Texas Tech University Health Sciences Center Ambulatory Clinics Consent to Treatment/Health Care Agreement	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.

ADVANCE DIRECTIVE:

Has an Advance Directive been signed?	____ YES	____ NO
If yes, is it still in effect?	____ YES	____ NO
Has a signed copy been provided to TTUHSC?	____ YES	____ NO

NOTICE OF PRIVACY PRACTICES:

I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

I certify that I have read this form or it has been read to me*.

Date	**Print Name**	**Patient/Other legally authorized person**
Time	**Witness/Translator***	**Relationship to Patient**

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: March 3, 2016

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? The following uses do **NOT** require your authorization, except where required by Texas Law.

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    - **Help with public health and safety issues.**
        - We can share health information about you for certain situations such as:
            - Preventing disease
            - Helping with product recalls
            - Reporting adverse reactions to medications
            - Reporting suspected abuse, neglect, or domestic violence
            - Preventing or reducing a serious threat to anyone's health or safety
    - **Conducting Research**. We can use or share your information for health research.
    - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
    - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    - **Address workers' compensation, law enforcement, and other government request.**
        - We can use or share health information about you:
            - For workers' compensation claims
            - For law enforcement purposes or with a law enforcement official
            - With health oversight agencies for activities authorized by law
            - For special government functions such as military, national security, and presidential protective services
    - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

REGIONAL PRIVACY OFFICER AT AMARILLO 1400 COULTER ROAD AMARILLO, TX 79106 (806) 414-9607	REGIONAL PRIVACY OFFICER AT LUBBOCK 3601 4TH STREET, STOP 8165 LUBBOCK, TX 79430 (806) 743-9541	REGIONAL PRIVACY OFFICER AT THE PERMIAN BASIN 800 WEST 4TH STREET ODESSA, TX 79763 (806) 743-9539

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.

BP-A0528
JUN 10

TRANSITIONAL DRUG ABUSE TREATMENT
AUTHORIZATION FOR RELEASE OF INFORMATION CDFRM

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Inmate Name	Register Number	Date
Date of birth	CCC Dismas Charities	Judicial District Northern District

I authorize the Federal Bureau of Prisons to :

☒ **Release Information To:**

Name/Facility: USPO, BOP, RRC, TTUHSC-Southwest Institute for Addictive Diseases

Address: 3601 4th Street, MS 8103, Lubbock TX 79430-8103

☒ **Obtain Information From:**

Name/Facility: USPO, BOP, RRC, TTUHSC-Southwest Institute for Addictive Diseases

Address: 3601 4th Street, MS 8103, Lubbock TX 79430-8103

This is to include:

☒ **Treatment Summary and Referral Form**
☒ **Substance Abuse Assessment**
☒ **Mental Health Assessment**
☒ **Treatment Plans**
☒ **Monthly Progress Report**
☒ **Discharge Summary**
☒ **Sign In/Out Sheets**
☒ **Other (Describe)** Any information/documentation to facilitate treatment while in CTS

The purpose of the disclosure is to inform the person(s) listed above of my attendance, progress and continuation of substance abuse or mental health treatment .

I understand this authorization is voluntary and that I may refuse to sign this authorization.

I understand that my alcohol and/or drug tre atment records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164. 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.

I understand that this authorization will expi re on _____. I understand that I may revoke this authorization at any time by sending a written request to the Transitional Drug Abuse Coordinator at SCRO-Community Treatment Servics, 322 Marine Forces Dr., Grand Prairie, TX 75051 .

I have read the above or I have had it read to me and I authorize the disclosure of Protected Health Information as stated.

Signature of Patient (Fax Signature Valid Original)	Date (Month, Day, Year)	Staff Witness

cc: Transitional Drug Abuse Treatment Office

BP-A0750 **Agreement to Participate in Community Transition Program**
JUN 10 **(Informed Consent)** CDFRM
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

This is to notify you that while residing in a Residential Reentry Center or on home confinement you are being referred for:

☐ Substance Abuse Evaluation and/or Treatment

☐ Mental Health Evaluation and/or Treatment

☐ Sex Offender and/or Treatment

The proposed treatment would include psychotherapy and may include psychiatric medications. However, you will not be given any psychiatric medications without your knowledge and consent.

