



# AFFORDABLE SUBSTANCE ABUSE TREATMENT

228 N. Lynnhaven Rd. Suite 118  
Virginia Beach, VA 23452

## ASSESSMENT AND TREATMENT PLAN

408942001 (SNOMED-CT) PREVENTION ASSESSMENT

Assessment based on the ASI Index, DSM-5, DAST, AUDIT, CUDIT and ASAM Dimensions

**A 2-hour notice is required for all cancellations. Please note that a \$25 fee will be added to your account in the event of a no-show on your part.**

### REGISTRATION - GENERAL INFORMATION

Today's Date \_\_\_\_\_ Session Began: \_\_\_\_\_ Session Ended: \_\_\_\_\_ Number of minutes: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: (Date of Birth) \_\_\_\_\_ Current Age: \_\_\_\_\_ Veteran \_\_ Yes, \_\_ No

Street Address \_\_\_\_\_ City: \_\_\_\_\_

State \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone # \_\_\_\_\_ How long have you lived at this address? \_\_\_\_\_

Home Phone # \_\_\_\_\_ years

Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_

### REFERRING / REPORTING AGENCY

CHESAPEAKE BAY ASAP  PROBATION  PRETRIAL  PARENTS  SELF  EMPLOYER

CASE MANAGER / P.O. \_\_\_\_\_ PHONE # \_\_\_\_\_

FAX# \_\_\_\_\_ EMAIL \_\_\_\_\_

### CHIEF COMPLAINT – DIAGNOSIS:

The reason why I'm here: \_\_\_\_\_

What have you done so far to solve it? \_\_\_\_\_

#### PERSONAL STATUS

#### OFFICE USE ONLY

GENDER IDENTITY \_\_\_\_\_ UDS \_\_ passed \_\_ failed for \_\_\_\_\_ sessions

RACE IDENTITY \_\_\_\_\_ DSM-5 \_\_\_\_\_ AUDIT \_\_\_\_\_ DAST \_\_\_\_\_ ASAM

MARITAL STATUS \_\_\_\_\_ Dual D? SUD + \_\_\_\_\_

MARRIED  NEVER MARRIED  SEPARATED  DIVORCED  WIDOWED

### ANY PRESCRIBED MEDICATIONS

**Please be aware that Chesapeake Bay ASAP does not allow medical marijuana use.**

Name: \_\_\_\_\_ Amount: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Amount: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Amount: \_\_\_\_\_ Frequency: \_\_\_\_\_

### CHECK ANY ISSUES THAT APPLY TO YOU PERSONALLY

DEPRESSION  MARRIAGE  ALCOHOL  SEX  INSOMNIA  OTHER

INTERNET  GAMBLING  WORK  FOOD  PORNOGRAPHY

ANXIETY  ANGER ISSUES  VIOLENCE  DRUGS  INTERNET

## EDUCATIONAL BACKGROUND

My highest degree education    HS    GED    College    Professional certifications

## ARREST HISTORY

ARREST DATES	EXPLAIN ANY ARRESTS (IF D.U.I. - LIST BLOOD ALCOHOL CONTENT (BAC))	
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:

## TYPES OF SUBSTANCE USERS

**We have identified the following types, or categories of substance users. Please check the one(s) you identify with most.**

