ATOPS Addiction Treatment Outpatient Services

Admissions Application

Which class will you be attending:_____ When will you be starting classes:_____

First Name: _____ Last Name: _____ Date of Birth: _____

Phone Number: _____ E-mail address: _____

Address: _____ Apartment Number: _____ City: _____

State: _____ Zip Code: _____ ***The following questions will be used to register you for an on-line assessment which will be sent to you by e-mail****

How long have you lived at this address: _____ years _____ months Is this residence owned by your family? Yes ☐ No ☐

Birth City:_____ Marital Status:_____ Last 4 Digits of SSN:_____

Mother's First Name:_____ # of persons living on income:_____ # of children under 18:_____

Highest grade completed:_____ Employment Status:_____ Age first used alcohol:_____

# of prior substance abuse treatment:_____ Are you a military service veteran:_____ Last Name at birth:_____

Primary substance:_____ How many days in the last 30 did you use your primary substance:_____

Please complete whichever is applicable to your case:

Attorney's Name: _____ Probation Officer:_____

Address:_____ Case Number: _____

_____ County of Offense: _____

Attorney's Email:_____

Please select your preferred methods of contact:

☐ Cell Phone

☐ If Text (list your cell phone carrier):_____

☐ Work Phone:_____

☐ Mailing Address

☐ E-mail

☐ Home Phone:_____

☐ Other(please specify):_____

How did you hear about us? *(please select one)*:

☐ Internet Search ☐ Detox Unit: _____

☐ OBH website ☐ Yellow Pages ☐ Other:_____

Ph:(303)329-3105
Fax:(303)600-6645

ADDICTION TREATMENT OUTPATIENT SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize Addiction Treatment Outpatient
(your name)

Services to exchange information with _____
(name of person and organization)
Please list your PO's or Attorney's 1st and last name

from my records, which must be limited by nature and extent as specified below:

☐ enrollment
☐ cooperation
☐ attendance (hours and weeks completed
☐ treatment status and progress
☐ education and treatment levels
☐ fee payment
☐ compliance with ancillary services
☐ discharge status
☐ participation and progress in education and/or treatment

The purpose or need for above disclosure is:
☐ to coordinate legal requirements(s) fulfillment and counseling services
☐ other purposes please specify_____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon, and unless expressly revoked earlier.

This consent will automatically expire two (2) years after the date of my signature as it appears below, or on the following earlier date, condition, or event as specified below

_____
(specify date or event or condition upon which it will expire)

Signature: _____ Date _____

Prohibition on redisclosure:
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 client (Sec. 2.32).

ADDICTION TREATMENT OUTPATIENT SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize Addiction Treatment Outpatient
(your name)

Services to exchange information with **Department of Revenue – Division of Motor Vehicles**
(name of organization)

from my records, which must be limited by nature and extent as specified below:

☐ enrollment
☐ cooperation
☐ attendance (hours and weeks completed
☐ treatment status and progress
☐ education and treatment levels
☐ fee payment
☐ compliance with ancillary services
☐ discharge status
☐ participation and progress in education and/or treatment

The purpose or need for above disclosure is:
☐ to coordinate legal requirements(s) fulfillment and counseling services
☐ other purposes please specify_____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon, and unless expressly revoked earlier.

This consent will automatically expire two (2) years after the date of my signature as it appears below, or on the following earlier date, condition, or event as specified below

_____
(specify date or event or condition upon which it will expire)

Signature: _____ Date _____

Prohibition on redisclosure:
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 client (Sec. 2.32).

TELEHEALTH & TELEMEDICINE CONSENT FORM

DEFINITION OF SERVICES:

I hereby consent to engage in telehealth/telemedicine with Addiction Treatment Outpatient Services. Telehealth/telemedicine is a form of behavioral health and psychiatric service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth/telemedicine involves the communication of my medical/mental health information, both orally and/or visually. Telehealth/telemedicine has the same purpose or intention as psychotherapy and psychiatric treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth/telemedicine:

CLIENT'S RIGHTS, RISKS, AND RESPONSIBILITIES:

- I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with Addiction Treatment Outpatient Services.
- I understand that there are risks and consequences of participating in telehealth/telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my behavioral health/ medical information could be accessed by unauthorized persons.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems.
- In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be asked to attend sessions at the agency.
- I understand that I may benefit from telehealth/telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
- If I am experiencing a crisis, I can contact Colorado Crisis Services at 1(844) 493-8255 (text "Talk" to 38255). In an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in Telehealth/telemedicine. I am responsible for providing the necessary computer, tablet or phone and internet access for my telehealth/telemedicine sessions, and for arranging a location with privacy that is free from distractions or intrusions for my session. It is the responsibility of the treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to researchers or other entities shall not occur without my written consent.
- This will be reviewed bi-annually.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION PROVIDED ABOVE REGARDING TELEHEALTH/TELEMEDICINE AT Addiction Treatment Outpatient Services.

