

COURT REFERRED

Welcome:

If you have been referred for substance abuse treatment from an agency or from the courts, please refer to the list below. We hope this information helps you make the choice that is best for you and your needs.

Times and Prices:

Groups are 90 minutes, individual sessions are 50 minutes, and prices are listed below.

Intake session	(Substance Abuse): \$40
Individual session	(Substance Abuse): \$40
Group session	(Substance Abuse): \$20
Treatment Needs Assessment	(Substance Abuse): \$100
Men's Group:	Monday 5:00-6:30 PM
	Wednesday 5:00-6:30 PM
Women's Group:	Tuesday 5:00-6:30 PM

All appointments other than group sessions will be scheduled on an individual basis.

How we can help you:

At Summit Family Counseling, LLC we are dedicated to helping you accomplish your goals. To help, we provide free faxing of court compliance documents so the court system is aware that you are attending. Also, we provide individualized treatment goals that are specifically catered to meet your personal needs. We thank you for your consideration.

Homework Assignments:

For substance abuse homework assignments, click below.

Appointments:

For appointment times, location, and other information call Bruce Parsons:

Office: 702-568-5888, ext. 225

Direct Line: 702-353-1148

If I'm unavailable, please leave a detailed message. I'll call you back as soon as possible. Thank you.

I look forward to getting started. Thank you.

Bruce M. Parsons

Bruce M. Parsons, MS, LADC, MFT-Intern, Owner of Summit Family Counseling, LLC

**Summit Family Counseling, LLC
Substance Abuse Intervention Project
Confidentiality of Alcohol and Drug Client Records**

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by this program. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser **UNLESS:**

1. The client consents in writing
2. The disclosure is allowed by a court order
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client at the program, or against a person who works for the program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child/elder abuse/neglect from being reported under State law to the appropriate State or local authorities.

Please sign below to acknowledge receipt of this document

Signature of Client

Date

Signature of Witness

Date

Reference: (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations)

Summit Family Counseling, LLC
Substance Abuse Intervention Project
Client's Rights

Client Name: _____

As a client of the Substance Abuse Intervention Project, your rights include, but are limited to, the following:

1. If the program receives funds from the Bureau of Alcohol and Drug Abuse, you have the right to be provided treatment regardless of whether or not you can afford to pay for it. Further, the program is prohibited from imposing any fee or contract that would be a hardship for you or your family.
2. You have the right to be provided treatment appropriate to your needs.
3. If you are transferred to another treatment provider, you have the right to be given an explanation of the needs for such a transfer and of the alternatives available, unless such transfer was made due to a medical emergency
4. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
5. You have the right to be informed of all program services that may be of benefit to your treatment.
6. You have the right to be informed of the name of the person responsible for the coordination of your treatment and of the professional qualifications of staff involved in your treatment.
7. You have the right to be informed of your diagnosis, treatment plan, and prognosis.
8. You have the right to be given sufficient information to provide for informed consent to any treatment for which you're provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimate of the costs of treatment and a description of the alternative to treatment.
9. You have the right to be informed if the facility proposes to perform experiments that affect your treatment, and the right to refuse to participate in such experiments.
10. You have the right to examine your bill for treatment and to receive an explanation of the bill.
11. You have the right to be informed of the programs' rules for conduct at the facility.
12. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
13. You have the right to receive respectful and considerate care.

14. You have the right to receive continuous care: to be informed of your appointments for treatment, the names of program staff available for treatment and of any need for continuing care.
15. You have the right to have any reasonable request for services satisfied by the program, considering its ability to do so.
16. You have the right to safe, healthful, and comfortable accommodations.
17. You have the right to confidential treatment. That is, other than those exceptions defined by law in which public safety takes priority, the program cannot release any information about you, including confirmation or denial that you are a client, without your consent.
18. Waiver of any civil or other rights protected by law cannot be required as a condition of program services.
19. You have the right to freedom from emotional, physical, intellectual or sexual abuse or harassment.
- 20. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor**
21. You have the right to grieve actions and decisions of facility staff that you believe are inappropriate, including, but not limited to actions and decisions that you believe violate your rights as a client. The facility is obligated to develop a grievance procedure for timely resolution of complaints from clients and post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retribution or other adverse consequences as the product of filing a grievance.
22. You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction. You have the right from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to the following:
 Bureau of Alcohol and Drug Abuse
 Attn: Statewide Program Coordinator
 505 E. King Street, Room 500
 Carson City, NV 89710
 (765) 687-4790
23. You have the right to be informed of your rights as a client. The forgoing is to be posted in the facility in a place where they are immediately available to you. You are to be informed of your rights and given a listing of them as soon as is practically possible upon your beginning treatment.

I have read, understand and have been provided a copy of the above Client's Rights.

Signature of Client

Date

Signature of Witness

Date

**Summit Family Counseling, LLC
Substance Abuse Intervention Project
Consent to Treat**

I, _____, agree to participate in the counseling/therapy process, and I will aid in the formation and completion of a treatment plan if necessary. I understand the possible growth, decisions, risk, and potential consequences of the counseling and therapy process.

I understand that changes that I may decide to make during my treatment have the potential of affecting my life in a dramatic way. Therefore, I recognize that I am responsible to make changes in accordance with those principles and standards that I am comfortable with. I am also aware that I may stop treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with the consequences for terminating treatment, e.g., answer to the judicial system if treatment was court ordered.

Appointments will be set up for me and I agree to attend as scheduled. If I am unable to make a scheduled appointment, I will call to cancel/reschedule as soon as possible, at least twenty-four hours in advance.

