KEY RECOVERY SOLUTIONS, LLC

## Consent to Admissions and Treatment

I, the under signed, need to be admitted to an outpatient clinic, and I hereby expressly consent to the Medical Staff, to clinic and to all other persons requested to render care to treat me and care for me in ways they judge to be proper and beneficial to me. I understand and agree that this care and treatment options may include all tests, examinations, diagnosis procedures and medical treatment that are deemed necessary.

1. ID
2. Insurance Information
3. Demographics
4. Diagnosis Information

Patient signature: _____ Date: _____

Staff Signature: _____ Date: _____

# KEY RECOVERY SOLUTIONS, LLC

## ADMISSION APPLICATION

Applicant's Name: _____ Age: _____ Sex: _____ Date: _____

Address: _____, _____, _____, _____

(Street) (City) (State) (Zip Code)

SSN: _____ DOB: _____ Home Phone: _____ Cell: _____

Email Address: _____ May we contact you this way? YES or NO

Other phone #'s applicant can be reached: _____ Relationship _____

Present Employment: _____

Address: _____ Phone: _____ Work Hours: _____

Type of work performed: _____ Monthly Earnings: _____ How Long: _____

Previous Employment

Employment: _____

Address: _____, _____, _____, _____

(Street) (City) (State) (Zip Code)

Reason for leaving: _____

How long unemployed: _____ Reason for unemployment: _____

Briefly list any employment skills or special training:

1: _____

2: _____

3: _____

School attended: _____ Highest education completed: _____

# KEY RECOVERY SOLUTIONS, LLC

## CLIENT DEMOGRAPHICS

Name: _____ Admission Date: _____

DOB: _____ SSN# _____

Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

Circle one: Married Living Together Divorced Single Widowed

911 Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Person: _____ Relationship _____

Emergency Contact Phone #: _____

Other Contact Person: _____ Relationship: _____ Phone: _____

Primary Physician: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

By signing below, I authorize (circle one) to contact the above-named Emergency Contact Person in the event of an emergency.

Client Signature: _____ Date: _____

# KEY RECOVERY SOLUTIONS, LLC

## Patient Intake: Medical History

Name: _____

Address: _____

Phone #: _____

DOB: _____ Age: _____ SSN# _____

Emergency Contact Person: _____

Current or past medical conditions (check all that apply)

( ) Hypertension

( ) Hepatitis C

( ) Head Trauma

( ) Liver Problems

( ) STDs

( ) Hepatitis B

( ) Currently Pregnant

( ) Epilepsy or seizure disorder

( ) HIV/AIDS

( ) Pancreatic Problems

( ) Abnormal Pap Smear

( ) GI disease

( ) Diabetes

( ) Thyroid Disease

( ) Cardiovascular - heart attack, high cholesterol, or triglycerides, angina

( ) Nutritional Deficiency

( ) Tuberculosis

Client Signature: _____ Date: _____

KEY RECOVERY SOLUTIONS, LLC

## DRUG SCREEN AGREEMENT

_____ agrees to arrive at their doctor appointments 15 minutes early with a full bladder to be drug screened. If patient is not able to be screened upon arrival of said appointment, you will be given one hour maximum to be drug screened. If past one-hour time frame, this can be considered immediate dismissal from the program. Once asked to produce urine specimen, you cannot leave the building.

_____ _____

Patient Signature Date

_____ _____

Clinical Director Date

# KEY RECOVERY SOLUTIONS, LLC

## FEE SCHEDULE

| | |
|---|---|
| **New Patent Intake** | **125.00** |
| **Established Patient** | **55.00** |
| **Targeted Case Management** | **334/541** |
| **Group Therapy** | **21.00** |
| **30 Minute Individual Therapy** | **45.00** |
| **60 Minute Individual Therapy** | **68.00** |
| **Assessment** | **68.00** |
| **Biopsychosocial** | **85.00** |

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

KEY RECOVERY SOLUTIONS, LLC

## EXPECTED SOURCE OF PAYMENT

1. Medicaid
2. Medicare
3. Private Insurance

Referral Source:

_____

_____

_____

Client Signature: _____ Date: _____

# KEY RECOVERY SOLUTIONS, LLC

Cabinet Ombudsman Address: 275 E. Main St., Frankfort, KY, 40601

Phone #: (502) 564-5497

## CLIENT'S RIGHTS

1. Client has the right to be treated with consideration and respect for personal dignity, autonomy and privacy.
2. Client has the right to be informed of the available program services.
3. Client has the right to give consent or refuse any services, treatment or therapy.
4. Client has the right to participate in the development, review and revision of one's individualized treatment plan and receive a copy of it.
5. Client has the right to be informed and the right to refuse any unusual treatment or hazardous treatment procedures.
6. Client has the right to confidentiality of communication and personal identifying information within the limitations and requirements for disclosure of client information under state and federal law regulations.
7. Client has the right to have access to one's own records.
8. Client has the right to be informed of the reason(s) for terminating participation in a program.
9. Client has the right to be informed of the reason(s) for denial of services.
10. Client has the right not be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, disability or HIV infection where asymptomatic or symptomatic or AIDS.
11. Client has the right to be informed of all client's rights.
12. Client has the right to exercise one's own rights without reprisal.
13. Client has the right to file a grievance in accordance with the program procedures.
14. Client has the right to have oral and written construction concerning the procedures for filing a grievance.
15. Client has the right to request a hearing, if involuntarily discharged, must be requested 48 hours of receipt of written notice of discharge.
16. Client has the right to continue treatment pending the outcome of the hearing.
17. Client has the right to be represented by an attorney, but client must pay the attorney, or other person chosen by the client.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

KEY RECOVERY SOLUTIONS, LLC

# PROGRAM RULES

Any violation of the rules is considered serious by this program, and the program staff will carefully review any violations. All violations will be recorded in the patient's clinical record and any violations can be contributing cause for discharge from the program. We want to work with you. Please discuss any questions or concerns about the following rules with counselor.

Stopping the use of illicit drugs is a goal of this program. The chronic use of Cannabis, Cocaine, Alcohol, Benzodiazepines, and any other drugs including prescribed or over-the-counter medications will not be tolerated while you are in our program. We understand that in addiction, slips sometimes occur, but if you are thinking of continuing the use of some substance, we encourage you to discuss it, in depth, with your counselor. The healing process cannot begin if you continue to use drugs and/or alcohol while in treatment.

## RULES OF THE USE OF THE PREMISES

These rules apply strictly to behavior at, or in the neighborhood of the program. We try to keep costs down by moving as little as possible - a goal we achieve by being seen as a good neighbor. Help us by always following these rules when you are at the clinic.

1. Park in a designated parking space that is appropriate for you to use. If you arrive before the program is open, remain in your car until it is time to enter the building. Do not stand outside your car or in a line by the door and never run from your car to the door. Do not throw trash in the parking lot including cigarette butts. Illegally parked vehicles will be towed at the patient's expense. Refer any parking problem to a staff member.
2. Do not knock on doors and windows, or otherwise draw unwanted attention to our other patients. You might set off an alarm.
3. You should avoid speaking to and socializing or congregating with anyone inside or outside the facility.
4. Sign in immediately upon entering the building. Avoid entering any other portion of the building.
5. If you have a counseling session schedule or are required to give a urine screen, you must do so before you dose or leave the building.

6. When you finish your business at the clinic, leave the building and drive away. Even if you intend to shop next door, driving around the block before returning to shop helps protect your confidentiality.

## GENERAL PROGRAM RULES

The following rules apply to your behavior while enrolled in our program.

1. Physical violence or threats toward another patient, an employee, or a business associate of the program will not be tolerated and will result in immediate and permanent expulsion from the program.
2. You must honor all agreements regarding payments for the services rendered. Any failure to meet your financial obligation is a very serious sign of non-compliance with treatment since it is a concrete measure of the value you place on treatment. Nonpayment of fees will result in involuntary discharge from treatment.
3. The on-site use, possession or sale of any drug (including alcohol) will not be tolerated. Bringing illicit drugs to the clinic is not permitted. Licit medications may be brought to show to staff members. Showing them to or sharing them with other patients is a serious rule infraction. Drug paraphernalia is not permitted on the clinic grounds. Firearms, illegal knives, or any other potentially lethal items are not allowed in the building or on the grounds. This includes combustible and hazardous materials.
4. Key Recovery Solutions will do observed drug screens and can be requested at any time. Failure to provide a urine specimen upon request is considered a refusal and is treated as a positive drug test result. Three refusals in ninety days or falsifying a UDS are grounds for discharge from the program.
5. You must come to the clinic neatly dressed. You are not to enter the parking lot intoxicated, impaired, or under the influence of any drug. Copies of any prescription must be recorded in your medical file. This is due to potential drug combination interaction that could cause a side effect or death.
6. If you miss your counseling appointment, the medical staff at their discretion can stop medication until you have a counseling session.
7. After missing two weeks of counseling and medication, you will be discharged by the medical staff.
8. You must report any changes in address, phone numbers, and employment and you must report any change of prescriptions.
9. You must report arrest or formal changes by law enforcement agencies. You must report if you are on parole or probation.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

KEY RECOVERY SOLUTIONS, LLC

**AGREEMENT FOR TESTING FOR SEXUALLY TRANSMITTED DISEASES**

As a participant in Key Recovery Solutions program, state regulations require testing for Sexually Transmitted Diseases every 3 months for MAT participants. I agree to be tested for STDs as needed to be compliant with state regulations for the Medication Assisted Therapy Program.