Client Signature **Date**

Staff Signature **Date**

Dr. Karen Moreau, P.hd Clinical Director

LEVEL II EDUCATION SERVICE PLAN

Name:_____

Please pick 1 goal you would like to focus on during your enrollment at ATOPS.

Your goal should be specific, measurable, attainable, and have a realistic date of achievement. We will check back with you at the end of Level 2 Education (in about 3 months) to see what progress you've made.

Please describe your treatment goal:

Why this goal is important to you:

How will you accomplish your goal?
Please describe the specific steps will you take in order to accomplish your goal:

1._____

2. _____

3. _____

When/How will you know you've accomplished your goal?

Client's Signature: _____

Therapist's Signature: _____
Karen R Moreau, Ph.D., CAS

EXPECTED REVIEW DATE_____

I,_____ ,acknowledge I have been offered a copy of this plan.
print your name

ADVANCE DIRECTIVES

Federal Law requires that we tell adult patients about Colorado laws relating to your right to make health care decision and Advance Directives. Your provider will provide mental health care whether or not you have an advance directive.

What is a Medical Advance Directive? Advance Directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. In Colorado, Medical Advance Directives include:

- **Medical Durable Power of Attorney**: This names a person you trust to make medical decisions for you if you cannot speak for yourself.
- **Living Will:** This tells your doctor what type of life supporting procedures you want and do not want.
- **Cardiopulmonary Resuscitation (CPR) Directive of "Do Not Resuscitate Order"**: This tells medical personnel not to revive you if your heart or lungs stop working.

Your provider will ask you if you have an Advance Directive. If you wish, your provider will put a copy of your Advance Directive in your file. If provider does not follow your Advance Directive, you may call the Colorado Department of Public Health and Environment at 303-692-2980.

Do you have an Advance Directive?
☐ YES
☐ NO

Would you like ATOPS to keep a copy on file?
☐ YES
☐ NO

Client Name (Printed) _____ Signature_____ Date_____

Witness (Printed) _____ Signature_____ Date_____

***We will complete the witness section upon receipt**

ADDICTION TREATMENT OUTPATIENT SERVICES

Payment Agreement

It is the policy of ATOPS to receive payment at the time of each Education/Therapy session.
Fees are as follows:

Intake Level II Education	$60.00
Level II Education (15.00/hr)	$30.00 Per Group
Level II Education & Level II Therapy – Workbook Workbook - Shipping, supplies & transport	$30.00 / $35.00 $10.00
Intake and Assessment for Level II Therapy – Existing ATOPS clients	$35.00
Intake and Assessment for Level II Therapy – New ATOPS clients	$65.00
Level II Therapy (17.50/hr)	$35.00 Per Group
Absences in excess of Allowed Amount	Per Group FULL COST OF SESSION
Letter for Court prior to hearing less than 10 days Notice	$50.00
Returned Check Charge	$35.00 ***Check writing privileges denied after 2 returned checks***
Paper Processing fee	$25

ALL RATES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE

Failure to pay for services rendered will result in your account being turned over to a collection agency.

Client's Signature _____ Date _____

GLOBAL ASSESSMENT OF FUNCTIONING

Please only select one

☐ I believe I have superior functioning in a wide range of activities; life's problems never seem to get out of hand. I am sought out by others because of my many qualities (100-91)

☐ I believe I have good functioning in all areas. I am interested and involved in a wide range of activities. I am socially effective. I am generally satisfied with life. I experience no more than everyday problems or concerns. (90-81)

☐ I may experience some symptoms to psychological stresses. I experience no more than a slight impairment in social, occupational or school functioning. Any symptoms that I experience are short-term and expectable reactions to the situation. (80-71)

☐ I experience some difficulty in social, occupational, or school functioning but generally I function pretty well. I have some meaningful interpersonal relationships (70-61)

☐ I experience moderate OR moderate difficulty in social, occupational, or school functioning (60-51)

☐ I experience serious symptoms OR serious impairment in social, occupational, or school functioning (50-41)

☐ I experience some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (40-31)

☐ My behavior is considered to be influenced by delusions or hallucinations OR serious impairment in communications or judgement OR inability to function in all areas (30-21)

☐ I believe I am in danger of hurting myself or others. I occasionally fail to maintain minimal personal hygiene. I occasionally experience gross impairment in communication (20-11)

☐ I experience a persistent danger to hurt myself or others. I experience a persistent inability to maintain minimum personal hygiene. I have experienced a serious suicidal act with the clear expectation of my death (10-1)

Name: _____

Date: _____

ADDICTION TREATMENT OUTPATIENT SERVICES

Welcome to Addiction Treatment Outpatient Services

You have chosen Addiction Treatment Outpatient Services (ATOPS) and ATOPS has chosen you. In order to make this relationship as productive as possible there are several things we think will help.

