification and related services information**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

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 [refer to agency Privacy Notice]**, and that in any event this consent expires automatically as follows:**

Choose One

[_____] **This consent shall expire one (1) year from the date executed, OR**
Client's Initials

[_____] _____
Client's Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Date: Executed this _____ **day of** _____ _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

_____ _____
Signature of Client Signature of Legal Guardian (when required)

Coastal Horizons Center, Inc.
615 Shipyard Boulevard
Wilmington, NC 28412

Privacy Notice Receipt Form

- I acknowledge that I have received the Privacy Notice for Coastal Horizons Center.
- I understand that the Privacy Notice discusses how my personal health care information may be used and/or disclosed, my privacy rights with respect to health care information, and how and where I may file a privacy-related complaint.
- I may obtain a copy of the Privacy Notice from:
  - the agency website (http://www.coastalhorizons.org), and/or
  - the waiting area receptionist, and/or
  - the agency Privacy Officer (910-343-0145).
- I understand that the terms of this Privacy Notice may be changed in the future, and these changes will be posted:
  - in the waiting area of the agency, and/or
  - on the agency website (http://www.coastalhorizons.org), and/or
- I understand that I may request a copy of the new Notice from the receptionist or by writing a letter to the Privacy Officer:

Privacy Officer
Coastal Horizons Center, Inc.
615 Shipyard Boulevard
Wilmington, NC 28412
(Phone: 910-343-0145)

"You May Refuse to Sign This Acknowledgement"

Print Name | Signature | Date

I refuse to sign this acknowledgement

Legal Guardian Signature (if necessary) Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Notice but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation presented us from obtaining acknowledgement
- Other (please specify)

Staff Signature | Date | Time of Day | Client Record Number

Enter Clients Name on "Print Name" Line if Client Refuses and Submit to Medical Records

DWI-Specific Client Rights / Grievances Information

(Client's initials) _____ I understand my basic rights as a client. These rights are outlined in the *Client Rights for Coastal Horizons Center, Inc* document.

(Client's initials) _____ I understand that if I have a complaint/grievance, I should contact the front desk staff to request and submit a Coastal Horizons Center grievance form.

(Client's initials) _____ 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 27699-3008
Phone: 984-236-5256 Fax: 919-508-0963

North Carolina Addictions Specialist Professional Practice Board
https://www.ncsappb.org/
https://www.ncsappb.org/ethical-complaint-form/

Katie Gilmore, Associate Executive Director
katie@recanc.com
P.O. Box 10126 Raleigh, NC 27605

Disability Rights NC
http://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 Signature: _____ Date: _____

Legal Guardian Signature (if necessary): _____ Date: _____

Counselor Signature/Credential: _____ Date: _____

Coastal Horizons Center, Inc. **Client Rights & Consent for Treatment**

CLIENT: _____ 1. Client to read, initial each section, and sign and date form.
2. Parent to initial each section and sign if client is minor.
RECORD NUMBER: _____ 3. CHC Staff will answer questions.

As a client of Coastal Horizons Center, Inc., or as the guardian of such a client, you are assured of certain rights. Among these rights is the right:

1. To dignity, respect, humane care, and freedom from mental, emotional, sexual and physical abuse, neglect and exploitation. You also have the right to receive treatment that is culturally sensitive to you, including sensitivity to social, psychological, physical, and spiritual factors.

2. To treatment, including access to medical care and habilitation, regardless of age, sex, religion, national origin, degree of mental illness, mental retardation, substance abuse, and to:

a. Participate in the development of your individualized written service plan developed within 30 days from admission.

b. Receive information on potential risks and possible benefits of treatment choices, to refuse any treatment offered, and to terminate treatment - unless you have been court-ordered to attend.

c. Not be excessively or unnecessarily medicated, and to have medication ordered and prescribed only by a physician with documentation of such prescriptions in your client record and in accordance with accepted medical standards.

d. Confidentiality as explained in the client handbook and in compliance with state and federal laws.

e. Not be physically restrained or subjected to search and seizure by any Coastal Horizons Center employee.