If you agree, you will be referred to a community-based treatment provider. You will be a voluntary patient. You do have a right to refuse this treatment now or at any time in the future. If you choose to do so, you should check the appropriate block below and sign this document acknowledging your refusal to receive an evaluation and/or treatment.

By signing this form, I acknowledge that I have discussed this document with the community-based treatment provider and I understand my rights and choices regarding community-based treatment.

☐ I hereby consent to an evaluation and/or treatment and will follow all rules to include:

1) attending all schedule treatment session;

2) activity participating in group sessions (e.g., appropriate self-disclosure, providing feedback);

3) taking medication as prescribed, (if applicable);

4) keeping all information discussed in group confidential; and

5) abiding by the rules and regulation of the Bureau of Prisons, community-based treatment provider, and the Residential Reentry Center.

☐ I refuse an evaluation and/or treatment.

Inmate Printed Name/Signature	Inmate Number	Date
Witness Signature	Printed Name/Title	Date

FOR STAFF USE ONLY

This inmate is ___ is not ___ competent to give informed consent for community-based treatment.

This assessment is based on the following:

Treatment Providers Signature	Printed Name/Title	Date

PDF *Prescribed by P7430* *Replaces BP-750 of MAY 02*

TTUHSC – School of Medicine
Department of Neuropsychiatry & Behavioral Sciences
Southwest Institute for Addictive Diseases
Lubbock, Texas

Consent to Release Information

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Consent to Release Alcohol and Drug Abuse, Medical, and/or Mental Health Patient Records and Information

I authorize disclosure of records/information about me between:

Southwest Institute for Addictive Diseases Program Name	**and**	Northern District of TX – Probation Name Relationship
3601 4th Street Address		1205 Texas Avenue Address
Lubbock, TX 79430 City, State, Zip		Lubbock, Texas 79401 City, State, Zip
(806) 743-9423 Phone Number		(806) 472-7001 Phone Number

I authorize SWIAD to release to, and/or request and receive from the above person(s)/agency, the following information as described below (check all that apply)

INFORMATION	TO BE RELEASED BY SWIAD	REQUESTED BY SWIAD
HIV		
TB		
AIDS		
Medical History		
Health Screening		
Lab Results		
Psychological Evaluation	✓	✓
Aftercare Planning		
Discharge Summary	✓	✓
Discharge Plan		
Progress Notes		
Initial Assessment		
Treatment Plan		
Other (Specify)		

This information is needed for the specific purpose of: Coordination of treatment

If not otherwise stated, the purpose is to assist program staff with my rehabilitation efforts.

Method for releasing (check all that apply): ✓ Telephone ✓ Written ✓ Questionnaire Form ✓ Conference ✓ Facsimile

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance on it, and that in any event this consent expires within one year of my signature. I understand this communication will reveal my presence as a patient at a treatment facility.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

TTUHSC – School of Medicine
Department of Neuropsychiatry & Behavioral Sciences
Southwest Institute for Addictive Diseases
Lubbock, Texas

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Consent for Emergency Medical Care

Drug Allergies:

_____

Person to be contacted in Case of Emergency:

Name: Telephone:

_____

Address:

_____

I authorize the staff of the Southwest Institute to seek emergency care for me in the event of serious illness, accident or emergency. I understand that the Southwest Institute and its staff shall not be held responsible for payment of any such medical bills, and further agree not to hold the Southwest Institute responsible for any services rendered.