<input type="checkbox"/> <b>SOCIAL/CONTROLLED USER (no diagnosis, early education)</b> <i>"I <u>always</u> get a sober driver."</i>	<input type="checkbox"/> I <b>never</b> use any type of altering substance <b>alone</b> <input type="checkbox"/> I <b>never</b> drive or operate anything motorized while impaired <input type="checkbox"/> I <b>always</b> get a sober driver. <input type="checkbox"/> I <b>only</b> drink/use any substance randomly and <input type="checkbox"/> I <b>always</b> limit the amount I use.
<input type="checkbox"/> <b>EPISODIC/PROBLEM USER due to emotional distress or celebration, (mild)</b> <i>"I drank more than <u>five</u> (for men) or <u>four</u> (for women) or more drinks in a day more than once within the last year." "I use for emotional reasons when I'm stressed or have a serious loss."</i>	<input type="checkbox"/> I may go for long periods of time without drinking / using <input type="checkbox"/> I drank or used beyond the norm for me on this occasion, but it had serious consequences <input type="checkbox"/> I drink/use as a reward, when something goes wrong, or on a special occasion, etc. <input type="checkbox"/> When I'm in an "episode," I don't keep count of much I drink or use. <input type="checkbox"/> I use substances for stress relief (to sleep, after an argument, to feel better, after a loss of loved one, etc.)
<input type="checkbox"/> <b>PROBLEMATIC, MODERATELY FUNCTIONING (moderate)</b> <i>"I have made some <u>poor choices</u> as a result of drinking alcohol and/or ingesting altering substances." "Substance use is causing dysfunction in my life."</i>	<input type="checkbox"/> I have had problems with drinking alcohol or using altering substances. (DUI/DWI, arrests, etc.) <input type="checkbox"/> I got a 2nd or 3rd substance-related driving arrest (DUI/DWI) for any reason <input type="checkbox"/> My BAC (Blood Alcohol Content) of .15 or higher or THC of 5 ml.+ <input type="checkbox"/> I refused the breathalyzer for any reason; don't know what my BAC was." (Virginia- informed consent).
<input type="checkbox"/> <b>SEVERE PROBLEMATIC, LOW FUNCTIONING (severe)</b> <i>"I often drink/use because I need to, or I might get sick."</i>	<input type="checkbox"/> people are telling me that I need help. <input type="checkbox"/> Drinking / using has caused serious dysfunction in my life <input type="checkbox"/> I feel like I can't stop. <input type="checkbox"/> it has taken me over a year to deal my legal issues or get help.

## MEDICAL/MENTAL HEALTH HISTORY

	Please Explain in the column below
<input type="checkbox"/> Do you have any ongoing health concerns?	
<input type="checkbox"/> Previously diagnosed with a mental health disorder?	
<input type="checkbox"/> Psychiatric hospital stay for any reason?	
<input type="checkbox"/> Previous counseling for any reason?	
<input type="checkbox"/> Have you ever attempted to hurt yourself or attempted to complete suicide?	
<input type="checkbox"/> Do you have any history of trauma?	
<input type="checkbox"/> Have you suffered any significant deaths/losses?	
<input type="checkbox"/> How is your current physical health?	Explain <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> bad
<input type="checkbox"/> Current sleep patterns.	Explain <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> bad

## FAMILY HISTORY OF SUBSTANCE ABUSE

Parents <input type="checkbox"/> yes <input type="checkbox"/> no	Grandparents <input type="checkbox"/> yes <input type="checkbox"/> no
Siblings <input type="checkbox"/> yes <input type="checkbox"/> no	

## MY SUBSTANCE ABUSE HISTORY

Alcohol	Age I first used _____	Date I last drank _____
Marijuana	Age I first used _____	Date I last used _____
Stimulants (cocaine, crack, amphetamine, Adderall)	Age I first used _____	Date I last used _____
Opiates (heroin, codeine, fentanyl, hydrocodone, Vicodin)	Age I first used _____	Date I last used _____
Other	Age I first used _____	Date I last used _____

How long was your last period of voluntary abstinence? \_\_\_\_\_

## EMPLOYMENT STATUS

full-time    part-time    unemployed    other

professional    sales    management    other   My financial income in the last year: \_\_\_\_\_

## RELIGIOUS/SPIRITUAL PREFERENCE

Religious affiliation \_\_\_\_\_ Level of activity \_\_\_\_\_

Are you comfortable with talking about the 12 steps of AA, spirituality, and God in your recovery? \_\_ Yes \_\_ No

If not, please explain \_\_\_\_\_

## DIAGNOSTIC QUESTIONNAIRE (adapted from the DSM-5)

(Please check the box(es) below for substances you have used)

ALCOHOL    MARIJUANA    COCAINE    OPIATES    STIMULANTS    OTHER

## Answer the questions as if today was currently the time of your arrest.

Please check and explain any descriptions that apply to you and your substance use.