- All conversations and records are confidential. This also means that what you hear and who you see must remain confidential.
- Some education groups have a predetermined length. In therapy groups your length of stay is determined by individual consultation with your therapist and the court.
- Any non-addicted participant should keep his or her use of alcohol within normally accepted standards.
- Please refrain from alcohol use prior to group sessions. The use of illegal drugs is not acceptable.
- If you are addicted and involved in recovery, then abstinence and your attendance at AA meetings is encouraged.
- Payment of fees is expected prior to the group or counseling session. You are welcome to pay in advance.
- Groups will start and end on time. If you are late without an important reason, please consider that you have missed that group. Interruptions are detrimental to everyone.
- Regular attendance is vital. Advance notification of absence is expected. Missed sessions are charges at the regular rate.

The Staff dedicates itself to providing you with quality treatment opportunities. It is our desire that you use this experience to work through problems and develop a more meaningful and satisfying life for yourself and others.

Rights and Responsibilities of Clients

- The right to expect that your lifestyle, religious preferences, values, cultural heritage and practices will be honored regardless of race, color, religion, national origin, age, sex, economic status, political affiliation or handicap.

- The right to confidentiality in all personal matters with sensitive concerns shown when these matters must be shared with other Staff.

- The right to review your clinical record.

- The responsibility to comply with the rules and regulations of the treatment center. Phone use must be limited in scope.

- The responsibility to arrive on time, pay promptly and treat the facility with care.

- The responsibility to take charge of your own personal property.

- The right to an independent clinical evaluation regarding ATOPS therapeutic decision to withhold portions of your clinical record from you on the basis of negative impact.

- The right and responsibility to participate with the staff in the assessment, planning, implementation and evaluation of your treatment program.

- The right and responsibility to follow stated policies in initiating and resolving grievances concerning care and treatment.

- The right to seek a second opinion regarding treatment recommendations

Signature: _____ Date:_____

Filing a Grievance

Contact Annie Burtis, Director of Admissions at or by telephone 303-329-3105 or email annie@atops.org. Provide her with a complete description of the reason(s) for your dissatisfaction, the date it occurred, the name of your therapist, the policy and procedure that concerns you, and any other pertinent details that will assist Ms. Burtis in understanding your dissatisfaction in order to resolve it satisfactorily. Our commitment is to have the issue resolved within 15 business working days. If we have not resolved it to your satisfaction by the 15th day, you have the right to contact the following entities for assistance.

The practice of registered, certified or licensed person in the field of psychology is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding mental health counselors may be addressed to:

Board of Mental Health Examiners
1560 Broadway, Ste.1350 Denver, CO 80202 (303) 894-7800
Board of Addiction Counselor Examiners
1560 Broadway, Ste. 1350 Denver, CO 80202 (303) 894-7800
Colorado Department of Human Services, Office of Behavioral Health
3824 W. Princeton Circle, Denver, CO 80236 (303) 866-7400
Colorado Department of Regulatory Agencies
1560 Broadway, Ste 110, Denver, CO 80202 (303) 894-7855
Behavioral Health Administration
3824 W. Princeton Circle, Denver, CO 80236 303-866-7400

I, _____ ,have been made aware of the ATOPS Grievance policy and offered/given a copy of this policy.
(print name)

Signature: _____

Date:_____

ADDICTION TREATMENT OUTPATIENT SERVICES

TREATMENT AUTHORIZATION

I hereby authorize ADDICTION TREATMENT OUTPATIENT SERVICES to administer such care (encompassing diagnostic procedures and psychological treatment) as is necessary in its judgment. No guarantee or assurance has been given by anyone as to the results that might be obtained

AGREEMENT

In consideration of ADDICTION TREATMENT OUTPATIENT SERVICES (ATOPS), agreeing to undertake the care of _____ (**client's name**), I hereby agree to the following:

1. ATOPS does not assume any responsibility for loss/or breakage of any valuables, personal articles, or belonging brought to the center by the client.

2. ATOPS shall be help harmless for any and all claims, suits, damages, costs, losses, and expenses in any matter resulting from or arising out of self-inflicted injury by me.

3. That I shall be financially responsible to ATOPS for any loss or damage suffered or incurred to ATOPS which was caused by me.

4. I hereby accept and assume full responsibility for payment of all costs, charges and expenses for processional services rendered to me by ATOPS and further understand agree that any such billing is due and payable at the time of service unless other arrangements have been made.