Date on which this consent expires: _____
(One year from current date)

_____ _____
Patient Signature Date

_____ _____
Witness Date

TTUHSC – School of Medicine
Department of Neuropsychiatry & Behavioral Sciences
Southwest Institute for Addictive Diseases
Lubbock, Texas

Patient Demographic Information

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Name	
Address	
City	State / Zip Code
Date of Birth	Social Security Number
Home Phone	Work Phone
Cell Phone	Age

Client Signature _____ Date _____

Witness _____ Date _____

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Patient, Family, Significant Other Rights

Upon request, at any time throughout the span of treatment, patients/families/SO may receive an explanation of their rights. These rights will be in a language that he or she understands. These rights will be explained within 24 hours after being admitted. All staff members and volunteers shall have a working knowledge of these rights, and are to assist patients in exercising any and all of these rights. The facility must respect and protect patient rights. The Bill of Rights is as follows:

1. You have the right to get a copy of these rights before you are admitted, including the Commission's address and phone number.
2. You have the right to reasonable access to treatment, care and services regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your needs.
4. You have the right to be free from abuse, neglect and exploitation.
5. You have the right to be treated with dignity and respect of your personal values and beliefs.
6. You have the right to informed consent.
7. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
8. You have the right to be told about the programs rules and regulations before you are admitted.
9. You have the right to be told before admission:
   - The condition to be treated
   - The proposed treatment
   - The risks, benefits and side effects of all proposed treatment and medication
   - The probable health and mental health consequences of refusing treatment; and
   - Other treatments that are available and which ones, if any, might be appropriate to you
10. You have the right to accept or refuse treatment after receiving this explanation.
11. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
12. You have the right not to receive any unnecessary or excessive medication.
13. You have the right to refuse any videotaping, audio taping, or photography without it interfering with your care.
14. You have the right to have your family, significant other, and/or surrogate to be involved in your care.
15. You have the right to a treatment plan, designed to meet your needs, and you have the right to take part in developing that plan.
16. You have the right to designate a surrogate decision maker, if the individual served is incapable of understanding a proposed treatment, care, or service, or is unable to communicate his or her wishes regarding treatment, care, and services.
17. This right is applied to children as appropriate to their age, maturity, and clinical condition and the right of the family of individuals served to participate in such planning.
18. You have the right to meet with staff to review and update the treatment plan on a regular basis.

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

19. You have the right to participate in the consideration of ethical issues that arise in the provision of treatment, care, and services including:
    - Resolving conflict; and
    - Withholding resuscitative services or forgoing or withdrawing life-sustaining treatment when such procedures are within the scope of the organization, and participating in investigational studies or clinical trials.
20. You have the right to appropriate assessment and referral for the management of pain.
21. If you consent to treatment, you have the right to leave the facility unless a physician determines that you pose a threat of harm to yourself or to others.
22. You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others.
23. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
24. You have the right to communicate with people outside the facility. This includes the right to have visitors, to make telephone calls, and to send and receive sealed mail. This right may not be restricted on an individual basis by your doctor or the person in charge of the program. You may contact an attorney or any patient's rights review board at any reasonable time.
25. You have the right to be told, in advance, of all estimated charges and any limitations on the length of services that the facility is aware of.
26. You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
27. You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
28. You have the right to know the names and qualifications of all persons providing your treatment.
29. You and your family have the right to be assisted with protective services, if needed.
30. You have the right of access to pastoral services, in accordance with your needs.
31. You have the right to obtain a personal advocate when appropriate.
32. Your rights are protected and respected during research, experimentation, or clinical trials involving human subjects.
33. You have the right, if you consent, to participate in a research project:
    - The benefits to be expected;
    - The potential discomforts and risks;
    - Alternative services that might benefit you;
    - The procedures to be followed, especially those that are experimental in nature; and
    - You're right to refuse to participate in any research project without compromising your access to the organization's services.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Patient Name:_____

Medical Record Number:_____

Date of Birth:_____

Patient, Family Member, and/or Guardian Grievance Procedure

Patients, families, or significant others of the Southwest Institute for Addictive Disease have the right to file a grievance about any violation of client rights of commission rules.

You may complain directly to any staff member, however, we suggest you start with your primary counselor. Complaints may be submitted verbally or in writing. If you are unable to write, staff will assist you in writing the compliant. Pens, paper, envelopes, postage, and access to a telephone shall be provided (regardless of restrictions) upon request, in order to file a compliant.

If you are unsatisfied with the outcome of your compliant, you may have access to the Program Director, who will review and acknowledge your compliant within 24 hours (72 hours on week-ends). We will evaluate the grievance thoroughly and objectively, obtaining additional information as needed. You will be informed, in writing, of the findings and recommendations of your compliant within seven calendar days. We will take action to resolve all grievances promptly and fairly. If you remain unsatisfied, you may have access to the Director of Southwest Institute.