**YES.** Sometimes I have used more (\_\_\_ alcohol and or \_\_\_ illegal drugs) than I meant to for a longer period of time than I planned on. (Example: "I was going to have a beer with friends for an hour and shoot pool. Ended up drinking 3 beers and was there for 4 hours.")

If yes, please explain. \_\_\_\_\_

**YES.** I have tried to (or wanted to) cut down on or control the amount of my (alcohol / illegal drugs) use but didn't or felt I couldn't. (Example: "I've stopped drinking for weeks, even months, but picked back up later.")

If yes, please explain. \_\_\_\_\_

**YES.** I have spent too much time and/or money getting (alcohol / illegal drugs), using them, and recovering from their effects (hangovers, etc.). (Example: "Drinking/using has wasted a lot of my time and costs me too much!")

If yes, please explain. \_\_\_\_\_

**YES.** I have experienced cravings or urges to use (alcohol / illegal drugs). (Example: "Often, when I haven't drank/used for a while, I just feel like a drink or a little bit of drugs would help me feel a lot better.")

If yes, please explain. \_\_\_\_\_

**YES.** My \_\_\_ home, \_\_\_ work, or \_\_\_ school life has been negatively affected by my use (alcohol / illegal drugs). "I've shown up late, missed family events or meetings because of use. (Example: "Family members say I'm just not there for them like I used to be.")

If yes, please explain. \_\_\_\_\_

**YES.** I have experienced withdrawal symptoms after stopping my use. (Example: "I felt sick, had headaches, shakiness, dizziness, sweaty, heart palpitations, etc. after I stopped use.")

If yes, please explain. \_\_\_\_\_

**YES.** Even though my (alcohol / illegal drugs) use has caused relationship problems, I have continued to use. (Example: "My parents, spouse, girlfriend, etc. get upset over my use. We have argued about it.")

If yes, please explain. \_\_\_\_\_

**YES.** Because of my (alcohol / illegal drugs) use, I have given up on or reduced my involvement in certain hobbies, sports, social events, occupational, or recreational activities. (Example: "I don't play sports, enjoy hobbies, etc. like I used to because of my use.")

If yes, please explain. \_\_\_\_\_

**YES.** Even though (alcohol / illegal drugs) put me in danger, I used anyway. (Example: "I got a DUI, I drove any type of vehicle after drinking/using, or operated machinery, made risky choices, etc.") How many times did you drive/operate a vehicle, boat, machinery, etc. after drinking alcohol in the last year and did not get caught? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

**YES.** Despite realizing that my (alcohol / illegal drugs) use was causing physical and/or psychological problems (or making such problems worse), I continued to use. (Example: "It has complicated issues like diabetes, blood pressure, ADD, depression, etc.")

If yes, please explain. \_\_\_\_\_

**YES.** I consistently needed more of the substance (alcohol / illegal drugs) to get the same effect/high. (Example: "I used to get a buzz from 3 drinks, now it takes me 5 to feel the same way.")

If yes, please explain. \_\_\_\_\_

**YES.** I have used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever? (because of a death in the family, financial problems, work stress or other stressors)




If yes, please explain. \_\_\_\_\_

**TOTAL:** \_\_\_\_\_ The previous questions were adapted from the DSM-5 developed by the American Psychiatric Association. These questions helped you identify the type and severity of problems and physical symptoms related to your use of alcohol or other drugs over the last year. (DSM-5 = MLD4-5)

## ALCOHOL USE DISORDERS IDENTIFICATION TEST (A.U.D.I.T.)

**Questions about your ALCOHOL use in the last year or when you were drinking. If you have not gone to treatment when you were expected to, then answer for the time when you were drinking (at the time of your arrest). Place your answer's number under "score"**

12 fl oz of regular beer = 8-9 fl oz of malt liquor (shown in a 12 oz glass) = 5 fl oz of table wine = 1.5 fl oz shot of 80-proof distilled spirits (gin, rum, tequila, vodka, whiskey, etc.)