3. To live as normally as possible while receiving care and treatment/habilitation.

4. To refuse to be finger printed, audio-taped, video-tape or photographed unless you or your guardian gives consent.

5. To never have corporal punishment at a Coastal Horizons Center facility.

6. To pursue any grievances using the Client Grievance Procedure posted on the public bulletin board and in the OTS Client Handbook, or to contact Disability Rights NC (877) 235-4210 or (919) 856-2195 or www.disabilityrightsnc.org.

7. To consult with legal counsel or private physicians of your own choice at your own expense.

8. To protected privacy of your health information as stated in the Agency Privacy Notice.

9. To timely access to information pertaining to you, including your medical record, to assist you in decision-making.

I have been informed of these rights. _____ **(Client/Legal Guardian initials)**

A. REQUEST FOR TREATMENT

I do hereby request outpatient treatment for either a substance use and/or mental health disorder from Coastal Horizons Center, Inc. and voluntarily give consent for treatment according to my individualized treatment/case management plan. [GS 122C-57] I understand that I (or those others that I have designated in writing by completing an Authorization For Use and Disclosure of Protected Health Information form) may be contacted by staff on a follow-up basis after I have discontinued my involvement with this agency.

_____ **(Client/Legal Guardian initials)**

B. EMERGENCY MEDICAL CARE

In the event that I might need emergency medical care while attending Coastal Horizons Center, I give permission for the qualified agency staff to 1) administer emergency care to me & 2) contact 911 for additional medical care. A separate written Authorization for Use and Disclosure of Protected Health Information must be completed to notify family, friends, significant other(s) or primary physician.

_____ **(Client/Legal Guardian initials)**

C. PROGRAM AUTHORITY / UNDERCOVER AGENTS & INFORMANTS

Coastal Horizons Center, Inc. may not knowingly employ, or enroll as a client, any undercover agent or informant. [42 CFR Part 2, 2.17 a] Therefore, Coastal Horizons Center, Inc. will deny admission or terminate treatment services for any individual known to be an undercover agent or informant.

I have been informed of this notice: _____ **(Client/Legal Guardian initials)**

D. I have received a copy of the OTS Client Handout, and now understand and agree to abide by the rules & regulations of the program including all of the above.

_____ _____
Signature of Client/Date **Signature of CHC Staff/Date**

_____
Signature of Parent/Legal Guardian/Date (Optional)

Automated Appointment Reminder Information

Coastal Horizons Center has an automated system that can send **text** and **phone** appointment reminders for individual and doctor appointments. We can also send you an **email** reminder when you have missed an appointment. Group appointment reminders are not included in this feature.

Please Note:

- CHC will not reimburse for charges associated with automated reminder calls/texts.
- It is your responsibility to inform us of any changes to your contact information.

Call reminders occur **3 days** prior to your appointment and are made between 10 am and 6 pm, Monday through Friday. They state the following:

> ***"This call is to remind you of your appointment with [staff name] on [appointment date] at [appointment address]. Please arrive at least 30 minutes early if you are a new patient. Please also bring your insurance card and copay with you. To confirm this appointment press 1, to cancel this appointment press 2, to repeat this message press 4."***

Text reminders occur **2 days** prior, **and 1 day** prior to your appointments and are made between 10 am and 7 pm, Monday through Friday.

Text 1 reminder states:

> ***"Reminder for [YourName]'s appt. w/ [StaffName] on [ApptDate] at [FacilityAddr]. Reply "A" to ACCEPT, "C" to CANCEL. New patients please arrive 30 minutes early and bring your insurance card and copay with you."***

Text 2 reminder states:

> ***Reminder- [YourName]'s appt. w/ [StaffName] on [ApptDate] at [FacilityAdr]. Reply "A" to ACCEPT, "C" to CANCEL. New Pts please arrive early.***

Emails for missed appointment reminder states:

> ***Hi, we missed you for your scheduled appointment on [ApptDate] with [StaffName]. Please call our office at [FacilityPhone] to reschedule your appointment. We look forward to seeing you soon!***

If you choose to participate, you will be asked to make a choice from the following options on the Contact consent:

- To receive **both** automated call and text appointment reminders to the number listed in CHC electronic record and any number forwarded or transferred to that number.
- To receive **only** automated **texts** appointment reminders to the number listed in CHC electronic record and any number forwarded or transferred to that number.
- To receive **only** automated **call** appointment reminders to the number listed in CHC electronic record and any number forwarded or transferred to that number.
- To receive **emails** notifying me of a missed an appointment.