The Southwest Institute for Addictive Disease shall not discourage, intimidate, harass, or seek retribution against clients who try to exercise their rights of file a grievance. The Southwest Institute for Addictive Diseases shall not restrict, discourage, or interfere with client communication with an attorney or with the Commission for the purpose of filing a grievance.

All complaints and results of the investigation will be documented on the grievance form and placed in a notebook at the Program Director's office for inspection by the appropriate officials.

All complaints that cannot be resolved at the Southwest Institute for Addictive Diseases will be forwarded to the TTUHSC Coordinator for Patient Relations.

The Patient Relations Coordinator has the authority to report unresolved grievances to the clinicians' licensing board for investigation.

You may complain directly at any point in the grievance process to:

Texas Commission on Alcohol & Drug Abuse
P.O. Box 80529
Austin, Texas 78708
1-800-832-9623

Advocacy, Inc.
7800 Shoal Creek Blvd. #171-E
Austin, TX 78757-1024
1-800-252-9108

Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
512-458-7111

Texas State Board of Examiners of Psychologists
333 Guadalupe
Tower 2, Room 450
Austin, Texas 78701
1-800-821-3205

Texas Department of Mental Health & Mental Retardation
Office on Consumer Services & Rights Protection
P.O. 12699
Austin, Texas 78751
1-800-252-8154

Texas State Board of Medical Examiners
P.O. Box 2018
Austin, TX 78768-2018
1-800-201-9353

Texas State Board of Examiners of Professional Counselors
1100 W 49th St
Austin, Texas 78756-3183
1-800-942-5540

Texas State Board of Examiners of Marriage and Family Therapists
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

_____ _____
Patient Signature Date

_____ _____
Witness Date

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Confidentiality Agreement

Values Underlying Confidentiality

The principle of confidentiality is designed to advance certain values. These include reducing the stigma and discrimination associated with seeking and receiving substance abuse and mental health treatment, fostering trust in the treatment relationship, ensuring individuals' privacy in their health care decisions, and furthering individual autonomy in health care decision making.

Ethical and Legal Concern

Confidentiality is a matter of both ethical and legal concern. Each of the health care professions endorses confidentiality as a core matter. However, it is the law that establishes the basic rules that govern confidentiality in practice.

Federal Confidentiality Laws

An individual who seeks treatment for substance abuse or mental illness runs the risk of discrimination and invasion of privacy if information disclosed during treatment becomes known to third parties. In an effort to create incentives for people with substance use and alcohol problems to seek treatment, Congress enacted perhaps the strictest confidentiality law extant. As a result, Federal law governs the confidentiality of information which would identify a patient as receiving treatment services (42 U.S.C. 290dd-2; 42 C.F.R. 2.1, et seq.).

Southwest Institute

Confidentiality is an essential part of our treatment programs. Please adhere to our confidentiality policy by not disclosing any information about any patient or other visitors that you may see or meet in the clinic.

By my signature below, I agree to abide by this confidentiality policy.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

RULE §3.8023 Admission Criteria for Outpatient Treatment Service

An outpatient treatment service is defined as one consisting of at least one to two hours per week.

☐ **(1) Diagnostic Criteria:** Patient meets DSM-IV TR (2000) criteria for substance dependence or substance abuse and some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time

Dependence Criteria (Must meet at least 3):

☐ Tolerance, as defined by either of the following:

- ☐ A need for markedly increased amounts of the substance to achieve intoxication or desired effect
- ☐ Markedly diminished effect with continued use of the same amount of the substance

☐ Withdrawal, as manifested by either of the following:

- ☐ The characteristics withdrawal syndrome for the substance
- ☐ The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

☐ The substance is often taken in larger amounts or over a longer period than intended

☐ There is a persistent desire or unsuccessful efforts to cut down or control substance use

☐ A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

☐ Important social, occupational, or recreational activities are given up or reduced because of substance use

☐ The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been cause or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption

Substance Abuse Criteria:

☐ Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

☐ Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

☐ Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

☐ Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of Intoxication, physical fights)

☐ **(2) Medical Functioning:** The Patient is not bed-confined or has no medical complications that would hamper the Patient's participation in the outpatient service.