 about 5% alcohol     
  about 7% alcohol     
  about 12% alcohol     
  40% alcohol

The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

**Remember, a serving is  
12 oz. beer =  
5 oz. glass of wine =  
1.5 ounces of liquor**

Place the number that best describes your alcohol use in the gray column at the right	0	1	2	3	4	SCORE 0-4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
How many drinks do you have on a typical day when you're drinking? (12 oz. beer = 4 oz wine = 1.5 ounces liquor)	1 or 2	3 or 4	5 or 6	7,8 or 9	10 or more	
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session the night before? (eye opener)	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, in the last year	
Has a relative, friend, doctor (or any another health worker) been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year	
<b>TOTAL</b>						

**IF YOU DO NOT USE MARIJUANA OR ANY OTHER ALTERING SUBSTANCE, SKIP TO PAGE 8  
CANNABIS USE DISORDER IDENTIFICATION TEST**

**Have you used any cannabis over the past six months?      YES / NO**

**If YES**, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*

- |    |   |                  |                        |                        |                       |                             |
|----|---|------------------|------------------------|------------------------|-----------------------|-----------------------------|
| 1. | How often do you use cannabis?  | Never<br>0       | Monthly or less<br>1   | 2-4 times a month<br>2 | 2-3 times a week<br>3 | 4 or more times a week<br>4 |
| 2. | How many hours were you “stoned” on a typical day when you had been using cannabis?                                       | Less than 1<br>0 | 1 or 2<br>1            | 3 or 4<br>2            | 5 or 6<br>3           | 7 or more<br>4              |
| 3. | How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?       | Never<br>0       | Less than monthly<br>1 | Monthly<br>2           | Weekly<br>3           | Daily or almost daily<br>4  |
| 4. | How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?      | Never<br>0       | Less than monthly<br>1 | Monthly<br>2           | Weekly<br>3           | Daily or almost daily<br>4  |
| 5. | How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis? | Never<br>0       | Less than monthly<br>1 | Monthly<br>2           | Weekly<br>3           | Daily or almost daily<br>4  |

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?
- |       |                   |         |        |                       |
|-------|-------------------|---------|--------|-----------------------|
| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 0     | 1                 | 2       | 3      | 4                     |
7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:
- |       |                   |         |        |                       |
|-------|-------------------|---------|--------|-----------------------|
| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 0     | 1                 | 2       | 3      | 4                     |
8. Have you ever thought about cutting down, or stopping, your use of cannabis?
- |       |                                   |                               |
|-------|-----------------------------------|-------------------------------|
| Never | Yes, but not in the past 6 months | Yes, during the past 6 months |
| 0     | 2                                 | 4                             |

***This scale is in the public domain and is free to use with appropriate citation:***

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

This questionnaire was designed for self administration and is scored by adding each of the 8 items:

- Question 1-7 are scored on a 0-4 scale
- Question 8 is scored 0, 2 or 4.

Scores of 8 or more indicate hazardous cannabis use, while scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

## **The Twelve Questions of Marijuana Anonymous**

**The following questions may help you determine whether marijuana is a problem in your life. Place a check mark in any lines that apply.**

**Yes No**

- Has using marijuana stopped being fun?
- Do you ever get high alone?
- Is it hard for you to imagine a life without marijuana?
- Do you find that your friends are determined by your marijuana use?
- Do you use marijuana to avoid dealing with your problems or to cope with your feelings?
- Has your marijuana use led to financial difficulties and/or legal consequences?
- Does your marijuana use let you live in a privately defined world?
- Have you ever failed to keep promises you made about cutting down or controlling Our use of marijuana?
- Has your use of marijuana caused problems with your health, memory, concentration, or motivation?
- When your stash is nearly empty, do you feel anxious or worried about how to get more?
- Do you plan your life around your marijuana use?
- Have friends or relatives ever complained that your using is damaging your relationship with them?

