DENVER FAMILY THERAPY CENTER
COMPREHENSIVE PSYCHOTHERAPY SERVICES

CO-DIRECTORS
DAVID BLAIR, LCSW, CAC III
ROBERT KELSALL, LCSW

4891 INDEPENDENCE #165
WHEAT RIDGE, CO 80033
303-456-0600
FAX 303-456-0607

ADOLESCENT SUBSTANCE ABUSE PROGRAM CONSENT OF RELEASE

The Adolescent Substance Abuse Program (ASAP) is focused on helping adolescents experiencing life problems including the misuse and abuse of alcohol and other drugs. The program addresses the individual, the alcohol and drugs, and the environment. ASAP believes that this requires getting the parents or legal guardian involved with their adolescent in the program. When the adolescent and the parents or legal guardian participate in care together better treatment outcomes result. ASAP sees it as important to include other professional too. This might be other therapists, caseworkers, or probation officers. This happens by involving every adolescent, parent or legal guardian and other professionals in planning the goals for treatment, the discharge plan and the aftercare plan.

Parents and adolescents are required to sign written consent to release oral and written information to parents, legal guardian and other professionals.

I acknowledge that I have read this policy and had my questions answered. I understand that this treatment program will share urinalysis results and my treatment progress with the following agencies (CHECH ALL THAT APPLY) and I give ASAP permission to release this information to help with providing treatment services.

____ County Department of Social Services

____ County Juvenile Probation

____ Guardian ad Litem

____ Therapist

____ Family Members, please list name and relationship

____ Others (Be Specific)_____

_____ _____
Client Signature (Can be Parent or Guardian for a Minor) **Date**

_____ _____
ASAP Clinician Signature **Date**

***consent may be revoked with written notice**

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CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION B Y NON-SECURE TRANSMISSION

This communication is for the communication of Protected Health Information the Denver Family Therapy Center, Inc. (hereinafter "DFTC") may transmit without the written authorization of the client as described in the Uses and Disclosure section of DFTC's Notice of Privacy Policies and Practices.

I,_____, herby consent and authorize DFTC to communicate my Protected Health Information through the following non-secure transmission (please initial choices):

_____ Cellular/Mobile Phone, this includes text messaging

(Please Insert Cell Phone Number_____)

(Secondary Cell Number if needed_____)

_____ Unsecure Email

(Please Provide Your email_____)

Please Circle One: Work Personal

_____ Other Media (example, Skype)

(Please Describe_____)

_____ I do not wish to have my Protected Health Information transmitted electronically

Should we agree to communicate by the approved communication listed above, i.e. test, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, I cannot guarantee that those communications will remain confidential. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure out communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party.

I,_____, understand that DFTC may use and disclose the following Protected Health Information without my written authorization. However, I consent to DFTC transmitting the following Protected Health Information by the above selected electronic communications (please initial your choices):

_____ Information related to scheduling
_____ Information related to billing and payments
_____ Information related to your mental health treatment (ex. personal materials, forms, suggested articles, etc.)
_____ Information related to DFTC's operations
_____ Other Information. Please Describe:_____

_____ _____

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CONSENT FOR TAPING

In order to provide you with exemplary service, the Denver Family Therapy Center, Inc., requests permission for two-way mirror observation and audio/video taping of sessions. These tapes will be used by the therapist to assist in better understanding of your family situation and to facilitate quality training of staff and interns. Any information of the tapes will be kept strictly confidential and treated in a professional manner.

You are under no obligation to agree to this or any future taping(s) and should understand that refusal will not alter the services you receive. We welcome any questions or commenets you have about the process.

I/We_____, on the behalf of myself and my minor children, do hereby give consent for the use of; two-way mirror, audio recording equipment and video recording equipment. This release will begin upon date of signing and will expire with termination of treatment unless otherwise specified.

I have been given an opportunity to examine, and an explanation of the use of said equipment as a part of my therapy.

I understand that the only purpose of such equipment and observations will be to: 1) act as an aid to my therapy, and 2) act as an aid for professional, teaching, and/or research purposes, as in professional seminars, workshops and/or classrooms.

