



Behavioral Health Services

Consent to Participate in Tele-Health Substance Use or Mental Health Services

I voluntarily give my consent for DCCCA, Inc. to facilitate mental health or substance use assessment and treatment services with to myself, my child, my family or other (specify)

_____.

I understand and acknowledge that Tele-Health is defined as services conducted via internet-based videoconference or by telephone.

I voluntarily give my consent for DCCCA, Inc. to contact me by phone, text, videoconference or email.

I understand and acknowledge that federal, state and other regulatory guidelines may, in certain circumstances allow verbal consent to participate in treatment and to authorize release of information.¹

I understand and acknowledge that DCCCA staff will not communicate with me via social media platforms including but not limited to Facebook, Twitter, Instagram, Facebook Messenger

I understand and consent to the need and right of DCCCA, Inc. to summon emergency medical service or transportation and to release appropriate information for such service or billing purposes.

I understand that this consent is voluntary and that I can withdraw my consent for treatment at any time.

Client Name/Guardian (and relationship to client)

Client/Guardian Signature

Date

¹ Federal and state regulations currently allow for verbal consent, in lieu of written consent, during the COVID-19 period.

DCCCA Behavioral Health Services

Notice of Privacy Practices

DCCCA Behavioral Health Services maintains client records consisting of personal, financial, social, and medical information. This information is used for diagnosis and treatment and also for contacting, scheduling, and determining financial ability, claims for third-party payers. Non-identifiable source information may also be used for reporting required by the state licensing agencies, need verification to county boards, and medical education. The Healthcare Portability and Accountability Act (HIPAA) establishes Privacy Rules that govern the uses and disclosures of this information. **We will not use or disclose your health information without your consent or authorization**, except as described in this notice or otherwise required by law.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

(* Notes Authorization for DCCCA Behavioral Health Services to release PHI is signed by client/legal representative prior to release.)

Routine Types of Disclosures

- Treatment of client: for use by a physician, nurse or other member of your healthcare team to determine the best course of treatment for you.*
- Third party payers (insurance companies and governmental funding agencies): for use in payment collection and may include the diagnosis, treatment received, and date of treatment. (K.S.A. 65-5603)*
- Health professionals or subsequent healthcare provider: to assist in your care after you are no longer being treated by this facility or in addition to this facility.*
- Officers of the court: When treatment is a requirement of the court, health information will be disclosed to the appropriate agencies as required by law.*
- To medical personnel when a medical condition poses an immediate threat to the health of the client and/or emergency medical intervention is warranted.

Non-Routine Types of Disclosures

- Communications with family/significant others: Using our best judgment, we may disclose to a family member, other relative, or to a close personal friend, health information relevant to that person's involvement in your care or payment related to your care.*
- Schools: In a collaborative effort to provide treatment to a minor, testing results and information gathered in therapeutic assessments may be disclosed.*
- Public health agency: We may disclose (if required by law) to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Suspected child or dependent adult abuse.
- Law enforcement: Health information may be disclosed in response to a valid court order.
- Employee Assistance Program/Employer: Limited health information may be disclosed to the extent necessary to comply with applicable laws when treatment is at the request or referral of an employer.*
- Workers compensation: We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation.*
- Certain qualified individuals or organizations may have access to client records for audit or evaluations for them to determine our compliance with state and federal regulations.
- Business associates: We provide some services through collaboration with other human service agencies. We also have Business Associate Contracts or Chain of Trust Partner Agreements with other organizations to provide safeguards for protected health information disclosures, required to conduct DCCCA Behavioral Health Services' operations in providing client care and services.

This is an example of Uses and Disclosures and not a complete list. If you have a question concerning disclosure, please contact the Executive Director.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD

Although your health records are the physical property of DCCCA Behavioral Health Services, you have certain rights with regard to the information contained therein.

- ❑ **You have the right to obtain a copy of this Notice of Information Practices.** The Notice is available to you in paper form.
- ❑ **You have the right to inspect and obtain a copy of your health information upon written request.** This right is not absolute and in certain situations, we can deny access, if access might cause harm to the client or another individual. You do not have a right to access information generated by an entity other than DCCCA Behavioral Health Services. Psychotherapy notes, separated from the medical record or information that was obtained from someone other than a healthcare provider under a promise of confidentiality are not covered by this right to access.
 - In other situations, when access to treatment information is denied, DCCCA Behavioral Health Services will inform you of the reason for denying access and how to seek a review of that decision. The reviewable grounds for denial include but are not limited to:
 - a) The access is reasonably likely to endanger the life or physical safety of the individual or another person, as determined by a qualified mental health professional.