Total Yes Answers \_\_\_\_

<https://marijuana-anonymous.org/the-twelve-questions-of-marijuana-anonymous/>

**Note about cannabis use:** It is considered while an individual is in the VASAP and ASAT program, they are on probation. Marijuana may NOT be used unless prescribed by a true health practitioner. It is both disrespectful and unacceptable for any participant to attend groups under the influence of any altering substances (at least 6 hours before group medical marijuana must cease).

### DAST: DRUG ABUSE SCREENING TEST

For Substance Use (other than alcohol).	CHECK IF YES
1. Have you used drugs other than those prescribed for medical reasons?	<input type="checkbox"/>
2. Have you abused prescription drugs? (borrowed someone's prescription, bought someone's medication, taken more than the standard dose, etc.)	<input type="checkbox"/>
3. Do you use more than one substance at a time? (alcohol plus marijuana, for example)	<input type="checkbox"/>
4. Do you struggle with stopping drug use even if you want to?	<input type="checkbox"/>
5. Have you had "blackouts" or "flashbacks" because of drug use?	<input type="checkbox"/>
6. Do you ever feel bad about your drug abuse?	<input type="checkbox"/>
7. Does your spouse/significant other (or parents) ever complain about your involvement with drugs?	<input type="checkbox"/>
8. Has drug abuse ever created problems between you and your spouse/significant other (or parents)?	<input type="checkbox"/>
9. Have you ever lost friends because of your use of drugs? (i.e. certain people no longer want to associate with you because you use).	<input type="checkbox"/>
10. Have you ever neglected your family or missed work because of your use of drugs?	<input type="checkbox"/>
11. Have you ever been in trouble at work because of drug abuse?	<input type="checkbox"/>
12. Have you ever lost a job because of your drug abuse?	<input type="checkbox"/>
13. Have you gotten into fights when under the influence of drugs?	<input type="checkbox"/>
14. Have you engaged in illegal activities to obtain drugs? (bought, sold, distributed, or stolen for drugs, etc.)	<input type="checkbox"/>
15. Have you ever been arrested for possession of illegal drugs?	<input type="checkbox"/>
16. Have you ever experienced withdrawal symptoms because of drug use?	<input type="checkbox"/>
17. Have you had medical or mental health problems because of use (memory loss, lack of focus, depression, hepatitis, convulsions, or bleeding, etc.)?	<input type="checkbox"/>
18. Have you ever gone to anyone for help for a drug problem?	<input type="checkbox"/>
19. Have you ever been involved in a treatment program specifically related to drug use?	<input type="checkbox"/>
<b>TOTAL BOXES CHECKED</b>	

## CLIENT STATEMENTS ASSESSMENT

Questions about your ALCOHOL or SUBSTANCE use in the last year, or when you were drinking/using. If you have not completed treatment in the last year, then answer for the time when you were drinking/using the most (at the time of your arrest). If your answer is YES, put a 10 in the right column. If it is a NO, leave it blank.

STATEMENT		A YES = 10
"I realize I have an alcohol or other substance abuse <b>problem</b> . (Getting a DUI is a problem)."		
"I have had serious <b>consequences</b> from drinking/substance use." (arrest, jail, health, etc.)		
"I had an offense before this one within the last <b>6 years</b> ." (DUI, drunk in public, etc.)		
"I <b>drank/used</b> while I was in treatment or on probation." (i.e. since enrolling in ASAP program)		
"I have been to a <b>detox, treatment</b> , or a medical program before." (due to substance abuse).		
"My BAC was a <b>0.15</b> or higher." (or I refused the breathalyzer)		
"I've had one or more <b>non-driving</b> conviction/offense." (drunk in public, or other substance-related).		
"I had an <b>interlock violation</b> , or positive reading on a breathalyzer device or drug screen during ASAP."		
"I got another alcohol or other drug-related conviction/offense." (during the ASAP probationary period).		
"I have been using a substance that can be <b>addicting</b> ." (has the potential to lead to dependence).		
"I didn't <b>complete</b> my treatment assessment as instructed by VASAP."		
"I didn't <b>complete treatment</b> as required by a prior treatment provider."		
"People around me at <b>home</b> drink/use."		
"People around me at <b>work</b> drink/use while at work."		
"My life seems <b>dysfunctional</b> (out of control) from drinking/using."		
"I shouldn't have to stop drinking/using. No one can tell me I can't have a drink/use drugs."		
"I get/feel <b>defensive</b> when confronted about my use."		
"I have an <b>emotional reason</b> to use." (loss of a family member, bad mood, bad day, etc.)		
"I began alcohol / altering drug use at ___ years of age." (if under 21, write in a score of <b>10</b> )		
"Drinking/using has created <b>other health issues</b> ."		
<b>TOTAL</b>		