Coastal Horizons Center, Inc.
NOTICE OF PRIVACY PRACTICES

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

Coastal Horizons Center is required by law to maintain the privacy and confidentiality of information about your health, health care, and payment for services related to your health and to provide you with this notice of our legal duties and privacy practices with respect to your protected health information (PHI). Not all situations are described. Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 & 164, the Confidentiality Law 42 C.F.R. Part 2 governing substance abuse treatment records, and state law North Carolina General Statute 122-C that governs mental health, substance abuse, and developmental disability services. Under these laws, Coastal Horizons Center may not say to a person outside of Coastal Horizons Center that you attend(ed) or receive(ed) services, nor may Coastal Horizons Center disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by these laws. We must protect and secure health information that we created or received about your past, present and future health condition, services we deliver or payment for your health care. When we use or disclose this information, we are required to abide by the terms of this notice.

There are other entities (such as a laboratory) with whom we have entered into a Business Associates Agreement and share your health information necessary to the service they provide for us. These Business Associates are obligated by law to appropriately safeguard your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. Coastal Horizons Center staff involved in your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

For Payment. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. We may use your information to develop accounts receivable information, bill you, and with your written consent, provide information which may include your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment, to your insurance company or other third party payors.

Health Care Operations. Health Care Operations refers to activities undertaken by Coastal Horizons Center that are regular functions of management and administration activities. We may use your information in monitoring our service quality, staff training and evaluation, medical reviews, contacting you for appointment reminders, provide you with additional information regarding your treatment or other health-related benefits, auditing functions, compliance programs, business planning and accreditation, certification, licensing and credentialing activities.

Public Health Activities. We may use or disclose your protected health information for public health activities to a public health authority authorized by law to collect or receive such information. This would be for the purpose of preventing or controlling disease (such as HIV/AIDS, tuberculosis, syphilis), injury, or disability.

Required by Law. We may use or disclose your protected health information to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law we must make disclosures of your protected health information to you upon your request. We must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Law Enforcement. We may disclose protected health information to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, or in connection with the reporting of a crime in an emergency. We may disclose your protected health information if you committed a crime on program property or against program personnel.

Public Safety. If you are in a mental health treatment program only, we may disclose your protected health information to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Child Abuse and Neglect. We may disclose your protected health information to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only.

Health Oversight. We may disclose your protected health information to health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program and peer review organizations performing utilization and quality control.

Specialized Government Functions. If you are or have been a member of the United States Armed Forces, we may disclose your protected health information as required by military command authorities. We may disclose your protected health information to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.

Persons Involved in Your Care. We may disclose your protected health information to a relative, close personal friend, or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose the minor's protected health information to a parent, guardian or other person responsible for the minor except in limited circumstances.

Research. We may use and share your health information for certain kinds of research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.

Deceased Patients. We may disclose protected health information regarding deceased patients for determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death by coroners or medical examiners.

Under 42 C.F.R. Part 2, generally, you must sign a written authorization before Coastal Horizons Center can share information for treatment purposes, for health care operations or payment of services. You may revoke any written authorization. The revocation must be in writing. You should understand that we are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the treatment and care that we have provided to you. However, the federal law permits Coastal Horizons Center to disclose minimum necessary information without your written permission:

1. For research, audit or evaluations,
2. To report a crime committed on Coastal Horizons Center's premises or against Coastal Horizons Center personnel;
3. To medical personnel in a medical emergency,
4. To appropriate authorities to report suspected child abuse or neglect;
5. As allowed by a court order.
6. Among our workforce, on a need to know basis, to coordinate your care,
7. Among our workforce or within an entity having direct administrative control, on a need to know basis, to conduct our health care operations,
8. To individuals or entities that help Coastal Horizons Center conduct duties in serving you with whom we have a Qualified Service Organization (QSO) or Business Associate (BA) agreement.