Signature: _____ Date: _____

ADDICTION TREATMENT OUTPATIENT SERVICES

DISCLOSURE STATEMENT

ADDICTION TREATMENT OUTPATIENT SERVICES (ATOPS) is a substance use disorder treatment program licensed by the Division of Behavioral Health, Colorado Department of Human Services. Treatment Center Licenses 1284.00, 1284.01 and 1284.02. The counseling Staff employed at ATOPS and their qualifications are as follows:

__X__ **Dr. Karen Moreau** earned her PhD in 1996 from the University of Denver. She is credentialed in Colorado as a Licensed Professional Counselor# 308 and as a Certified Addiction Specialist, #3237. She has been in the field of addiction counseling and mental health counseling since 1987.

****

The practice of registered, certified or licensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding addiction counselors may be addressed to:

Board of Addiction Counselor Examiners
1560 Broadway, Ste. 1350, Denver, CO 80202
303-894-7800

The Office of Behavioral Health has the general responsibility for regulating practices of licensed substance use disorder treatment programs in the State of Colorado. Questions and complaints may be directed to:

Colorado Department of Human Services
Office of Behavioral Health
3824 W. Princeton Circle, Denver, CO 80236
303- 866-7400

Telehealth Only Disclosure

Please be aware, Addiction Treatment Outpatient Services (ATOPS)offer telehealth treatment - **ONLY**. If you are seeking in person treatment, ATOPS will need to refer you to another agency.

ATOPS is using HIPPA compliant ZOOM for our classes

To attend class you will need video access, microphone access, and a quiet place in a which you can be alone.

Sharing of the class link is never permitted and will result in immediate discharge from our program.

Please refrain from being in your vehicle and smoking/vaping during class

Signature: _____ Date:_____

ADDICTION TREATMENT OUTPATIENT SERVICES

The regulatory requirements applicable to mental health professionals are as follows:

- **Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy** in Colorado, but is not licensed or certified by the State and is not required to satisfy any standardized educational or testing requirements.
- **Certified Addiction Technician (CAT)** must be a high school graduate or the equivalent, complete required training hours and 1000 hours of clinically supervised work experience.
- **Certified Addiction Specialist (CAS)** must have a Bachelor's degree in the behavioral health sciences or field; complete additional training above the CAT, and 3000 hours of clinically supervised work experience.
- **Licensed Addiction Counselor** must have a clinical Master's degree, meet the CAS requirements, and pass a national examination in addiction treatment.
- **Licensed Social Worker** must hold a master's degree in social work.

Psychologist Candidate, Marriage and Family Candidate and a Licensed Professional

- **Counselor Candidate** must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and a

- **Licensed Professional Counselor must** hold a master's degree in their profession and have two years of post-masters supervision.
- **Licensed Psychologist** must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Board that registers, certifies or licenses the registrant, certificate holder or licensee.

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Revised Statutes as well as other exceptions in Colorado and federal law. For example, mental health professionals are required to report child abuse and neglect, threats of harm to self and others, & elderly abuse to authorities. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly.

I understand that my alcohol and/or drug treatment records are protected under the Federal Confidentiality Regulation, 42 C. F. R., Part 2, governing Confidentiality of Alcohol and Drug Abuse Patient Records. Confidential information cannot be disclosed without my written permission unless otherwise provided for by the regulations.

Exceptions to confidentiality may also be found in the Notice of Privacy Rights you were provided

I have read the preceding information, it has been provided to me verbally, and I understand my rights as a client or as the client's responsible party.

_____	_____	_____
Printed Name	Signature	Date

ATOPS Addiction Treatment Outpatient Services

CLIENT AGREEMENT FORM

Group Goals: to provide clients with education and information to enable them to determine the role of chemical use in their personal lives, to provide alternative behavior patters to chemical use, and to develop a more beneficial and holistic lifestyle. In so doing, we will strive to reduce substance-related criminal and traffic offenses and to identify and treat alcohol/drug dependence.

Client Commitments: To help assure the success of group processes, it is necessary for group members to make and abide by certain commitments; we must maintain report concerning your attendance, attitude, and fee records.

Absences: Level II Education

You are allowed a certain number of excused absences during the 12 weeks of Level II Education. You are allowed 3 "excused" absences during the 12 weeks. These absences are a "no questions asked" basis and there will be no charge for these absences. We allow a certain number of excused absences throughout the program.

Level II Education: 24 hours over 12 weeks = 3 excused absences

Absences: Level II Therapy

You are allowed a certain number of "excused" absences based on the number of therapy hours you are required to complete. The absences are on a "no questions asked" basis and there will be no charge for them. The absences may not be used all at one time.