_____

Client Name

_____

Client Signature Date/Time

# KEY RECOVERY SOLUTIONS, LLC

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

X _____ hereby authorize _____

*Name of agency sharing protective health information

to share with _____ the following protected health information from my record:

Printed Name: _____ DOB: _____

and _____

*Include only information needed to accomplish state reason below.

AUTHORIZATION TO RELEASE INFORMATION AND MEDICAL RECORDS

UNDER TITLE 42, CFR, PART II, AND HIPPA

Health information is protected by Federal Law, Federal Regulations (42 CFR Part 2, and HIPPA) prohibits this information from being further disclosed without the specific written consent of you or as otherwise permitted by such regulations. Further disclosure of this information to another party or parties by those agents to whom you have authorized its release is legal. A general information for the release of medical or other information is NOT sufficient for this purpose.

I understand that I may revoke this consent to release information at nay time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of confidentially.

This authorization to release information shall expire on: _____

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

REVOCATION OF AUTHORIZATION: I HEREBY RESCIND MY AUTHORIZATION TO RELEASE INFORMATION TO THE ABOVE-NAMED PERSON OR AGENCY.

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

# KEY RECOVERY SOLUTIONS, LLC

48 INDEPENDENCE DRIVE
HAZARD, KY 41701
Phone # (606) 487-0100
Fax # (606) 487-0175

1. I agree to acknowledge that I am required to keep my counseling appointments as scheduled; and if my counselor does not contact me at the scheduled time, I understand that it is my responsibility to contact my counselor.
2. If any of my personal information should change, including address, phone number, and/or insurance, I understand that it is my responsibility to inform the front desk personnel at Key Recovery Solutions of those changes.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

# GAD 0-7

| **Over the last 2 weeks, how often have you been bothered by the following problems?** (use "✓" to indicate your answer) | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

(For office coding: Total Score T _____ = _____ + _____ + _____ )

**Source:** Spitzer RL. Kroenke K. Williams JB. Lowe R. A brief measure for assessing generalized anxiety disorder: the GAD-7 Arch Intern Med. 2006;166(10:1092-1097.

# Still struggling with depressive symptoms?

**Sharing all your symptoms with your healthcare provider is the first step to finding out if it could be more than depression.** Answer these questions and discuss the responses with your provider. This is not meant for self-diagnosis, so please bring it with you to your next appointment.

## Mood Disorder Questionnaire

**Please answer the questions as best you can by putting a check in the appropriate box.**

| 1. Has there ever been a period of time when you were not your usual self and ... | Yes | No |
|---|---|---|
| ... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | | |
| ... you were so irritable that you shouted at people or started fights or arguments? | | |
| ... you felt much more self-confident than usual? | | |
| ... you got much less sleep than usual and found that you didn't really miss it? | | |
| ... you were more talkative or spoke much faster than usual? | | |
| ... thoughts raced through your head or you couldn't slow your mind down? | | |
| ... you were so easily distracted by things around you that you had trouble concentrating or staying on track? | | |
| ... you had much more energy than usual? | | |
| ... you were much more active or did many more things than usual? | | |
| ... you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? | | |
| ... you were much more interested in sex than usual? | | |
| ... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | | |
| ... spending money got you or your family into trouble? | | |

2. If you checked Yes to more than one of the above, have several of these ever happened during the same period of time?

| Yes | No |
|---|---|
| | |

3. How much of a problem did any of these cause you? (Like being unable to work; having family, money, or legal troubles; and/or getting into arguments or fights)

| No Problem | Minor Problem | Moderate Problem | Serious Problem |
|---|---|---|---|
| | | | |

The Mood Disorder Questionnaire (MDQ) was developed by Robert M.A. Hirschfeid, MD (University of Texas Medical Brnach), and published in the Am J Psychiatry. (Hirschfeld RMA, Williams, JBW, Spitzer RL, et al. Develolpment and validation oif a screening instrument for bipolar spectrum disorder; the Mood Disorder



UNB126236 07/19