Notice of Privacy Practices

- b) The health information makes reference to another person and such information is likely to cause substantial harm to the other person, as determined by a qualified mental health professional.
- c) The request is made by the individual's designee and providing the information to the designee is likely to cause substantial harm to the individual or another person, as determined by a qualified mental health professional.

For these reviewable grounds, the Executive Director will review the decision of the provider denying access and provide the client a written explanation of the reason for denial within 60 days

- ❑ **You have the right to request a correction or amendment to your health information.** We do not have to grant the request if the record was not created by our agency. In such instances, you must seek correction or amendment from the agency creating the record. If they correct or amend the information, we will file the change in our record. We do not have to grant the request if the record is accurate and complete or if the record is not available to you as described immediately above. If your request for correction or amendment is denied, DCCCA Behavioral Health Services will inform you of the reason for denying access. If the request for correction or amendment to the record is granted, the change will be made to your medical record and the correction/amendment distributed to those you identify to us as needing the information. When appropriate, the correction or amendment may be distributed to other entities, as defined in the Uses and Disclosures section of this Notice.
- ❑ **You have the right to request restriction on uses and disclosures of your health information for treatment, payment, and health care operations.** "Health care operations" consist of activities that are necessary to carry out the operations of DCCCA Behavioral Health Services, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law like mandatory reporting of child and adult abuse, and in those cases, you do not have a right to request restriction. The Consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If the restriction is granted, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication request. Refer to the consent form.
- ❑ **You have the right to obtain an accounting of "non-routine" uses and disclosures, other than those for treatment, payment, and health care operations.** We do not need to provide an accounting of uses and disclosures for:
 - a) The facility directory or to persons involved in the individual's care as provided in 164.510 (uses and disclosures requiring an opportunity for the individual to agree or object, including notification to family members, personal representatives, or others responsible for the care of the individual).
 - b) National security or intelligence purposes under 164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object, see chapter 16).
 - c) Those made to correctional institutions or law enforcement officials under 164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
 - d) Those made prior to April 14, 2003.After receipt of a valid, written request for non-routine accounting, we will provide the accounting within 60 days. The accounting will include the date of each disclosure, the name and address of the entity who received the health information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure that informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of a written request for disclosure.
- ❑ **You have the right to revoke your consent or authorization to use or disclose health information, except to the extent that we have already taken action in reliance on the consent or authorization.**

If you believe your privacy rights have been violated, you can file a complaint with DCCCA Behavioral Health Services Executive Director or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, YOU HAVE THE RIGHT TO REQUEST A COPY OF THE NEW NOTICE.

HOW TO CONTACT US: If you have questions about this policy, please write or call:
Director of Behavioral Health Services
DCCCA
3312 Clinton Parkway
Lawrence, KS 66047
1.785.841.4138





Behavioral Health Services

Consent to Treatment and for Use and Disclosure of Individually Identifiable Health Information

Client Name: _____ Client ID: _____

I consent to treatment and services delivered by the clinical staff of DCCCA Behavioral Health Services. I also understand that treatment and services are not an exact science and may involve risks. I understand there is no guarantee that the outcome of my treatment may be what I want it to be.

I understand that as a part of my healthcare, DCCCA Behavioral Health Services receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that DCCCA Behavioral Health Services and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals within DCCCA Behavioral Health Services concerning my care
- Disclose Protected Health Information (PHI) to insurance companies and other party payors or agents, to the extent necessary to collect payment for treatment and services rendered by DCCCA Behavioral Health Services
- Conduct routine health care operations, such as quality assurance, utilization review (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I have received a copy of the **DCCCA Behavioral Health Services' Notice of Information Practices** that explains the uses and disclosures that DCCCA Behavioral Health Services may make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. DCCCA Behavioral Health Services has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that DCCCA Behavioral Health Services cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that DCCCA Behavioral Health Services reserves the right to change its notice and the practices detailed therein prospectively.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, DCCCA Behavioral Health Services may refuse to provide me health care services unless applicable state or federal law requires DCCCA Behavioral Health Services to provide such services.

I understand that I have the right to request restrictions/objections on the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. I further understand that DCCCA Behavioral Health Services is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or DCCCA Behavioral Health Services notifies me that it is no longer going to honor the request.