Track A = 42 hours of therapy (21 groups) = 3 excused absences
Track B = 52 hours of therapy (26 groups) = 4 excused absences
Track C = 68 hours of therapy (34 groups) = 5 excused absences
Track D = 86 hours of therapy (43 groups) = 6 excused absences

You may not use more than 2 absences consecutively.

Absences over the allowed number of excused absences will be charged at the normal group rate.

Please note: We are required to report and inform probation and motor vehicle of the groups you have attended during a reporting period, as well as, the groups you have not attended.

I have read and understand the contents of this agreement and do agree to observe these rules and regulations

Signature: _____ Date:_____

Causes for Non-Cooperative Termination:

1. Failure to participate in group discussion and assignments
2. Disruption of any group meeting
3. Excessive absences
4. Failure to respond to warning letters
5. ATTENDING ANY SESSION FOLLOWING THE USE OF ALCOHOL/DRUG USE
6. Failure to remain compliant on monitored sobriety: random breath testing antabuse, random urine testing
7. Failure to pay fees

Signature: _____ Date:_____

Notice of Federal Requirements Regarding Confidentially of Alcohol and Drug Abuse Patient Records

The confidentially of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a patient as an alcohol or drug abuser ***UNLESS***:

1. The patient 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.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulation.

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

Federal laws and regulations do not protect any information about suspected child abuse or neglect, threats of harm to self and others, as well as, elderly abuse from being reported under State law to appropriate State or local authorities. (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.)

Signature: _____ Date: _____

ADDICTION TREATMENT OUTPATIENT SERVICES

Requests for Documentation

We are pleased to provide written documentation on your behalf to the court, your Attorney, and/or Motor Vehicle.

The following rules will apply to all requests:

1. **10 days** advance written notice required for all requests.

2. **Less than 10 days** written notice **will result in a $50 priority draft fee**.

3. Requests are **only** accepted via email to admissions@atops.org OR info@atops.org.

4. All request **must** include the following information: court date, name, address, e-mail, fax number, & phone number of the person to receive the information

Signature: _____ Date: _____

COLORADO
Department of Corrections
Division of Adult Parole

Revised January 2019

Interstate Compact Unit
940 N Broadway
Denver, CO 80203
P 303.763.2408 F 303.861.1548
DOC_interstatetreatment.state.co.us

OUT-OF-STATE OFFENDER CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or DMV? ☐ Yes ☐ No

2) Do you have any pending cases, Probation/Parole supervision, or warrants in any other state? ☐ Yes ☐ No

If yes to 1 or 2, please answer the following questions:

3) In what state was the crime committed? _____

4) Who are you to report the treatment to? _____
(Example: Court, Judge, Probation Parole, etc.)

5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? ☐ Yes ☐ No

6) **For DUI Offenders only**: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? ☐ Yes ☐ No

Your Name: _____ Date of Birth: _____

Social Security Number: 999-99-9999 Place of Birth: _____

Signature: _____ Today's Date: _____

If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your Probation officer, parole officer, judge Or diversion officer. _____

_____

_____

_____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

Form C

Emergency Action Plan

TELEHEALTH MEDICAL EMERGENCY

- Should a medical emergency occur during a telehealth class ATOPS will report it to local authorities

1. The therapist will confirm the location of the individual
2. ATOPS staff will search online find the numbers for local police, fire department, mobile crisis unit, crisis hotline, etc.
3. ATOPS staff will contact local police, fire department, mobile crisis unit, crisis hotline, etc. and stay on the line until help arrives
4. If ATOPS staff notice/hear any concerning behaviors or statements in group they will contact local authorities for a welfare check on that individual

EMERGENCY REPORTING AND EVACUATION PROCEDURES

Types of emergencies to be reported to personnel are:

- MEDICAL
- FIRE
- SEVERE WEATHER
- BOMB THREAT
- TERRORISTIC THREAT
- CIVIL DISTURBANCE

SEVERE WEATHER AND NATURAL DISASTERS

Tornado:

- When a warning is issued by sirens or other means, seek inside shelter. Consider the following:
  - Small interior rooms on the lowest floor and without windows,
  - Hallways on the lowest floor away from doors and windows, and
  - Rooms constructed with reinforced concrete, brick, or block with no windows.
- Stay away from outside walls and windows.
- Use arms to protect head and neck.
- Remain sheltered until the tornado threat is announced to be over.

Earthquake:

- Stay calm and await instructions from the Emergency Coordinator or the designated official.
- Keep away from overhead fixtures, windows, filing cabinets, and electrical power.
- Assist people with disabilities in finding a safe place.
- Evacuate as instructed by the Emergency Coordinator and/or the designated official.

Flood:

If indoors:

- Be ready to evacuate as directed by the Emergency Coordinator and/or the designated official.
- Follow the recommended primary or secondary evacuation routes.