☐ **(3) Family, Social, and Academic Dysfunction:** The Patient must meet the criteria of at least one clause out of clauses (a) and (b) below:

☐ (a): Patient's social system and significant others are supportive of recovery to the extent that the Patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the Patient's addiction.

☐ (b): Patient has no primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system or to become involved in a self-help fellowship.

☐ **(4) Emotional/Behavioral Status:** The Patient must meet the criteria under all three clauses (a) - (c) below:

☐ (a): Patient is coherent, rational, and oriented for treatment.

☐ (b): Mental state of the Patient does not preclude the Patient's ability to:

☐ (i): Comprehend and understand the materials presented;

☐ (ii): Participate in rehabilitation/treatment process.

☐ (c): There is documentation that the Patient expresses an interest to work toward rehabilitation/treatment goals.

Notes:

_____

_____

_____ _____
Counselor Date

_____ _____
Qualified Credential Counselor Date

Client Name: _____
Medical Record Number: _____
Date of Birth: _____

Financial Agreement

We are pleased that you have chosen our facility for your treatment. As a client, you have the right to full informed consent about your care, including the cost for services. The cost of the Southwest Institute's services is contingent upon specific program admission.

$_____ ☐ Assessment Services
$_____per _____ ☐ Criminal Justice Services
$_____per _____ ☐ Collegiate Program
$_____per _____ ☐ Mental Health Counseling
$_____per _____ ☐ Tobacco Intervention Program

Program services may include (contingent on the specific program): consultation, screening, psychological assessment, group and individual psychoeducational or counseling sessions, case management, UAs, discharge planning, and continuing care sessions.

By signature below, I agree to accept total financial responsibility for my treatment. I understand that I am responsible for the cost of treatment services, regardless of the status of my insurance.

_____ _____
Client Date

_____ _____
Counselor Date

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Treatment Contract

I understand that my stay in the Southwest Institute treatment program depends upon several factors including my progress in treatment, the Southwest Institute Treatment team recommendations, contracting agency (i.e., Federal, State, or County Government) requirements, and specific program enrollment. I agree to participate for that length of time or for whatever time the Treatment Team recommends. If I decide to withdraw from the program, I will discuss this decision with my counselor.

While in treatment I will:

- Attend all required groups, individual counseling sessions, and support meetings;
- Be on time for all activities;
- Call, in advance, if I need to reschedule an appointment;
- Complete all administrative forms;
- Abstain from all substances of abuse, including alcohol;
- Disclose any prescription drugs I am taking;
- Maintain my own medical management or primary care physician;
- Not come into the Southwest Institute while under the influence. If I come to the Southwest Institute under the influence, I will call for a taxi or a ride home;
- Actively participate in developing and obtaining my personal treatment goals;
- Not bring any tobacco products onto the grounds or within the building;
- Not participate in any violence, fighting, possess knives or guns or make any verbal threats;
- Adhere to the Southwest Institute Confidentiality Agreement;
- Actively participate in developing and maintaining a continuing care plan;
- Respect the program staff and my fellow patients.

I have received a patient and family handbook and have reviewed the above statements with a counselor. I agree to support this Treatment Contract.

_____ _____
Patient Name Date

_____ _____
Counselor Date

TTUHSC – School of Medicine Department of Neuropsychiatry & Behavioral Sciences Southwest Institute for Addictive Diseases Lubbock, Texas	Patient Name:_____ Medical Record Number:_____ Date of Birth:_____
PATIENT HANDBOOK VERIFICATION	

Please sign below showing you received the Patient Handbook from the Southwest Institute of Addictive Diseases. **PLEASE DO NOT SIGN IF YOU DID NOT RECEIVE ONE.**

_____ _____

CLIENTS SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

General Health Screening

I. Presenting Issue

Why are you coming to the Southwest Institute? _____

_____

II. Current Medical Status

Names of physicians who currently treat you:

Primary Care Provider: _____

Phone: _____

Other doctors/specialists: _____

Date of last examination by physician/provider: _____

List any health problems you are having right now: _____

III. Medications

Prescription Medications

Over-the-Counter Medications

Are you ***allergic*** to any medications or substances? *(Please detail)*

_____

_____

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

IV. Medical History

List surgeries and dates: _____

_____

PLEASE CHECK ANY OF THE PROBLEMS BELOW THAT YOU HAVE EXPERIENCED

	No	Yes	Past	Current	Comments
HEAD					
Memory Problems					
Headaches					
Seizures					
Serious head injury					
Dizziness or fainting					
History of stroke					
EYES. EARS, NOSE, THROAT					
Double vision					
Glaucoma					
Cataracts					
Sudden decrease or loss in vision					
Do you wear contacts or glasses?					
Ear pain					
Problems with hearing					
Persistent ringing or buzzing in ears					
Hay fever/inhalant allergies					
Frequent nose bleeds					
Other nasal problems					
Significant teeth or gum problems					
Tooth or gum pain or masses					
CHEST					
Shortness of breath					
Cough					
Coughing up blood					
Asthma / wheezing					
History of lung disease					
History of pneumonia					
Emphysema					
CARDIOVASCULAR					
History of heart disease					
History of heart murmur					
History of heart surgery or procedure					
Chest pain, pressure, tightness, angina					
High blood pressure					
Leg or ankle swelling					
GASTROINTESTINAL					
Abdominal pain					
Nausea or vomiting					
Diarrhea					
Vomiting blood					

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

General Health Screening

	No	Yes	Past	Current	Comments
Blood in bowel movements					
Black or tarry stools					
Ulcers					
Liver problems					
Pancreatitis/ disorders of pancreas					
Gallbladder problems					
URINARY TRACT					
Kidney disease/infection					
Kidney stones					
Bladder infections					
Pain or discharge during urination					
Blood in urine					
MALE					
Prostate problems					
Testicular lumps/pain					
Discharge from penis					
FEMALE					
Irregular menstrual periods					
Missed period(s)					
Bleeding between periods					
Currently pregnant/possibly pregnant					
Recent pap smear (date)					
Vaginal discharge					
Birth control pills					
Breast lumps or nipple discharge					
History of mammogram (most recent date)					
BLOOD / CANCER					
Bleeding or bruising problems					
Anemia					
Cancer					
Blood transfusions					
INFECTIOUS DISEASES					
Tuberculosis					
AIDS/HIV +					
Hepatitis					
Mononucleosis					
Sexually transmitted disease					
Other infectious diseases					
NUTRITION					
Problem with appetite					
Eating disorder					
Problems swallowing					
Problems keeping food down					
Difficulty getting adequate nourishment					
Weight change of ≥ 10 pounds past month					
Restricting food					
Purging (vomiting, laxatives)					

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

OTHER	No	Yes	Past	Current	Comments
Diabetes					
Thyroid problems					
Recent fever					
Recent weight loss					
Recent night sweats					
Difficulty sleeping					
Bumps or sores that don't go away					
Numbness or tingling in arms/legs					
Weakness in arms/legs					
Back problems (describe)					
Neck problems (describe)					
Arthritis/joint problems					
Broken bones					

V. Pain

Are you currently having problems with physical pain? ☐ Yes ☐ No

If yes – Please circle your pain intensity on the below scale:

Little to no pain intense pain

1 2 3 4 5 6 7 8 9 10

Please describe

Location of your pain	
Onset of your pain	
Things that lessen your pain	
Things that make your pain worse	
Present pain treatment	
Effectiveness of pain treatment	
Effects of pain on your daily life, sleep, & relationships	

VI. Tobacco Use

Do you use tobacco? ☐ Yes ☐ No

If no - have you ever used tobacco in the past? ☐ Yes ☐ No

If yes - ☐ Cigarettes ☐ Chewing tobacco ☐ Snuff

How much tobacco do you use? _____

How long have you used tobacco? _____

VII. Caffeine Use

How many cups of coffee do you drink each day? _____ Tea? _____ Soft drinks? _____

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

VIII. Family History

Has any of your relatives ever experienced?