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that DCCCA Behavioral Health Services has already taken action in reliance on my earlier effective consent. I have been informed if I have concerns about the protection of my rights, including my privacy rights, I may contact DCCCA Behavioral Health Services Director or the regional consultant with the Kansas Department of Aging and Disability Services.

Client/Guardian Signature

Date

Witness Signature

Date



DCCCA

Behavioral Health Services Contract for Care/Informed Consent

Client Name: _____

I, _____, hereby request treatment at DCCCA Behavioral Health Services. I hereby give permission for treatment and, if receiving treatment in a residential facility, the performance of any diagnostic procedure deemed advisable by the designated consulting physician and/or their designated assistants.

I agree to the following conditions:

1. Unless I qualify for assistance from KDADS, Medicaid or applicable third party payment, I will pay for services rendered according to the fee agreement for such services immediately. Prior to admittance, I will make satisfactory arrangements for payment of services.
2. I have received, read and will abide by the rules and guidelines in the program packet while receiving services from DCCCA Behavioral Health Services and will participate actively in therapeutic services offered at this facility.

For clients in residential treatment:

3. I will not possess or sell drugs or alcoholic beverages, medications, potential weapons and items judged to be potentially dangers to myself and/or others while in treatment. In fulfilling this condition, I will submit myself and my belongings to property search.
4. I am responsible for any valuables kept.

I am aware that if I violate this agreement, I may be asked to immediately leave this facility and/or suffer any rightful consequences for my behaviors in terms of City, County and/or State codes and ordinances.

Client/Guardian Signature

Date

Witness Signature

Date

DCCCA Client Rights

As a client of a DCCCA program, you have rights.

You have the right:

1. To be treated with dignity and respect,
2. To be free from any form of abuse, neglect, exploitation, restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
3. To a safe, sanitary, and humane living environment that provides privacy, and promotes dignity,
4. To receive treatment services free of discrimination based on your race, religion, ethnic origin, age, disabling or a medical condition, and ability to pay for the services,
5. To have service, expectations and rules explained to you in a language you can understand, prior to services beginning,
6. Ask and receive information regarding the DCCCA employee(s) who will be serving you
7. To privacy in treatment, including the right not to be fingerprinted, photographed, identified in any media form, or recorded without consent, except for:
 - a. Photographing for identification and administrative purposes,
 - b. Video recordings used for security purposes that are maintained only on a temporary basis,
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising your rights,
9. To confidential, uncensored, private communication that includes letters, telephone calls, and personal visits with an attorney, personal physician, clergy, Department of Aging and Disability Services Staff, or other individuals unless restriction of such communication is clinically indicated and is documented in the client record,
10. To practice individual religious beliefs including the opportunity for religious worship and fellowship as outlined in program policy,
11. To be free from coercion in engaging in or refraining from individual religious or spiritual activity, practice, or belief,
12. To receive an individualized treatment plan that includes the following:
 - a. Your participation in the development of the plan,
 - b. Periodic review and revision of your written treatment plan,
13. To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health,
14. To receive a referral to another program if we are unable to provide a treatment service that you request or that is indicated in the your assessment or treatment plan,
15. To have your information and records kept confidential and released only as authorized by federal law and regulations,
16. To be treated in the least restrictive environment consistent with your clinical condition and legal status,
17. To consent in writing, refuse to consent, or withdraw written consent to participate in research, experimentation, or a clinical trial that is not a professionally recognized treatment without affecting the services available to you,
18. To exercise the program's grievance procedures,
19. To receive a response to a grievance in a timely and impartial manner,
20. To be free from retaliation for submitting a grievance to this program, the Department of Aging and Disability Services, or another entity,
21. To receive one's own information regarding: medical and psychiatric conditions, prescribed medications including the risks, benefits, and side effects, whether medication compliance is a condition of treatment, and discharge plans for medications,
22. To obtain a copy of your clinical record at your own expense,
23. To be informed at the time of admission and before receiving treatment services, except for a treatment service provided to a client experiencing a crisis situation, of the: fees you are required to pay, and refund policies and procedures, and
24. To receive treatment recommendations and referrals, if applicable, when you are to be discharged or transferred.