If outdoors:

- Climb to high ground and stay there.
- Avoid walking or driving through flood water.
- If car stalls, abandon it immediately and climb to a higher ground.

Blizzard:

If indoors:

- Stay calm and await instructions from the Emergency Coordinator or the designated official.
- Stay indoors!
- If there is no heat:
  - Close off unneeded rooms or areas.
  - Stuff towels or rags in cracks under doors.
  - Cover windows at night.
- Eat and drink. Food provides the body with energy and heat. Fluids prevent dehydration.
- Wear layers of loose-fitting, light-weight, warm clothing, if available.

If outdoors:

- Find a dry shelter. Cover all exposed parts of the body.
- If shelter is not available:
  - Prepare a lean-to, wind break, or snow cave for protection from the wind.
  - Build a fire for heat and to attract attention. Place rocks around the fire to absorb and reflect heat.
  - Do not eat snow. It will lower your body temperature. Melt it first.

If stranded in a car or truck:

- Stay in the vehicle!
- Run the motor about ten minutes each hour. Open the windows a little for fresh air to avoid carbon monoxide poisoning. Make sure the exhaust pipe is not blocked.

- Make yourself visible to rescuers.
  - Turn on the dome light at night when running the engine.
  - Tie a colored cloth to your antenna or door.
  - Raise the hood after the snow stops falling.
- Exercise to keep blood circulating and to keep warm

I, _____, have been made aware of the ATOPS Emergency Action Plan and offered/given a copy.

_____
Signature

_____
Printed Name

_____
Date

NOTICE OF PRIVACY PRACTICES

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

My commitment to my clients' privacy includes the following information:

My practice is dedicated to maintaining the privacy of my clients' personal health information as part of providing professional care. I am required by law to keep my clients' information private. These laws are complicated, but legally I must give my clients this important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices and my clients may have copies of the longer version at any time to read and reference. In this abbreviated Notice of Privacy Practices, I cannot cover all possible situations, so I encourage my clients to speak with me about any additional questions or problems and/or visit www.hhs.gov/ocr/hipaa.

If my clients or I want to use or disclose (send, share, release) client information for any purpose not documented in this Notice Privacy Practices, I will discuss this with the client and ask him/her to sign a Release of Information Form in order for private information to be distributed.

The following are examples of when the law requires me to share client information without completing a Release of Information Form with a client in advance:

1. There is a serious threat to my client's health and safety, the health and safety of another individual, and/or the public; inclusive of child abuse and/or neglect or abuse and/or neglect of elderly or disabled individuals. In situations like these, I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Particular lawsuits and court proceedings that are in progress.

3. A law enforcement official needs information to investigate a crime and/or a criminal.

4. Worker's compensation and other health benefit programs requesting information to process claims submitted for reimbursement and/or status to support medical necessity for ongoing treatment coverage.

    a. All medical claims reimbursement is handled by our billing firm listed below:

OfficeAlly
PO Box 872020
Vancouver, WA 98687-2020
Ph 360-975-7000
Fax 360-896-2151

******SEE REVERSE SIDE FOR SIGNATURE******

There are some other situations like those addressed above; however, most do not arise very often. For more information, please request a review of the longer version of the Notice of Privacy Practices or visit the website mentioned above.

Clients' rights regarding their health information:

1. Clients can ask me to communicate with them about their health and related issues in a particular way or at a certain place that feels private. For example, a client may ask me to call his/her home instead of his/her work to schedule or cancel an appointment. I will do my best to accommodate my clients' needs.

2. Clients have the right to ask me to limit what I tell people involved in their care or the payment of their care. This includes family members and friends.

3. Clients have the right to look at the health information I have about them such as medical and billing records. Upon request, I can obtain a copy of these records for each client; however, I may charge a fee for copy costs.

4. If a client believes that the information in his/her records is incorrect or incomplete, the client can ask me to make some kinds of changes (called amending) to his/her health information, within reason. A client must make this request in writing and send it to me. The client must tell me the reasons why s/he wants me to make changes.

5. Clients have the right to a copy of this Notice of Privacy Practices. If I change this Notice of Privacy Practices, I will inform my clients and make new copies available upon request.

6. Clients have the right to file a complaint if they believe that their privacy rights have been violated. Clients can file a complaint with me and the **Department of Regulatory Agencies, Mental Health Section,** 1560 Broadway, Suite 1350, Denver, CO 80202, **Office of Behavioral Health,** 3824 W. Princeton Cir., Denver 80236, **Bd of Addiction Counselor Examiners,** 1560 Broadway, #1350, Denver, CO 80202. All complaints must be in writing. Filing a complaint will not change the health care I provide to my clients in any way.

