

United Community Services, Inc.

Client Information Form

GENERAL

Name: _____ Date of Birth: _____ Date: _____

Social Security #: _____ Marital Status: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Why do/did you want to get on methadone? _____

What do you want to get out of methadone treatment? _____

Education: (years) _____ Have you ever been in the armed forces? _____

What is your county of residence _____ Are you pregnant? Y N Date Due _____

Name of person to contact in case of an emergency? _____

What is their relationship to you? _____ Phone: _____

I, _____, do hereby authorize the staff of United Community Services, Inc. to contact the above named individual in the case of a medical emergency. I further authorize United Community Services, Inc. to contact the appropriate medical personnel in such an event, as I am unable to do so. This release expires automatically 60 days after my discharge.

Signature _____ **Date** _____

Promissory Note

I agree to pay \$8.00 per dose for the cost of my treatment at United Community Services, Inc. My signature on this Promissory Note constitutes a legal obligation on my part. I acknowledge that full payment is a part of the treatment process and that it is essential to be paid on time and that any requests to modify the payment arrangement must be approved by the supervisor. I understand that I may be placed on administrative detoxification schedule if I am unable to pay.

Patient Signature: _____ *Date:* _____

Name: _____

What are some things you would like to work on while involved with the methadone treatment program?

1. _____
2. _____
3. _____

What are some of your short and long term goals?

1. ST/LT _____
2. ST/LT _____
3. ST/LT _____
4. ST/LT _____

What are some of your strengths that will help you achieve your goals?

1. _____
2. _____
3. _____

List some of your barriers/weaknesses that could interfere with your achieving your goals.

1. _____
2. _____
3. _____

List the persons or agencies that you need to have a release signed to:

1. _____
2. _____
3. _____

United Community Services, Inc.

401 SW 8th Street

Des Moines, IA 50309

**CONSENT FOR THE RELEASE OF OR TO OBTAIN CONFIDENTIAL INFORMATION
INCLUSIVE OF ANY AND ALL MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT
RECORDS**

I, _____, authorize United Community Services, Inc. to disclose
to/receive from: **Iowa Central Registry**

The following information: **Methadone treatment medical records**

The purpose or need for such disclosure is: **Methadone maintenance/detoxification**

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. This consent expires _____ or sixty days past discharge.

Signature of Client

Date

I-SMART

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize United Community Services to disclose to _____ the following information:

- () Admission (Until Discharge ,+365 days)
 - () Client Information (Profile) (Until Discharge ,+365 days)
 - () Behavioral Health Assessment (Until Discharge ,+365 days)
 - () Client Screening (Until Discharge ,+365 days)
 - () Discharge (Until Discharge ,+365 days)
 - () GPRA Assessment (Until Discharge ,+365 days)
 - () DHA /DASA ATR Screen II (Until Discharge ,+365 days)
 - () Intake Transaction (Until Discharge ,+365 days)
 - () Mental Status Report (Until Discharge ,+365 days)
 - () RSS Plan Goal (Until Discharge ,+365 days)
 - () SASSI Scores (Until Discharge ,+365 days)
 - () TAP Assessment (Until Discharge ,+365 days)
 - () Treatment Plan (Until Discharge ,+365 days)
 - () Treatment review (Until Discharge ,+365 days)
 - () Treatment Transaction (Service) (Until Discharge ,+365 days)
 - () Medical Information (Until Discharge , + 365 days)
- Other Disclosures _____

The purpose of the disclosure authorized herein is to _____

I understand that my records are protected under 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 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as indicated with each disclosure item above. I understand that generally United Community Services Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature of participant _____ Date _____

Signature of witness _____ Date _____

Signature of parent, guardian or authorized representative when required _____

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making 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 is 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-SMART

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize United Community Services to disclose to Polk County Health Department the following information:

- Admission (Until Discharge ,+365 days)
- Client Information (Profile) (Until Discharge ,+365 days)
- Behavioral Health Assessment(Until Discharge ,+365 days)
- Client Screening (Until Discharge ,+365 days)
- Discharge (Until Discharge ,+365 days)
- GPRA Assessment (Until Discharge ,+365 days)
- DHA /DASA ATR Screen II (Until Discharge ,+365 days)
- Intake Transaction (Until Discharge ,+365 days)
- Mental Status Report(Until Discharge ,+365 days)
- RSS Plan Goal(Until Discharge ,+365 days)
- SASSI Scores(Until Discharge ,+365 days)
- TAP Assessment (Until Discharge ,+365 days)
- Treatment Plan (Until Discharge ,+365 days)
- Treatment review (Until Discharge ,+365 days)
- Treatment Transaction (Service) (Until Discharge ,+365 days)
- Medical Information (Until Discharge, + 365 days)