	No	Yes
Depression		
Schizophrenia		
Anxiety disorder		
Manic-Depression/Bipolar Disorder		
Psychiatric treatment		
Other psychiatric problems		
Cancer		
Diabetes		

List any significant health problems in your family:

Mother's Side		Father's Side	
Grandmother		Grandmother	
Grandfather		Grandfather	
Mother		Father	
Aunts		Aunts	
Uncles		Uncles	
Cousins		Cousins	
Siblings			
Children			

Patient Signature _____ Date _____

STAFF USE ONLY BELOW THIS LINE

1. Do you think patient's health problems will impact their ability to participate in/benefit from program? ☐ Yes ☐ No

2. If patient is not currently seeing a physician, was last exam over one year ago?
   ☐ Yes ☐ No

3. Recommend referral to physician: ☐ Yes ☐ No
   ☐ Medical problem ☐ Eating disorder evaluation/treatment ☐ Physical exam
   ☐ Pain evaluation/treatment ☐ Psychiatric evaluation

Counselor Signature _____ Date _____

Physician Signature _____ Date _____

TTUHSC – School of Medicine
Department of Neuropsychiatry & Behavioral Sciences
Southwest Institute for Addictive Diseases
Lubbock, Texas

Patient Name:_____
Medical Record Number:_____
Date of Birth:_____

Patient Problem List

Place a check mark by the most pressing problems that you have. You may add other problems which may not be listed.

1. _____
2. _____
3. _____

___Suicidal thoughts
___Depression (Feeling blue/down)
___Do not want to be here
___Physical/Mental withdrawals
___Denial/Avoidance of the problem
___Conflict with children
___Emotional problems
___Compulsiveness
___Spouse/Relationship problems
___Sexual problems
___Rigidity
___Housing
___Legal
___Anxiety
___Fear
___Stigma
___Low self-esteem
___Anger
___Resentment
___Guilt

___Remorse
___Grief
___Self-Pity
___Dependency
___Dishonesty
___Passive/Aggressiveness
___Insomnia (Difficulty sleeping)
___Worry/Fears
___Lack of friends or family
___Loneliness
___Impulsiveness
___Spiritual conflict
___Finances
___Employment
___Weight/Eating problems
___Gambling
___Health Problems
___Stress
___Hurting self (cutting, etc...)

Briefly explain these problems:

_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Witness Date

GLOBAL FAMILY RATING FORM

Based on your recent interactions with other members, please evaluate the quality of your family's current functioning using the following scale:

1 - *Most Unhealthy Functioning*
2 - *Extreme Difficulties*
3 - *Serious difficulties*
4 - *Moderate Difficulties*
5 - *Mild Difficulties*
6 - *Mildly Healthy*
7 - *Moderately Healthy*
8 - *Very Healthy*
9 - *Extremely Healthy*
10 - *Healthiest Functioning*

For each of the identified dimensions of family functioning please write in the number from the above scale (1 to 10) that most accurately reflects your perceptions.

FAMILY DIMENSIONS:

1. ___ COMMUNICATION (*quality and effectiveness of information exchange, sharing information, listening, providing feedback, receiving and understanding feedback*)

2 ___ NEGOTIATION OF CONFLICT (*ability to recognize and deal with differences in a mutually beneficial manner, ability to achieve consensus, distribution of power*)

3. ___ SUPPORT AND NURTURANCE (*warmth, mutual concern, mutual helpfulness, expression of affection*)

4. ___ FAMILY ROLES (*consistency and clarity of roles, conduciveness of expectations to individual interests and abilities*)

5. ___ PROMOTION OF CHILD DEVELOPMENT (*parental expectations, behavior management, attention to children's emotional, physical, and social needs*)

6. ___ CLOSENESS (*belongingness, sense of family identity, mutual reliance, investment in family relationships and activities*)

7. ___ STABILITY (*resilience, organization, problem-solving, response to crisis*)

8. ___ ABILITY TO CHANGE (*flexibility, openness to new ideas and resources, sensitivity to multiple perspectives*)

9. ___ MOOD (*range of feelings expressed, emotional climate of family, response to discomfort, congruence to situation*)

___ GLOBAL (*overall functioning*)