Your Rights

This section will briefly mention your privacy rights. If you would like to know more about these rights, please contact the Privacy Officer at (910) 343-0145.

Right to a Copy of Notice: You have a right to receive a paper copy of our Notice at any time. In addition, a copy of this Notice will always be posted in our waiting area and on the Coastal Horizons Center website: http://www.coastalhorizons.org.

Right to inspect and request copy of record: In most cases, you have the right to look at or get copies of your records. You must make the request by writing a letter to the Privacy Officer or completing an Access Request Form. You may obtain an Access Request Form from the receptionist. You may submit the completed Access Request Form to your service provider or the receptionist. Coastal Horizons Center will respond to your request within 30 days. In some cases, Coastal Horizons Center may deny your request.

Right to Request Amendment to Record: If you believe that your health information is wrong or some information is missing in your record, you must request, in writing, that Coastal Horizons Center correct or add to the record by writing a letter to the Privacy Officer or completing an Amendment Request Form. You may obtain an Amendment Request Form from the receptionist and you may submit the completed Amendment Request Form to your service provider or the receptionist. Coastal Horizons Center will respond within 60 days of receiving your request. Coastal Horizons Center may deny the request if it is determined that the information is:

- correct and complete, or

- not created by Coastal Horizons Center and/or not part of agency records, or
- not permitted to be disclosed, i.e., information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement that you provide in response, added to your health information. If Coastal Horizons Center approves the request for amendment, we will change the information in your record, inform you, and tell others who need to know about the change.

Right to Request an Accounting of Certain Disclosures: You have the right to request an accounting (a detailed listing) of disclosures that Coastal Horizons Center has made for the previous 6 years (beginning April 14, 2003). If you would like to receive an accounting, you may send a letter to the Privacy Officer or complete an Accounting Request Form. You may obtain an Accounting Request Form from the receptionist.

Request a Restriction of Uses or Disclosures: You have the right to ask that Coastal Horizons Center limit how your health care information is used or disclosed. You may make requests in writing by completing a Restriction Request Form. You may obtain a Restriction Request Form from the receptionist and submit the completed form to the receptionist or your service provider.

Right to Request an Alternate Method of Contact: You have the right to ask that we send your health care or billing information to or contact you at an address or phone number than is different than your home. We must agree to your request as long as it is reasonably easy for us to do so. You must make this request in writing by completing an Alternate Contact Request Form. You may obtain these forms from the receptionist and submit the completed form to the receptionist or your service provider.

Breach Notification: You have the right to be notified in the event that we (or one of our Business Associates) discovers a breach of unsecured protected health information involving your protected health information.

Out of Pocket Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to your health plan for purposes of payment or health care operations, and we will honor that request.

Psychotherapy Notes: We will, in accordance to Federal law, obtain your written authorization to release your psychotherapy notes, if any, that are contained in your health records.

How to File a Complaint or Report a Violation: If you believe your privacy rights have been violated or you are dissatisfied with the Coastal Horizons Center privacy policies, procedures or practice, you can file a complaint or grievance in person or in writing with/to any appropriate staff member or the Privacy Officer. You may obtain a complaint form from the receptionist or the Privacy Officer. Individuals may also file a written complaint with the US Department of Health and Human Services (DHHS) Office for Civil Rights (OCR) by mail or e-mail at the address listed below:

Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775
E-mail: OCRmail@hhs.gov

Or by visiting the following website: www.hhs.gov/ocr/filing-with-ocr/

Violations of the Confidentiality Law is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Coastal Horizons Center will not take any action against you or change our treatment of you in any way if you file a complaint.

Coastal Horizons Center may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all health care information that we maintain.
If we make changes to the Notice, we will:

- Post the new Notice in public access areas at our service sites,
- Have copies of the new Notice available upon request,
- Post the new Notice on the agency website at: http://www.coastalhorizons.org

For More Information: If you have questions or would like additional information, you may speak to your service provider or the Privacy Officer at (910) 343-0145.