Clients may contact me with questions or concerns regarding this notice or my health information privacy policies at 303-329-3105. The effective date of this notice is August 2014.

Finally, clients may have other rights that are granted to them by the laws of this state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they may arise.

Client's Name Printed:_____

Client's Signature:_____ Date:_____

test

Name: _____

Date: _____ Location: _____

Questions 1-14 relate to facts about alcohol, other drugs and driving.
Please select your answer from the drop down menu.

1. **Which will sober you up?**
   A. black coffee
   B. eating a full meal
   C. time
   D. exercise
   E. all of the above

2. **Which part of the driving task is affected by alcohol consumption?**
   A. vision
   B. judgment
   C. reflexes
   D. all of the above
   E. only A & C

3. **Which of the following has the highest alcohol content?**
   A. a 12-oz bottle of beer (5%)
   B. a 5-oz glass of wine (12%)
   C. a 1.5-oz shot of liquor (40%)
   D. a 12-oz wine cooler (5%)
   E. they all have approximately the same alcohol content

4. **Approximately what percentage of the U.S. population does not drink alcohol?**
   A. 65%
   B. 50%
   C. 35%
   D. 20%
   E. 5%

5. **If 100 men and women each drank four ounces of whiskey in one hour, reaction time would probably:**
   A. speed up in most men, but slow down in most women
   B. stay the same for most people
   C. speed up for about 20 people, but slow down for about 80 people
   D. slow down in all 100 people
   E. unsure

6. **Implied consent means:**
   A. Drivers who have been drinking should refuse a breath test to avoid penalties.
   B. If a person admits to an officer that he/she has been drinking, he/she will be arrested automatically.
   C. All licensed drivers automatically agree to take a test to measure alcohol or drug content in the body.
   D. If a person is underage, he/she can only drink when parents are present.

7. **Which of the following factors does <u>not</u> influence a person's BAC?**
   A. type of drink
   B. gender
   C. tolerance
   D. muscle mass
   E. they all influence BAC

8. **Which of the following can be signs of alcohol/other drug addiction or dependency:**
   A. requiring a greater amount of the drug to achieve the desired effect
   B. trying to reduce or stop using and failing to do so
   C. spending a lot of time obtaining, using or getting over the effects of using
   D. continuing to use alcohol/other drugs despite the problems it is causing
   E. all of the above

9. **Which of the following best describes the action of alcohol on the body:**
   A. depressant
   B. stimulant
   C. both stimulant and depressant
   D. neither stimulant nor depressant

10. **If a person goes to bed at 2 am with a BAC level of .20, approximately what time will the person's BAC return to 0?**
    A. 6 am
    B. 9 am
    C. Noon
    D. 4 pm

11. **The synergistic effects (the combined effects) of drug use refers to:**
    A. a bad trip
    B. the negative effects of drugs on a person's ability to drive
    C. a person's ability to think more clearly
    D. the ability of one drug to cancel out the impact of the other
    E. the multiplied effects that result when two drugs are taken together

E

12. Which step is <u>not</u> required to have your license reinstated:

A. completion of the suspension or revocation period
B. payment of the reinstatement fee
C. completion of public service hours
D. completion of Level I or Level II
E. All of the above

E

13. If a person refuses to take a chemical test (breath, blood, urine) to measure BAC, he/she:

A. can take multiple tests at a later time
B. will only have to pay a fine
C. faces a minimum revocation of 1 year
D. cannot be convicted of a DUI

E

14. If three different people drink the exact same amount of alcohol, they will:

A. feel approximately the same
B. have the same BAC
C. be able to drive about the same
D. all of the above
E. it's impossible to predict because everyone responds differently

Questions 15-25 relate to drinking and driving attitudes and behavior. People feel differently, so there are no "right" or "wrong" answers.

E

15. If I have just one or two drinks, my driving could be affected.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

16. I would not feel safe riding with a driver who has consumed 6 drinks in 2 hours.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

17. My arrest was nobody's fault but my own.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

18. I need to change some of my alcohol or other drug use patterns.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

19. I have confidence in my plan to avoid future problems with alcohol or other drugs.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

20. Impaired driving can pose a danger to myself and others.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

21. I am less likely to abuse alcohol or other drugs as a result of my arrest experience.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

22. It's important to have people who will support me in my plan to avoid future problems with alcohol and other drugs.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

23. I think coming to this class is a good opportunity to learn important information and plan ahead.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

24. I will not go out drinking again unless I have a way to get home without driving myself.

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

E

25. Changing my behavior involves more than simply promising myself "I'll change."

A. strongly disagree
B. disagree
C. I don't agree or disagree
D. agree
E. strongly agree

INFECTIOUS DISEASE MEDICAL SCREEN

Name_____ Date _____

I understand that my responses to this screen 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 HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state Law authorizes the disclosure.

