Tután Recovery Services LLC
Empowering Others

Attach Copy of Identification Card

Demographics

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Name: First, Last Middle Initial	ID #:	DOB:	Age:	Gender:	SSN:
Physical Address:		Mailing Address (if different from physical address):			
Home Phone:	Cell Phone:		Message Phone:		
Emergency Contact:	Emergency Contact Phone #:		Relationship:		

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiin/Pacific Islander ☐ Alaskan Native: ___Inupiaq ___Athabascan ___Yupik ___Tlingit ___Haida___Tsimshian ☐ Other: _____

Ethnicity:(circle one) Not Spanish-Hispanic-Latino / Chicano / Cuban / Hispanic / Mexican American / Puerto Rican / Latino / Unknown Interpreter Needed: ☐ Yes ☐ No

Referral Source: ☐ DOC ☐ ASAP ☐ ATR ☐ OCS ☐ VA ☐ Self-Referral ☐ CITC ☐ Other: _____

Contact Type: ☐ Phone ☐ Walk-In ☐ Other_____

Veteran Status: ☐ Never in Military ☐ Active Duty ☐ National Guard Reserve ☐ Retired ☐ Combat ☐ Dependent ☐ Vietnam ☐ Gulf War ☐ Iraq War ☐ Afgan War ☐ Veteran ☐ Other: _____

Education: ☐ H.S. Diploma ☐ G.E.D ☐ Vocational ☐ College ☐ Other: _____

English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

Health Status: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor ☐ Other: _____
If Female, are you pregnant? _____ Yes _____No If yes, when is your due date? _____

Special Needs: Physical/Medical/Mental): _____

Employment: ☐ Unemployed, Not Looking for Work ☐ Unemployed, Looking for Work) ☐ Employed Full-Time ☐ Employed Part-Time ☐ Seasonal Employment Annual Income: $_____
Employer Name and Address: _____
Employer Phone: _____
Insurance Provider: _____ Insurance ID#: _____

Presenting Problem: In your own words, what brings you here today?_____
_____
_____
_____

Effective: 7/1/14
Revised: 11/1/14
Location: Shared Drive/Forms/Client Forms/Initial Packet

Have you ever-injected drugs? ☐Yes ☐ No Date of AOD (Alcohol or Drug) last use: _____
Are you currently participating in an opioid replacement therapy program? ☐Yes ☐No
With Whom? _____
Do you use tobacco? ☐Yes ☐No If yes what type: _____cigarettes _____cigars other_____
Number of Prior Substance Use Treatment Admissions:_____
Number of non-treatment Substance hospitalizations in the past six months? _____
Number of Prior Mental Health Treatment Admissions? _____
Number of times that you have participated in a Self-Help group in the last 30 days? _____

Current Living arrangements:(circle one)

Assisted Living	Correctional Detention Facility	Crisis Residence Foster Care
Group Home	Residential Treatment	Transitional Housing
Halfway House	Shelter	Homeless
Therapeutic Foster Care	Nursing Home	Residence with services
Private Residence w/o Supportive Services		Other_____

Household Composition: (circle one)

Live alone	Live with children	Live with relative
Live with non-relative	Live with significant other	
Live with significant other & Children		Other_____

Describe current legal status: (circle all that apply)

180 day commitment	90 day commitment	30 day commitment
Case Pending	Community Sentencing	Deferred Prosecution
Deferred Sentence	Emergency Commitment	Incarcerated
Informal Probation	No Involvement	Probation/Parole-length____
Protective Custody	Office of Children's Services	Court Order for Treatment

Number of Arrests in the last 30 days: _____

Have you ever been physically, verbally, emotionally, or sexually abused? ☐Yes ☐No
Please Explain: _____
Do you have a Domestic Violence Protective Order in place? ☐Yes ☐No

Are you currently safe? ☐Yes ☐ No

_____

Other comments include any urgent circumstances relating to your current situation.