Other Disclosures _____ VDRL Test Results _____

The purpose of the disclosure authorized herein is to determine medical information

I understand that my records are protected under 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 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as indicated with each disclosure item above. I understand that generally United Community Services Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature of participant _____ Date _____

Signature of witness _____ Date _____

Signature of parent, guardian or authorized representative when required _____

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making 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 is 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.

United Community Services, Inc.

Name: _____

COLLATERAL CONTACTS

As a part of our program evaluation, the Iowa Consortium for Research conducts post-treatment reviews of services we provide. Please provide the names of three contacts that would be able to give the consortium information about your whereabouts. The researcher will not give any information about why they are trying to locate you or any information about your receiving services from UCS. They will identify themselves as a health research analyst from the University of Iowa. When they contact you for the follow up questionnaire they will offer you a gift certificate for your participation in the study.

Contact #1 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

Contact #2 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

Contact #3 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

United Community Services, Inc.

Name: _____

Patient Informed Consent and Consent to Participate in Opioid Pharmacology Treatment

It is necessary that you fully understand the nature of the treatment we provide. We are a methadone outpatient treatment center. You need to provide us a signed statement indicating your consent to begin the treatment effort before you can be admitted into treatment:

1. As part of your treatment at this center we will be prescribing a daily medication called Methadone to you.
2. The Methadone is a habit-forming narcotic substance which will stop you from entering into withdrawal, it will also stop any cravings you may have for other narcotics, i.e. Heroin, Morphine, Dilaudid, etc.
3. The Methadone will be prescribed for you by a physician and given to you by a pharmacist, and it will be necessary for you to take this medication every day while your are in treatment.
4. The potential discomforts and/or risks are that the Methadone is habit-forming, and you will become physically dependent upon the Methadone in place of your usual narcotic.
Because you will become physically dependent upon the Methadone it will be necessary to slowly detoxify or reduce your daily dose before you can become totally drug-free. Abrupt stopping of your daily Methadone can cause you to go into withdrawal the same as any other narcotic withdrawal. Some of the side-effects some people encounter from Methadone are constipation, sweating, nausea, lightheadedness, sleepiness, dizziness, urine retention or slowness, or skin rash. ***All of these side-effects, however, are temporary and will pass as your body becomes tolerant to the Methadone. You must also use care when operating a car or dangerous machinery.***
5. In addition to the prescribing of Methadone, you will be assigned a counselor to work with you. You will have a schedule of meetings established for you with the counselor. You will also be expected to establish a treatment plan in conjunction with your counselor and to establish treatment plan goals. The treatment purpose is to help you do better in life and not just the prescribing of Methadone. Therefore your progress in treatment is determined by the meeting of your treatment plan goals and not just drinking the Methadone.
6. The benefit you will gain from treatment is a cessation of narcotics cravings and a freedom from your expensive, dangerous and decidedly unhealthy use of narcotics. Also you will experience a new-found sense of freedom from your habit and an ability to pursue other desires in life. Society too will benefit from this treatment because you will not be engaging in illegal behaviors to finance your present habit and you will not be at risk for spreading Hepatitis or AIDS by sharing needles.
7. The physician, pharmacist and other staff are always available to answer any questions you may have.
8. You may elect to discontinue treatment at any time, **but you are hereby advised that stopping treatment abruptly, without slow detoxification, will cause you to enter withdrawal and become ill**, although not generally life threatening.
9. Periodically you will be required to tell us your wishes regarding treatment continuation, treatment plan goals. At that time treatment may be altered to meet your wishes, detoxification begun if you so desire, or treatment continued if you so desire and if you are continuing to make progress.

Continued on next page

Consent to Participation in Opioid Pharmacotherapy Treatment

Name: _____ Date: _____

I hereby authorize and give voluntary consent to the Division and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by the program physician, or his/her designee, in accordance with Federal and State regulations. It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me. I understand that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my opioid pharmacotherapy or my chances of successful recovery from addiction. Some medications, Talwin, Nubane, Stadol, Rifampin, and Dilantin most notably, can cause you immediate withdrawal. I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised tapering.