In signing this release, I am doing so voluntarily without any coercion or compulsion. I understand that said equipment will be handled with appropriate professional discretion.

I understand that I may revoke my consent at any time with written notification and the submission of a revocation of consent form.

_____ _____

Client Signature (Can be Parent or Guardian for a Minor) **Date**

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CONSENT FOR FOLLOW-UP

I authorize Denver Family Therapy Center, Inc., to contact me and my immediate family during, and after the termination of treatment to gather information for follow-up and research studies. I understand that all information will be kept strictly confidential as outlined in Colorado Law 12.43.214(1)(d) CRS: Privileged Communications.

_____ _____

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PATIEN COMPLAINT PROCEEDURE

Adolescent Substance Abuse Program

Policy:

Patients, Parents, and/or guardians have a right to voice complaints or appeals about the organization or care provided.

Procedure:

- All patient, parent, and/or guardian complaints will be processed immediately without alteration, interference or unreasonable delay.
- All complaints can be in written form.
- The Program Manager will provide a written response to the patient, parents and/or guardian within three working days.
- All complaints will be documented in the patient's chart, with investigating findings and resulting action taken by the program.
- If the patient, parent, and/or guardian are unsatisfied with the findings they can appeal the decision by notifying the Director of the Denver Family Therapy Center, Inc., in writing, of the dissatisfaction. The Director will have five working days to investigate the complaint and provide a written response to the appeal.
- Under no circumstances will the patient, parent, and/or guardian be subject to any adverse actions as a result of filing a complaint.
- A copy of the complaint mus be forwarded to the Alcohol and Drug Abuse Division
  4055 S. Lowell Blvd. Denver, CO 80236

_____ _____
Patient **Date**

_____ _____
Parent/Guardian **Date**

_____ _____
ASAP Staff **Date**

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RISK ACKNOWLEDGEMENT

I acknowledge that I have been informed that continued drug or alcohol use can increase my risk of contracting diseases such as Tuberculosis, Hepatitis (A, B and C), HIV, and other communicable diseases. I also acknowledge that my continued use of substance may increase my risk for becoming pregnant or getting someone pregnant.

_____ _____

Client Signature (Can be Parent or Guardian for a Minor) **Date**

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TB SCREENING TOOL

Name:_____ Date: ____/____/____ Time: ____/____

Assessed by: _____

QUESTIONS			*VALUE*
1. Have you ever had a positive TB skin test? Last CXR: Results:_____ Date:_____	YES	NO	3
2. Have you ever been diagnosed with TB?	YES	NO	3
* If yes, was it in the past 2 years?	YES	NO	2
* If yes, did you have & complete TB treatment?	YES	NO	3
3. Have you ever received INH or other TB drugs?	YES	NO	3
4. Have you had contact with someone with TB?	YES	NO	2
5. Have you had a cough for more than 3 weeks?	YES	NO	1
6. Have you coughed up blood/colored mucous for more than 3 weeks?	YES	NO	2
7. Do you have swollen, non-tender lymph nodes? (neck, supraclavicular, auxiliary?)	YES	NO	2
8. Have you lost more than 10 lbs. over the past six months without trying to?	YES	NO	1
9. Have you had recurrent fevers and/or night sweats for more than 3 weeks?	YES	NO	1
10. Have you ever shared I.V. needles?	YES	NO	2
11. Have you tested positive for HIV?	YES	NO	2
12. Have you ever been homeless/lived in shelters?	YES	NO	2
13. Are you a diabetic?	YES	NO	1
14. Were you born in or have you lived outside the U.S. in any of these world areas? Asia Africa Latin America Caribbean	YES	NO	2
			_____

If answer "YES" to any of the above, circle the value for that question.
Add all circled values for total to determine RISK category.

TOTAL _____

If total points are:

13 – 33 = HIGH RISK
7 – 12 = MODERATE RISK
0 – 6 = LOW RISK

Notify MD: Evaluate for **TB Precautions.**
Patient education re: respiratory secretions; do PPD within 8 hours or CXR ASAP.
Usual infection control procedures.