It will not affect your enrollment if you choose to refuse this form. Please sign & select one of the following options:

☐ **I have read and understand the above. Signature**_____

☐ **I have read and understand the above and I am refusing this form. Please give a reason:** _____

_____

Please select the one most accurate response to each questions.

1. YES ☐ NO ☐	Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)?
2. YES ☐ NO ☐	Have you ever been or are you now on long-term hemodialysis (blood cleansing)?
3. YES ☐ NO ☐	Are you a recipient of clotting factor made prior to 1987?
4. YES ☐ NO ☐	Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood?
5. YES ☐ NO ☐	Were you born to a mother who had hepatitis?
6. YES ☐ NO ☐	Have you ever had symptoms of liver disease or abnormal liver functions/enzyme test?
7. YES ☐ NO ☐	Have any of your sexual partners been infected with hepatitis B or C?
8. YES ☐ NO ☐	Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. Unsterile needles?)
9. YES ☐ NO ☐	Mark all of the following that currently apply to you or that applied to you in the past: ☐ CLOSE contact with active TB ☐ Medical condition that increases risk of TB disease (e.g., HIV, other immune disorders, diabetes, silicosis, {black lung} or coal miners disease, bleeding/clotting disorders, specific malignancies, kidney failure, etc.) ☐ Abnormal chest x-ray showing fibrotic lesions ☐ Resident or employee of a high risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.) ☐ Health care worker or volunteer who serves high-risk clients ☐ Foreign-born person who has arrived within the last five years from countries that have a high TB incidence or prevalence(e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia) ☐ Person from a medically underserved, low-income population ☐ Member of a high risk racial, ethnic, or other minority population with an increased prevalence

	of TB (e.g. Asian and pacific Islanders, Hispanics, African-Americans, Native Americans, migrant farm workers, homeless persons) ☐ History of inadequately treated TB
10. YES ☐ NO ☐	Have you had a cough from more than three (3) weeks?
11. YES ☐ NO ☐	Have you coughed up blood/colored mucous?
12. YES ☐ NO ☐	Do you have swollen, non-tender lymph nodes?
13. YES ☐ NO ☐	Have you had a prolonged loss of appetite or unexplained weight loss of ten (10) pounds or more?
14. YES ☐ NO ☐	Have you had recurrent fevers or heavy night sweats for more than three (3) weeks?

RESONSE GUIDE:

If you answered "Yes" to any question #1-7, please see your counselor for a referral to be screened for hepatitis B and C.

If you answered "YES" to question #8, please see your counselor for a ferral for infectious disease screening and testing.

If you answered "YES" to any of the categories in question #9, please see your counselor for a referral to be screened for tuberculosis.

If you answered "YES" to any question #10-14 , please see your counselor immediately for a referral for tuberculosis screening and treatment.

12. ***(If answer to question 7 is "YES")*** *On the screen you stated that you have injected drugs. Describe those times-when, what drugs, use of sterile syringes or bleach, etc.*

13. *How often are you drunk or high when you have sex?*
    What drugs do you use and how often do you use them when you have sex?

14. *Have you ever been so drunk or high that you blacked out or can't remember what happened during sex?*
☐ *YES* ☐ *NO (If Yes, describe those times.)*

15. *What kinds of support do you feel that you would need to help you make the changes necessary to lower the risk that you will get and or spread HIV?*

INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

Transfer responses from the infectious Disease Behavioral Screen onto this form and total the corresponding numeric values.

1. YES (5) No (0)	**6. YES (20) NO (0)**
2. YES (10) NO(0)	**7. YES (30) NO (0)**
3. NEVER (20) SOMETIMES(15) ALWAYS (10) NO ANAL SEX (0)	**8. YES (30) NO (0) Sometimes (15)**
4. YES (15) NO (0)	**9. YES (30) NO (0) Sometimes (15)**
5. YES (10) NO (0)	**10. YES (30) NO (0) Sometimes (15)**

My SCORE_____

SCORING GUIDE

SCORE IS OVER 120	**HIGH RISK** A score over 120 indicates you are at high risk for acquiring/transmitting HIV and/or Hepatitis. See your counselor right away for referral to your local county health department or the Colorado Department of Public Health and Environment for further evaluations and follow-up.
SCORE IS 30-119	**MEDIUM RISK** A score of 30-119 indicates that you are at medium risk for acquiring/transmitting HIV and or Hepatitis. See your counselor for more information about way that you can reduce your risk and other programs that can help you.
SCORE IS 0-29	**LOW RISK** A score of 0-29 indicates that you are at low risk for acquiring HIV and/or Hepatitis. Low Risk doesn't mean no risk. See your counselor if you have any questions or concerns about behaviors that may place a person at risk.