Methadone when taken alone and in accordance with the physician's schedule is safe. Taking certain other drugs or medications with the Methadone, however, can cause you a medical emergency, which could be fatal. The use of other analgesics (painkillers) or tranquilizers, anti-depressants, alcohol, or any other central nervous system depressant can cause respiratory depression, hypertension (inadequate blood pressure) over-sedation, coma and even death. You must also use care when operating a car or dangerous machinery. Remember that your doctor or dentist must be informed of the Methadone you are receiving.

For Female Patients of Childbearing Age: There is no evidence that methadone pharmacotherapy is harmful during pregnancy. The fetus is at most risk when the mother continues an involvement with other chemicals. Also, withdrawal from certain drugs causes uterine contractions that could lead to premature delivery or spontaneous abortion. If you are Pregnant or become pregnant you must receive pre-natal care from an OB-GYN physician who has been informed of your status as a Methadone patient.

YOUR SIGNATURE ON THIS FORM MEANS YOU FULLY UNDERSTAND ALL OF OUR TREATMENT METHODS AND THAT YOU AGREE AND GIVE CONSENT TO THESE PROVISIONS AND THAT YOU WILLINGLY DESIRE OUR TREATMENT.

I have received a copy of the Informed Consent form.

Signature of Client

Date

Witness: _____

United Community Services, Inc.

Statement of Understanding & Treatment Agreement

I, _____, have received a copy of, have read, and/or have had explained to me, and understand the following information:

(Please Initial each location)

_____ I have received a copy of the Client Handbook and information on HIV/AIDS. I was also given the opportunity to read, ask questions, and/or had explained to me the contents of this book. I completed a substance abuse questionnaire that was given to me during the intake and answered the questions in an honest manner to the best of my ability.

_____ I have received a copy of the cost of my outpatient services. A treatment plan was developed with me and the details were explained to me and I received a copy of that plan. A schedule of the days and times that groups are available were given to me.

_____ The general nature and goals of this Treatment Program have been discussed with me as well as the rules governing client conduct and infractions that could lead to discharge from the program and the policy on follow-up contact

_____ The hours of medication dosing and other treatment service that are available

_____ What the cost of my treatment is and how this figure has been determined

_____ What the rights and responsibilities of the client are

_____ The Grievance Procedure

_____ What the rules and regulations concerning urinalysis testing are.

_____ The rights and responsibilities of the client, Federal Confidentiality laws, rules and regulations have been discussed with me.

I, therefore agree to participate in treatment at **UNITED COMMUNITY SERVICES, INC.** Furthermore, I understand and agree that in order to be successfully discharged from treatment or positively transferred to another Methadone program I must adhere to and comply with all program requirements and treatment issues set forth in the treatment plan. The treatment requirements include but are not necessarily limited to the following:

1. Total participation in all scheduled appointments and activities unless prohibited by a documented medical emergency or cancellation of activities by the service provider.
2. Complete payment for all cost(s) incurred during my involvement with **UNITED COMMUNITY SERVICES, INC.** \$8.00 per dose for private pay or based on sliding fee scale as identified in promissory note for subsidized clients.
3. Adequate progress in the program as judged by the clinical staff.
4. I will act in a responsible manner.

Furthermore, I acknowledge this has been explained and outlined to me and that I understand the requirements and my obligations.

Client's Signature: _____ Date: _____

Methodone Central Registry Check/Authorization

Lucas State Office Building, 321 E. 12th Street
Des Moines, IA. 50309
Division of Health Promotion, Prevention & Addictive Behavior Fax (515) 281-4535

Program Name: **United Community Services, Inc.** Federal I.D. # IA. 10,015M
Address: 401 SW 8th Street Phone # (515) 280-3860
Des Moines, Iowa 50309 Fax # (515) 883-2683

Program Contact Person Requesting Authorization: _____

1. Patient's admission date: _____

2. Patient's Name _____

3. Patient's S.S.# _____ or SARS# (if applicable) _____

4. Patient's D.O.B: ____/____/____ Patient's Gender: () Male () Female
Month Day Year

5. Patient's Address: _____

6. Patient's Home Phone _____ Patient's Work Phone _____

7. Patient's employment status: ()Employed()Unemployed()Disabled()Homemaker()Student

If patient is employed out of home, list occupation, work location and hours

If unemployed, how long?

Counselor's Signature: _____ Date: _____