This Notice is effective on April 14, 2003
This Notice revision is effective on March 3, 2017

SALCE SURVEY

(Substance Abuse / Life Circumstance Evaluation Survey)

OFFICIAL USE INFORMATION	
Most Recent BAC	
Number of Alcohol/Drug Arrests (Include most recent)	
Number of Accidents in the past two (2) years	
Number of Driving Points (Do **NOT** include alcohol/drug-related points, if possible)	
Number of Misdemeanor Arrests (Do **NOT** include alcohol/drug related arrests)	
Number of Felony Arrests	
Number of Alcohol/Drug Treatments	

INSTRUCTIONS:

Please read and answer all of the following questions. Honestly answer each question as you think it applies to you.

Do not spend too much time on any one question. A single answer by itself is not as important as all your answers taken together.

Fill in the information below and then go to Question 1 (one).

Last Name:_____ First Name:_____ M.I.:_____

ID Number _____ Today's date: _____

1. How old are you? **1.** ____

2. What is your race? **2.** ____

1. White
2. African American
3. Hispanic
4. Native American
5. Asian
6. Multi-racial/Other
7. Refused

3. What is your sex? **3.** ____

4. How many years of school have you completed? (GED=12) **4.** ____

5. What is your current marital status? **5.** ____

1. Married
2. Never married
3. Divorced
4. Separated
5. Widow/widower
6. Divorced-remarried
7. Living together
8. Divorced-living together

6. Using the scale below, where 1 is the very worst and 9 is the very best, select the number that best reflects your feelings about the marital status you selected in the last question. **6.** ____

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

7. What is your employment status? **7.** ____

1. Employed
2. Unemployed
3. Student
4. Student-employed
5. Homemaker
6. Retired
7. Employed part-time
8. Other

8. Using the scale below, where 1 is the very worst and 9 is the very best, select the number that best reflects your feelings about the employment status you selected in the last question. **8.** ____

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

9. What is your income level? **9.** ____

1. $0 - $5,000
2. $5,001 – 10,000
3. $10,001 - $15,000
4. $15,001 – 20,000
5. $20,001 – 25,000
6. $25,001 or more

Y N

10. Are you always a good listener no matter whom you are talking to? **10.** ◯◯

11. Pick the number that best represents how you feel about your physical health. **11.** ▭

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

12. Does the sign “No Turn on Red” mean you must wait for the green light before turning? **12.** ◯◯

13. Do you drink as much as or less than the average drinker? (An average drinker is whatever you think is average. If you drink as much or less than average, answer “Yes”.) **13.** ◯◯

14. Are you always careful about the way in which you dress? **14.** ◯◯

15. Have you ever tried social drugs – “Pot, Cocaine, etc.” or street drugs? **(Do not include alcohol.)** **15.** ◯◯

16. Has a doctor prescribed medication to help you relax? **16.** ◯◯

17. Do people think of you as a person who can drink a lot without getting drunk? **17.** ◯◯

18. Do you usually have a drink or two before going to social gatherings to help you relax? **18.** ◯◯

19. Do you always stop and help when someone needs a helping hand? **19.** ◯◯

20. Do you have at least one drink a day, five days out of seven? **20.** ◯◯

21. Pick the number that best represents how you feel about your current social life. **21.** ▭

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

22. In the past two years, have you tried social drugs, “Pot, Cocaine, etc.” or street drugs? **(Do not include alcohol.)** **22.** ◯◯

23. Do you believe your use of drugs keeps or has kept you from being as effective as you would like? **(Do not include alcohol.)** **23.** ◯◯

24. Are you sometimes irritated by people who ask favors of you? **24.** ◯◯

25. Are your table manners at home as good as when you eat out in a restaurant? **25.** ◯◯

26. Have you drunk three bottles of wine (not “wine coolers”) or twenty bottles of beer, or a fifth of liquor (whiskey, vodka, etc.) in one day? **26.** ◯◯

27. Do you usually have a drink or two whenever you are depressed? **27.** ◯◯

28. Have you feared that you were going crazy or losing your mind? **28.** ◯◯

29. Indicate the number of times you have been arrested for a felony offense. **(Do not include drunk driving arrests.)** **29.** ▭