If you are a residential client, you have the following additional rights:

1. To receive visitors, and make telephone calls as established, unless:
 - a. The program coordinator or designee determines and documents in the client record, a specific treatment purpose that justifies waiving this right, and
 - b. You are informed of the reason the right is to be waived and your right to submit a grievance regarding this treatment decision.
2. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:
 - a. The program coordinator or designee determines and documents in the client record, a specific treatment purpose that justifies waiving this right, and
 - b. You are informed of the reason the right is to be waived and your right to submit a grievance regarding this treatment decision,
3. To maintain, display, and use personal belongings, including clothing according to program policy,
4. To be provided with meals that meet your nutritional needs, a referral to medical services to maintain your health, safety, or welfare, if indicated, and opportunities for social contact and daily social, recreational, or rehabilitative activities.

DCCCA Client Rights

GRIEVANCES

A grievance is any client-initiated complaint or concern regarding the program or staff. Written, verbal or anonymous complaints of apparent or suspected rights violations will be addressed in the following manner:

1. Notify the counselor assigned to you of your complaint.
2. If the issue is not resolved, or if the complaint is against your counselor, you may ask to speak to the Clinical Coordinator or designee. When at all possible, the Clinical Coordinator will meet with you within 8 working hours.
3. If the issue remains unresolved, you may submit a written grievance to the Program Coordinator. The Program Coordinator will respond to the grievance within two working days.
4. If efforts to resolve the situation have been unsuccessful using the process in 1-3 above, a written grievance may be submitted to the Director of Behavioral Health Services. A written or verbal response will be made within a reasonable length of time, generally less than one week.

If you have a grievance we prefer that you notify the program using the procedure above to seek resolution. However you may also choose to contact KDADS or your assigned Managed Care Organization (MCO). You may find out who your MCO is by asking the DCCCA Program Coordinator or, for Medicaid members, looking at your insurance card.

**KDADS
Survey, Certification and
Credentiaing**
New England Building
503 S. Kansas Ave.
Topeka, KS 66603
Phone 785- 296-4986

**BLOCK GRANT FUNDED
Beacon Health Options**
Grievance Coordinator
Kansas Tower
100 SE 9th Street
5th floor, Suite 501
Topeka, KS 66612
Phone 1-866- 645-8216

**MEDICAID MCOs
Aetna Better Health of Kansas**
9401 Indian Creek Pkwy, Suite 1300
Overland Park, KS 66210
Phone 1-855-221-5656

**United Healthcare
Community Plan**
10895 Grandview Dr., Suite 200
Overland Park, KS 66210
Phone 1-877-542-9238

Sunflower State Health Plan
Member Services
8325 Lenexa Dr.
Lenexa, KS 66214
Phone 1-877-644-4623

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by this program. Generally, the program may not say to a person outside the program that a client attends the program, has previously attended the program or disclose any information identifying a client as an treatment participant unless:

1. The client consents in writing
2. The disclosure is allowed by a court order or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
4. The disclosure is made to protect the client or another person from serious injury.

Confidentiality applies once a person has been referred or made application to the program, throughout treatment, and after completion of treatment or discharge.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State and local authorities.

Violation of the Federal law and regulations may be reported to a United States Attorney or to the Kansas Department of Aging and Disability Services.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)



DCCCA
IMPROVING LIVES

DCCCA, INC
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	DCCCA#:
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I hereby authorize _____, an employee of DCCCA, Inc. to:

- Disclose information to
 Request information from
 Exchange information with

Name:

Address:

City:

State:

Zip Code:

Phone (optional):

Fax (optional):

Check and initial type of information authorized to be requested or disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Admission Intake | <input type="checkbox"/> Medical History, Lab results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychological Evaluation Report | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Psychiatric Evaluation Report | <input type="checkbox"/> Summary of Treatment |
| <input type="checkbox"/> Substance Abuse Evaluation Report | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Presence in Program | <input type="checkbox"/> Verbal or written Progress Reports/Consultations |
| <input type="checkbox"/> School Progress Reports/Records | <input type="checkbox"/> HIV/AIDS Information |
| <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Child Respite Information |
| <input type="checkbox"/> Other, specify: | |

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

I understand that this information will be used for the purpose of:

- Assessment
 Treatment
 Case Coordination
 Follow-up Care
 Other (specify): Case Management

This authorization shall remain in effect, as of _____ (date of customer/legal guardian signature) until _____ (date). **If this item is left blank, the authorization shall remain effective for 365 days after the signature date listed below.**

I, the undersigned, have read the above and authorized the request or disclosure of Protected Health Information (PHI) as described.

I understand that services are not conditioned upon the execution of this authorization.