_____
_____
_____

_____ _____
Client Signature: Date:

_____ _____
Witness Signature: Date:

Cc: Client
Client File

FOR OFFICE USE ONLY:

Assessment Appt. Date: _____ Time: _____
Assigned Assessor: _____

Effective: 7/1/14
Revised: 11/1/14
Location: Shared Drive/Forms/Client Forms/Initial Packet

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, DOB_____, hereby request/authorize:

Tután Recovery Services, LLC
1675 C. Street, Suite 201
Anchorage, AK 99501
Telephone: (907) 563-0555
Fax: (907) 563-1122
tutanrecovery@gmail.com

and

Name: _____
Agency: _____
Address: _____
City: _____, State: ____ Zip: _____
Telephone: _____
Fax: _____
Email: _____

For the purpose of the release of the following information (Please initial):

_____ Admission/Assessment
_____ Sharing with other Providers
_____ Attendance
_____ Aftercare Progress
_____ Personal Records
_____ Other: _____

_____ Coordination of Care
_____ Treatment Plan Updates
_____ UA Results
_____ Legal
_____ Leave Message for Client
_____ Other: _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individuals(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (If applicable) or eligibility for benefits on whether I provide this authorization, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR parts 160 and 164, and cannot be disclosed with your written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken reliance on it and that in any event this consent expires automatically as follows: (Please Initial) _____18 months post discharge, **or** _____other terms:_____. (Specify the date, event, or conditions upon which this consent expires) IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILLTERMINATE ON _____/_____/_____.

By my signature below I indicate that I have read this document, or have had it read to me, that I fully understand its meaning, that I have consented to its terms knowingly and voluntarily, that I have not been under any undue duress or influence of alcohol or drugs in making this agreement.

_____ _____
Client Signature: Date:

_____ _____
Witness Signature: Date:

Cc: Client Files
Service Agency

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Effective: 7/1/14
Revised: 11/1/14
Location: Shared Drive/Forms/Client Forms/Initial Packet

PAYMENT & MISSED APPOINTMENTS

All appointments set in the appointment book are subject to a $25.00 missed appointments fee if they are canceled or rescheduled within 24 hours of their scheduled date, or if you do not show or call for your appointment. You will not be rescheduled for an appointment until the $25.00 has been paid in full.

All fees are expected at the time of services or you will not be allowed to attend your session.

ACKNOWLEDGEMENT:

I, _____, understand that my signature below indicates that I have read the information on *"Payment and Missed Appointments Fee charge"*, and that I fully understand each section. I was given an opportunity to ask questions regarding payment and missed appointments. I have knowingly and voluntarily consent to the terms of each one, and that I was neither under any duress or force nor under the influence of alcohol or other drugs at this time that I signed this document.

_____ _____

Client Signature: Date:

_____ _____

Staff Signature: Date:

Cc: Client
Client Files

Effective: 7/1/14
Revised: 11/1/14
Location: Shared Drive/Forms/Client Forms/Initial Packet

Refund Policy

- Tután Recovery Services, LLC does not provide refunds for any monies paid. **NO EXCEPTIONS.**

  Any Checks that are returned to us for insufficient funds will be accessed an additional $25.00 service fee and continuation of program will be reviewed by Treatment Staff.

- This includes pre-P\paid assessments and sessions. It is ***your*** responsibility to follow through with all appointments.

- If you have any questions or concerns, please contact Eydie Flygare or Elisha at 907-563-0555, Monday through Friday, 9:00 AM – 5:00 PM.

ACKNOWLEDGEMENT:

I,_____, understand that my signature below indicates that I have read the information on *"Refund Policy"*, and that I fully understand each section.I had the opportunity to ask questions regarding the refund policy.
I have knowingly and voluntarily consent to the terms of each one, and that I was neither under any duress or force nor under the influence of alcohol or other drugs at this time that I signed this document.

_____ _____
Client Signature: Date:

_____ _____
Staff Signature: Date:

Cc: Client
Client Files

Effective: 7/1/14
Revised: 11/1/14
Location: Shared Drive/Forms/Client Forms/Initial Packet