30. Can you stop drinking after two drinks, whenever you want? **30.** ◯◯

		Y	N
31.	When driving a car, if the traffic light over your lane stays red when on-coming traffic starts, should you wait until it turns green before proceeding?	**31.**	
32.	Pick the number that best represents your ability to handle stress.	**32.**	
	Very Worst 1 2 3 4 5 6 7 8 9 Very Best		
33.	On a few occasions, have you given up doing something because you thought too little of your ability?	**33.**	
34.	Has your family and/or friends ever complained about your drinking?	**34.**	
35.	Have you ever knowingly said something to hurt someone's feelings?	**35.**	
36.	Have you ever felt that you abused the use of prescription or social/street type drugs?	**36.**	
37.	Do you sometimes think that when people have troubles, they only got what they deserved?	**37.**	
38.	Have you experienced at least one blackout – a time of drinking in which you carried on activities without later remembering them?	**38.**	
39.	Do you usually have a drink or two to calm down when you are angry?	**39.**	
40.	Have you been in treatment or counseling for emotional problems?	**40.**	
41.	Have you ever “played like you were sick” to get out of something?	**41.**	
42.	Pick the number that best represents how you feel about your life at this time.	**42.**	
	Very Worst 1 2 3 4 5 6 7 8 9 Very Best		
43.	Do you believe your use of alcohol keeps or has kept you from being as effective as you would like?	**43.**	
44.	Do you feel guilty about your drinking?	**44.**	
45.	Have there been times when you were quite jealous of the good fortune of others?	**45.**	
46.	Before making a left hand turn at an intersection, should you yield to oncoming traffic?	**46.**	
47.	In order to get the same effects, have you found you needed to increase the amount of social/street drugs you were trying? **(Do not include alcohol.)**	**47.**	
48.	Have you ever been irritated when people expressed ideas very different from your own?	**48.**	
49.	At times, have you really insisted on having things your own way?	**49.**	
50.	Indicate the number of times you have been arrested for an alcohol/drug related offense.	**50.**	
51.	Indicate the number of times you have been in a treatment program for alcohol or drug problems. **(Do not include court-ordered substance abuse education.)**	**51.**	

		Y	N
52.	Have you ever felt the urge to tell someone off?	**52.**	

53. Pick the number that best represents your current legal situation. **53.** ____

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

		Y	N
54.	Have there been times when you felt like disobeying people in power even though you knew they were right?	**54.**	
55.	Has your drinking ever caused problems with your family and/or friends?	**55.**	
56.	Do you find it difficult to get along with loud-mouthed, “bossy”, or obnoxious people?	**56.**	
57.	Do you try some type of social/street drug at least four times a month? **(Do not include alcohol.)**	**57.**	
58.	Has your wife/husband or children ever been in counseling regarding emotional or behavioral problems? **(If you have never been married, answer “No”.)**	**58.**	
59.	Has your wife/husband attended an Alanon meeting because of your drinking? **(If you have never been married or if you don’t know what Alanon is, answer “No”.)**	**59.**	
60.	Have you attended, or thought about attending, an A.A. meeting because of your drinking?	**60.**	
61.	Do you like to gossip at times?	**61.**	
62.	Have you ever felt that you were punished without cause?	**62.**	

63. Pick the number that best represents your financial situation at this time. **63.** ____

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

		Y	N
64.	Do you feel guilty about your use of drugs or medication? **(Do not include alcohol.)**	**64.**	
65.	Have your family and/or friends ever complained about your use of drugs or medication? **(Do not include alcohol.)**	**65.**	
66.	Before voting, do you carefully investigate the background and record of each person running for office?	**66.**	
67.	Have you ever intensely disliked anyone?	**67.**	
68.	Has your wife/husband/friend ever threatened to leave because of your drinking?	**68.**	
69.	More than once, have you gotten violently angry while drinking or using drugs?	**69.**	
70.	Have there been times when you took advantage of someone?	**70.**	
71.	On occasion, have you had doubts about your ability to succeed in life?	**71.**	
72.	Have you tried several times to stop drinking, but ended up drinking again?	**72.**	

		T	N
73.	Have there been some occasions when you felt like smashing things?	**73.**	
74.	Pick the number that best represents your current family life. (Enter 0 if this does not apply to you)	**74.**	

