Dismas House of Kansas City, Inc.

Consumer Registration and Consent to Treatment Form

Patient's Last Name:	First Name:	Middle Name:	Social Security no.: ___-___-____	Birth date:

Age:	Gender: ○ M ○ F	Do you practice a religion/faith? ○ Yes ○ No	What is your ethnicity?	Other
			If yes, what is your religious preference?	

Street address:	City:	State:	ZIP Code:	Email Address:

Home Phone:	Cell Phone:	Alternate Phone:	In Case of Emergency, who should we contact? :

Are you being required to enroll in treatment or recovery support services? ❑ Yes ❑ No

If yes, who is requiring you to enroll? (Check all that apply):

❑ Probation/Parole Officer
❑ Division of Family Services
❑ Court Ordered
❑ Judge
❑
Other_____

Are you currently employed? ○ Yes ◉ No

If no, would you like assistance seeking employment? ○ Yes ○ No

If yes, where are you employed?

Employer Name:	
Employer Address:	
Employer Phone:	

Emergency Contact Phone:	Relationship:

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, what were you convicted of?

Are you currently on local, state for federal supervision? ❑ Yes ❑ No

If you are providing permission for this agency to make report of your enrollment or participation, select the box below, and provide the appropriate contact information below:
☐ **I agree** ☐ **I do not agree**

What is/are your drug(s) of choice?

Are you currently taking medication for a mental health concern? ❑ Yes ❑ No

If yes, please list the medication(s):

Are you currently taking medication to assist with your recovery? ☐ Yes ☐ No

If yes, please list the medications:

Who administers your medication?

Referral Name:	
Referral Phone Number:	
Referral Fax Number:	
Email Address:	

Please list all medications for which you have a current prescription:

Please list any over the counter medications you've taken in the last 30 days:

How many people are in your household?		Do you have Medicaid? ❑ Yes ❑ No	Do you have private insurance? ❑ Yes ❑ No	If yes, what is your insurance company?
What is your monthly household income?		If yes, what is your DCN?		

CONSENT TO TREATMENT

The above information is true to the best of my knowledge. I consent to participate in substance abuse treatment, recovery supports and/or behavioral management counseling at DISMAS HOUSE OF KANSAS CITY, INC. I agree to allow Dismas House of KC to manage my RSS voucher services (if applicable).

Signature:	Date:

Dismas House
of Kansas City, Inc.

Consent for Telephone Follow-up Contact

I, _____, authorize **DISMAS HOUSE OF KANSAS CITY, INC.** to maintain contact with me during my treatment and recovery services and for up to one year following my discharge. The purpose of maintaining contact is to support continued recovery, update contact information and obtain a Government Performance and Results Act (GPRA) follow-up interview. The GPRA follow-up interview will take place between five (5) and eight (8) months following the intake GPRA

I understand if I do not sign this authorization, I will not be denied treatment; however, I will lose the benefit of my ATR voucher, and the coordination agency being able to contact me by telephone to arrange the follow-up GPRA.

I also consent to participate in the follow-up, coordination and tracking services. I understand the ATR voucher coordination agency listed above will interview me for these purposes during my time in treatment. I will be contacted after I complete treatment to be asked about my progress. If I cannot be interviewed face-to-face, I may need to be interviewed by telephone. Any names, addresses and telephone numbers of others that I provide during the intake process will only be used to locate me in order to talk to me personally. Nothing about my treatment, condition or the fact that I was in treatment, will be disclosed to these people or to anyone else.

I authorize the ATR voucher coordination agency listed above to use the information on the locator form to contact me or the individuals listed to obtain my current information.

_____ _____
Client Signature Date

_____ _____
Staff Witness Date

Informed Consumer Consent Contacts

Name:	Relationship	Phone (1)	Phone (2)	Email Address:
Self	Self			
Parent/Sibling:				
Significant Other:				
Case Manager:				
Friend:				
Other:				
Other:				

Dismas House
of Kansas City, Inc.

Notice of Privacy Practices Acknowledgement

I, _____, hereby acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____

CONSUMER SIGNATURE OR LEGAL GUARDIAN SIGNATURE
OR PARENT OF MINOR CHILD SIGNATURE

Date:

Dismas House
of Kansas City, Inc.

Questions About Your Substance Abuse History?

1.	Have you ever felt like you should cut down on your drinking or drug use?	☑ Yes ☐ No
2.	Have people annoyed you by criticizing your drinking or drug use?	☐ Yes ☑ No
3.	Have you ever felt bad or guilty about your drinking or drug use?	☑ Yes ☐ No
4.	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐ Yes ☐ No

How Can We Assist You Today?