I understand that DCCCA cannot assure that the recipient will maintain confidentiality of the information authorized to be released.

I understand that I may revoke this authorization at any time by providing written notice to my treatment provider except to the extent that action has been taken in reliance on the authorization.

Signature of Customer/Legal Guardian	Signature of Witness
Printed Name of Legal Guardian and Relationship	Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.



DCCCA

Behavioral Health Services

Authorization of Disclosure and Consent for Release of Confidential Information

I, (client name) _____ DOB: _____

Client ID: _____ SSN: _____

authorize **DCCCA Behavioral Health Services**, located at _____, to release information and obtain information contained in my records to/from the following individual or organization and only under the conditions listed below:

Name of **EMERGENCY CONTACT** to whom disclosure is to be made: _____

Address and phone number of emergency contact to whom disclosure is to be made: _____

Specific information to be disclosed: Information pertaining to emergency episode/event

The purpose and need for such disclosure: In the event that an emergency occurs and communication between parties is necessary

This consent to disclose may be revoked by me at any time EXCEPT: to the extent that action has been taken in reliance thereon. This release (unless expressly revoked earlier) expires upon: 90 days from the signature date.

Signature of client: _____ Date: _____

Signature of witness: _____ Date: _____

If applicable, signature of parent, guardian or legal representative:

Signature of representative: _____ Date: _____

Relationship: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.



Behavioral Health Services

Fee Agreement

Client Legal First Name:
Client Legal Last Name:
Client Legal Middle Initial:

Address

Street 1:
Street 2:
APT/Suite:
City:
State/Province:
Zip:

DCCCA uses your past 90 days of financial information and the agency's sliding fee scale to determine fee information. Insurance co-pays and deductibles are your responsibility as required by your insurance company. DCCCA staff will inform you of those amounts once verified by the insurance company. If your insurance company denies reimbursement or you choose to pay out of pocket for your services, your fee(s) per session are:

Current verified income: \$

Verified income is per: Month Year

Number of persons dependent upon this income:

Primary Service/Modality:

Based on verified income shown above

Fee Per Session:

Secondary Service/Modality:

Based on verified income shown above

Fee Per Session:

Comments:

Fee Waived: No Yes

Fee Waiver Explanation:

If the fee has been waived, Program Coordinator must approve this form.

Customer Agreement

I understand that DCCCA will exhaust all efforts to bill third party funders. However, I may be responsible for deductible and co-pay amounts for which reimbursement is denied. I understand that DCCCA will bill me for charges identified as my responsibility on my insurance company's Explanation of Benefits. These charges may be in addition to the established co-pay.

I understand that I may not be eligible for other funding sources and all fees are ultimately my responsibility.

I agree to pay the fees documented above at the time of service and to pay for all charges billed to me as a result of my insurance company's Explanation of Benefits. I understand that DCCCA may refund payments I have made if the service is reimbursed by a third-party payer, or if I have paid for services in advance and cannot continue treatment for reasons beyond my control. I understand being asked to leave treatment for consistent non-compliance is not considered beyond my control.

I acknowledge that the fees and Customer Agreement were verbally explained to me by a DCCCA staff. I understand that failure to pay the agreed upon fees may result in DCCCA discharging me from treatment. I further understand that successful discharge may be delayed until services are paid in full.

Signature of Customer/Legal Guardian	Signature of Witness
Printed Name of Legal Guardian and Relationship	Date



Behavioral Health Services Treatment Introduction Form

Your primary counselor is _____

We have discussed the outcome of your assessment and have recommended that you participate in the following treatment services. More than one service may be recommended.

- Individual counseling:** Your first appointment is _____
- Group counseling:** Your first group is _____
Group schedule: _____
- Intensive Outpatient Group:** Your first group is _____
Group schedule: _____
- Alcohol/Drug Information School Date:** _____
- Peer Support:** Your first appointment is _____

As a client, you will become an active member while in treatment. You will participate in the development of your treatment plan, service delivery, and discharge plan. Family members and other social supports will participate with you, if you agree, throughout your treatment. You may periodically be asked to submit a urine drug screen to verify your progress in treatment. With the appropriate releases signed, we will communicate with other professionals you work with and make referrals for additional community based supports. We will expect that you participate in recovery support groups while in treatment.

Contact Information:

Primary Counselor: _____

Counselor's Supervisor: _____

Peer Support Specialist: _____

After-hours Crisis Line: _____