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

75.	Do you sometimes feel angry when you don't get your way?	**75.**	
76.	Have you ever forgotten or overlooked your duties, your family, or your work for two or more days in a row because of drinking?	**76.**	
77.	Are you always courteous, even to people who are disagreeable?	**77.**	
78.	Have you experienced physical and emotional after-effects resulting from heavy drug use?	**78.**	
79.	Do you sometimes try to get even rather than forgive and forget?	**79.**	
80.	At least once while drinking, or using drugs, have you thought about killing yourself?	**80.**	
81.	Sometimes do you have to hide the fact that you had been drinking?	**81.**	
82.	Do you usually take medication to help yourself sleep at night?	**82.**	
83.	If you could get into a movie without paying and be sure you were not seen, would you probably do it?	**83.**	
84.	Pick the number that best represents your feelings about yourself in the past year.	**84.**	

Very Worst 1 2 3 4 5 6 7 8 9 Very Best

85.	After a night of heavy drinking, does a drink the next morning usually help get you going?	**85.**	
86.	After a heavy night of drinking, the next morning, do your hands noticeably shake?	**86.**	
87.	Do you always admit it when you make a mistake?	**87.**	
88.	Do you always practice what you preach?	**88.**	
89.	Have you tried several times to stop using drugs, but ended up using again?	**89.**	
90.	To avoid eye strain during a long trip, should you move your eyes across the road frequently rather than just stare at the road ahead of you?	**90.**	
91.	Have you ever lost a job because of drinking?	**91.**	
92.	Do you sometimes have a strong urge to drink or use drugs, even when you are not?	**92.**	
93.	When driving near homes, should you watch out for children darting into the streets?	**93.**	
94.	Is it sometimes hard for you to go on with your work if you are not encouraged?	**94.**	

95. From the list below, enter the number of the item that you used or tried most often during the past three years. **95.** ____

96. When was the last time that you used this drug (the item selected in **QUESTION 95**)? (Enter 0 if you entered 0 for question 95) **96.** ____

1. Today
2. Yesterday
3. Within the past week
4. Two to four weeks ago
5. One to two months ago
6. Three to six months ago
7. More than six months ago
8. More than a year ago

97. From the list below, write the number of the item that you used second most often during the past three years. **97.** ____

98. When was the last time that you used this drug (the item selected in **QUESTION 97**)? **(Enter 0 if you entered 0 for question 97)** **98.** ____

1. Today
2. Yesterday
3. Within the past week
4. Two to four weeks ago
5. One to two months ago
6. Three to six months ago
7. More than six months ago
8. More than a year ago

Choices for Questions 95 and 97

0.	None	
1.	Alcohol	(Includes beer, wine, wine coolers, liquor)
2.	Sedatives & Hypnotics	doriden, noludar, quaalude, sopor (Includes ludes)
3.	Barbiturates	amytal, nembutal, seconal, tuinal (Includes barbs, reds)
4.	Tranquilizers	librium, valium, miltown, equanil, rohypnol (Includes klonopin, xanax)
5.	Heroin	(Includes horse)
6.	Other Narcotics	opiates, codeine, oxycontin, darvon, demerol, dilaudid, morphine, opium, paregoric, percodan, talwin, methadone (Includes percs)
7.	Cocaine	(Includes coke, blow, toot)
8.	Crack	(Includes rock)
9.	Amphetamines	methamphetamines, speed, diet pills, MDA, Benzedrine, ice, MDMA, desoxyn, Dexedrine, preludin, Ritalin (includes crank, bennies, whites, crystal, black beauties, white crosses, mini thin, ecstacy)
10.	Hallucinogens	LSD, DMT, PCP, MDS, STP, mescaline, ketamine (Includes acid, microdot, window pane, blotter, GHB, shrooms, DOB)
11.	Inhalants	glue, gasoline, paint thinner (Includes solvents, hydrocarbons, nitrous oxide, whippets, amyl, amyl nitrite, isobutyl nitrite, poppers, snappers, rush, locker room, climax, paint, correction fluid, turpentine, toluene, sniff)
12.	Marijuana	hashish, THC, (Includes grass, herb, hash, pot, weed, joint, blunt, J,doobie,hemp, sinsemilla, ganja)
13.	Other Drugs	(Steroids, etc)