1. Are you experiencing any problems in your life today for which you are seeking assisstance?

2. How were you referred to Dismas House of Kansas City?

3. Do you have any special needs related to your physical or mental health?

4. Is there any additional information that you would like to share today?

Dismas House
of Kansas City, Inc.

Please Tell Us About Your Mental and Emotional Health.

Name: _____ DMH ID: _____ Date: _____

1. Within the past 12 months have you talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	☐yes ☐no
2. Within the past 12 months have you felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	☐yes ☐no
3. Within the past 12 months have you been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	☐yes ☐no
4. Within the past 12 months have you been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	☐yes ☐no
5. Within the past 12 months have you heard voices no one else could hear or seen objects or things which others could not see?	☐yes ☐no
6. Within the past 12 months have you been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions or thought about killing yourself?	☐yes ☐no
7. Within the past 12 months did you attempt to kill yourself?	☐yes ☐no
8. Within the past 12 months have you had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example: warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed.	☐yes ☐no
9. Within the past 12 months have you experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	☐yes ☐no
10. Within the past 12 months have you given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?	☐yes ☐no
11. Within the past 12 months have you felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	☐yes ☐no
12. Within the past 12 months have you experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	☐yes ☐no
13. Within the past 12 months was there a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?	☐yes ☐no
14. Within the past 12 months have you had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	☐yes ☐no
15. Within the past 12 months have you had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you have begun sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	☐yes ☐no
16. Within the past 12 months have you had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?	☐yes ☐no

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Informed Consent for Disclosure of Client Information

Attention: To recipient of information: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for release of medical or other information may not be sufficient.

I, _____ authorize the staff at **DISMAS HOUSE OF KANSAS CITY, INC** and _____ to make disclosure of the specific information listed in this document to: **DISMAS HOUSE OF KANSAS CITY, INC.** and to my parole officer, attorney and _____. I further authorize these two agents/agencies to communicate and disclose to one another.

The purpose or need for this disclosure is: **to establish the treatment and recovery support services that will contribute to my alcohol and/or drug abuse treatment, and to monitor my treatment progress. This disclosure will be made both verbally and in writing.** The specific information to be obtained/disclosed is: **contact information such as phone numbers and addresses.**

I understand that if I do not sign this authorization I will not be denied services; however, I will lose the benefit of my treatment provider knowing about the information I have given during intake, and a Recovery Support Coordinator will not be able to assist me in identifying and arranging for needed treatment and support services. I also understand that I will be responsible for any cost for treatment and/or recovery support services if I do not sign this authorization.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Pts. 160 & 164, and Wis. Adm. Code section HFS 92.05 and 92.06, and cannot be disclosed without my written consent. I may inspect and receive a copy of any material that is disclosed if I request it. I may revoke this consent at any time with WRITTEN NOTIFICATION, except to the extent that action has been taken and reliance on it.

I also consent to participate in alcohol and other drug abuse treatment, research, evaluation and follow-up. I understand the ATR Voucher Coordination agency listed above will interview me for these purposes during my time in treatment and I will be contacted after I finish treatment to be asked about my progress. If I cannot be interviewed face-to-face, I may need to be interviewed by telephone. However, any names, addresses and telephone numbers of others that I provide during the intake process for use in helping to locate me will be used only to determine my whereabouts and talk to me personally. Nothing about my treatment or condition for the fact that I was in treatment will be disclosed to these people or to anyone else.

This authorization for disclosure of information is effective for one (1) year after the on which I am **discharged** from Missouri Access to Recovery treatment, COMBAT treatment and/or recovery support services. A photocopy or facsimile of this authorization shall be as valid as the original.

I have read the statements above, and understand that by signing this consent for disclosure, I agree to the information and terms herein and thereby provide my consent:

_____ _____

CLIENT NAME **INTAKE DATE**

_____ _____

STAFF WITNESS **DATE**

NOTICE TO CLIENTS: if you would like a copy of this Authorization, and haven't already been offered one, please ask the intake staff. The agency is required by law to provide you with this information.

Dismas House of Kansas City, Inc.

Recovery Support Services
LRM Recovery Plan

Consumer Name:	DMH ID:	Date of Birth:

Presenting Problem:

Recovery Goals:

Goal 1 – Domain:

Goal 2 - Domain:

Goal 3 - Domain:

What are the supports needed to accomplish these recovery goals?

What are the barriers/challenges to accomplishing these recovery goals?

Additional Information:

_____ _____ _____ _____

Assessor Signature & Credentials: Date: LRM Signature: Date:

Save As