**Note about cannabis use:** It is considered while an individual is in the VASAP and ASAT program, they are on probation. Marijuana may NOT be used unless prescribed by a true health practitioner. It is both disrespectful and unacceptable for any participant to attend groups under the influence of any altering substances (at least 6 hours before group medical marijuana must cease).

## COMPLETE ABSTINENCE AGREEMENT

**You, The Client, must acknowledge that there will be complete abstinence from alcohol and all mind-altering substances (unless prescribed) while in treatment.**

Signed \_\_\_\_\_

Date \_\_\_\_\_





# AFFORDABLE SUBSTANCE ABUSE TREATMENT

228 N. Lynnhaven Rd. Suite 118  
Virginia Beach, VA 23452

## INFORMED CONSENT

### AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND PATIENT INDIVIDUAL FINANCIAL RESPONSIBILITY AND OBLIGATION

This document is to act as a set agreement for an approved payment plan based upon policy set by to Affordable Substance Abuse Treatment.

**(Please check all boxes that apply)**

- I understand that I am financially responsible for any copayment, cost share and/or deductible determined by my insurance carrier. In addition, I am responsible for any services deemed to be a non-covered benefit or if there is a lapse of coverage at the time medical services are rendered. Your benefits may vary based on the services provided.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- If my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the services rendered to me at time of service.
- If you are scheduled for an appointment and do not show, there will be a \$75 charge to your account.
- Should your account become delinquent and collection actions occur, you will be responsible for payment of all charges incurred as well as all collection agency costs and attorney fees up to 33 1/3%.
- I authorize the release of any medical information necessary for the processing of my medical claims. I hereby authorize my insurance company to pay benefits directly to /Affordable Substance Abuse Treatment (ASAT).

## INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to Affordable Substance Abuse Treatment of Virginia Beach on my behalf for any services furnished to me by the providers.

## MEDICARE REQUEST FOR PAYMENT

- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Affordable Substance Abuse Treatment of Virginia Beach. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Signature of Patient, Authorized Representative or Responsible Party Date Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Do we have your permission to leave a message regarding any test results or appointments on a voice machine at your home or mobile phone? \_\_\_ Yes \_\_\_ No

Do we have your permission to discuss any medical conditions or treatments and or leave a message with any household members? \_\_\_ Yes \_\_\_ No

Do we have your permission to share information regarding any treatment, attendance, urine screen results or appointments on a voice machine, email or text with the following individuals you may choose? \_\_\_ Yes \_\_\_ No

- I understand that by writing in or typing my name, I am electronically signing this document.

**(PLEASE NOTE: WE ARE REQUIRED TO HAVE YOUR SIGNATURE)**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



# AFFORDABLE SUBSTANCE ABUSE TREATMENT

228 N. Lynnhaven Rd. Suite 118  
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## CONSENT TO REPORT TO AGENCIES AND INDIVIDUALS MEDICAL RELEASE OF INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

(Please check all boxes)

### AUTHORIZATION TO RELEASE ALL RECORDS

I hereby authorize Affordable Substance Abuse Treatment of Virginia Beach to release all of my records to my insurer, governmental agencies, or any other entity, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for probation, court services, judges, precertification, authorization or referral to other medical provider.

	NAME	PHONE NUMBER
<input type="checkbox"/> PRETRIAL <input type="checkbox"/> PROBATION OFFICER		
<input type="checkbox"/> ASAP CASE MANAGER		
<input type="checkbox"/> ATTORNEY		
<input type="checkbox"/> FAMILY MEMBER		
<input type="checkbox"/> EMPLOYER		
<input type="checkbox"/> ASAT CASE MANAGEMENT	ASAT Team	757-456-0093
<input type="checkbox"/> OTHER		

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

# AFFORDABLE SUBSTANCE ABUSE TREATMENT

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## INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
GROUP #	GROUP #
MEMBER #	MEMBER #
SUBSCRIBER	SUBSCRIBER
SS#	SS#
DOB	DOB

Due to the many changes in insurance policies, it is no longer an easy task to keep up with everyone's insurance policies. Although we tried to stay aware of these changes it is not always possible. Therefore, we urge you as the patient to check with your insurance company regarding your coverage and if you need a referral. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred.

To assist you in finding out if you have coverage, the insurance company has a customer support number on the back of your insurance card. Some insurance plans require referrals to see a specialist from your primary care physician or primary care manager. If your insurance company requires such a referral, it is your responsibility to obtain and provide the referral to our office prior to being seen. Failure to do so may result in your either having to reschedule your appointment or except full responsibility for payment. In addition, all insurance companies require you to see physicians that participate with that said company. It is you, the patient's, responsibility to verify with the insurance that we are a participating provider.

If you happen to cancel or don't show up to your scheduled appointment time you may be charged a \$25 no-show fee for follow-up patients. After three no-call, no-show appointments you will not be able to reschedule.

All past due balances must be paid at the time of service unless you have arranged a payment plan with the office.

I understand that by typing my name, I am electronically signing this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



# AFFORDABLE SUBSTANCE ABUSE TREATMENT

228 N. Lynnhaven Rd. Suite 118  
Virginia Beach, VA 23452

## HIPAA PRIVACY OF PATIENT HEALTH CARE INFORMATION

Because there can be questions of privacy when healthcare information is transmitted electronically the Congress has established an all-inclusive sweeping privacy law called the **Health Information Privacy and Portability Act (HIPPA)** to be administered by the Department of Health and Human Services the act establishes standards for health care providers in obtaining and disclosing your personal health information. Although such information exchange has been routine in the past and even though we have never had a problem, the law mandates that you must now give specific written consent to continue these traditional communications relating to your personal health information and to facilitate payment.

We fully respect the privacy of your records, and we will continue to do all we can to make them secure and to protect their confidentiality. In order to provide the best possible health care and or to help third parties involved with payment for your account, we routinely share and request pertinent health information only with your other medical caregivers and with other concerned parties such as relatives and others involved in account payment such as insurers. We may, from time to time, need to confirm or discuss appointments or to discuss care related concerns on your home answering machine or directly to those answering your home phone or to phone callers identifying themselves as a relative or concerned party. This may also occur by cell phone if it has been listed.

In the course of your treatment, we sometimes have to disclose or receive your personal health information from other treatment-related facilities such as labs, durable medical equipment companies, pathologists for radiologists that might not be required to obtain your consent to release to us reports relating to your personal health, drug screens, etc.

HIPPA allows you to consent or refuse to the use of or disclosure of your personal health information as described above but concept or refusal must be in writing. HIPPA does recognize the necessity of information exchange for the optimum patient care, and it has provided for denial of treatment if you choose not to consent. If you choose to give consent by signing this document, you have the future right to revoke or restrict part or all of this personal health care information agreement but you may not revoke or restrict actions that have already been taken that relied on this or a previously signed consent of course you personally have the right at any time to access any information we have in your personal health records. Your signature below indicates your consent.

- ASAT prohibits discrimination against its clients on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information.
- If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone **else**, please call 911 for assistance. Your signature below indicates consent for us to help you and/or members your family.
- I understand that by typing my name and continuing this assessment evaluation, I am electronically signing this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_