I further understand that my counselor or therapist is obligated by law to inform appropriate parties if I am in danger, or I am causing danger to someone else. No person shall be denied treatment or be given inferior treatment services due to handicap, race, gender, religious orientation, sexual orientation, national origin and/or ability to pay for services.

Signature of Client

Date

Signature of Witness

Date

**Summit Family Counseling, LLC
Substance Abuse Intervention Project
Consent to Treat**

Dear Client:

This is the intake questionnaire that you will need to complete to start services. Also included are two assessments, a copy of your client's rights, and several one-page forms that explain your rights and confidentiality. Please read through each document thoroughly and complete the enclosed forms as best you can. The information requested in the packet is intended to give us a better idea of what issues have brought you to our agency for services.

After completing the intake paperwork, you will be entered into the computer and officially enrolled in our program. There is a \$40.00 fee for the enrollment. This fee is in addition to the costs for each group. Only cash or money orders will be accepted. A confirmation of your enrollment will be sent to the court upon completion of this paperwork. However, **YOU WILL STILL BE RESPONSIBLE TO BRING THE COPY OF THE ENROLLMENT NOTICE TO COURT.** Our copy is merely a back up.

After completing your paperwork today you will be scheduled to attend an intake appointment to review the paperwork you have completed today. You must have your intake appointment completed within four weeks of enrollment. Failure to comply may result in your case being referred back to Court Programs. **A \$40.00 fee will be added to your balance for every intake appointment not cancelled or rescheduled within a 24-hour period.**

Group therapy is one hour in length; fees are \$20.00 per session. Individual therapy is one hour in length; fees are \$40.00 per session.

I have understood and agreed to the above information.

Signature

Date

Sincerely,

Summit Family Counseling, LLC

Substance Abuse Intervention Project Client Contract

I, _____, understand the goals of this program and agree to participate fully. I am aware that the main purpose is to increase daily functioning in my home, work and community. To this end, I will accept responsibility for identifying those factors that have contributed to problems and for learning new skills to deal with these factors.

To successfully complete this program, please signify acceptance of each rule by initialing each line.

Attendance

_____ I will attend each session in full. Attendance is mandatory for _____ sessions. I will be permitted one (1) UNEXCUSED absence per 6 group sessions. More than one (1) UNEXCUSED misses or failure to comply may result in termination from the program and may require you to appear before the judge before being allowed to return to group. Any excused absences will require medical documentation from a medical doctor and must be provided the next attended session. ALL ABSENCES MUST BE MADE UP to fulfill your court mandated number of sessions. It should be noted that monthly progress reports will be sent to the court indicating your attendance, participation, progress (or lack of), and projected prognosis. Please note that progress notes will be sent out regularly.

Financial

_____ I will complete payment in full by the end of my series of classes. The fee for _____ sessions is \$_____. I agree to pay the weekly payment established. I am only responsible to pay for all scheduled sessions, including those I miss for unexcused absences. If I fail to do this, I realize a \$10 late fee will be added for each week I fail to pay. If I fall two payments behind in payment, or miss any scheduled payment, I realize that this could result in my suspension from the program. I am aware that the court will not recognize completion of the Substance Abuse Intervention Project unless payment in full is received. I understand that if the account is unpaid the agency may 1) commence a legal case; or 2) decide to send the outstanding balance to collections.

Compliance

_____ I will notify the agency at least two week prior to my next court date.

_____ I acknowledge and accept that I have engaged in the past problem behavior and it is my responsibility to change this behavior.

_____ I agree to participate fully in therapy by talking openly and processing personal feelings.

_____ I will complete all assignments as assigned. I understand that if homework is assigned it is considered a part of my participation and failure to complete homework may result in not receiving credit for that session. If I do not complete homework I understand this is considered non compliant and a session will be added at your regular group fee.

_____ I agree to arrive on time for sessions. We will, in turn, begin and end the sessions on time. Doors will be locked five minutes after scheduled starting time and late admittance will not be permitted.

_____ I agree not to use sexist or racist language or wear clothing that has sexist or racist messages.

_____ I will respect the confidence of the group by discussing sensitive issues only with other members of this program, only while attending this program.

_____ I will listen thoughtfully during group discussion. It is okay to disagree but I will do it assertively and respectfully.

_____ I agree not to use any substances, legal or illegal, while attending and completing my program at Horizon Family Therapy & Wellness.

_____ I will not attend my sessions under the influence of drugs and/or alcohol. The first incident will result in a warning; the second will result in expulsion from the program.

_____ I understand that random Substance Abuse Screenings may be given at any time and that I will be will be responsible for the cost. The cost is \$20.00. Failure to submit to a test or a test that shows positive for an illegal substance may result in being returned to the referring agency or being dropped from the treatment program.

_____ I understand and agree that violations of any of the terms of the Client Contract may lead to my termination from the treatment program and a written summary of my personal behavior and date of termination will be made to the referring agency.

Other

_____ I understand that the Substance Abuse Intervention Project's staff and contractors are mandated by law to report to the proper authorities any admissions or threats of child/elder abuse or other violent actions that may put myself or others at imminent risk. I also realize that potential victims may be warned.

Signature of Client

Date

Signature of Witness

Date

**Substance Abuse Intervention Project
AUTHORIZATION
To Release Confidential Information to Referring Agency**

Client Name: _____ Date of Birth: _____

I, hereby authorize Summit Family Counseling, LLC to contact the agency or person specifically listed on this form to exchange such information for the purpose of providing assessment, case management and/or treatment services for the client named above. The authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

Agency/ person authorized to release information:

Name _____

Address _____

City _____ State _____ Zip _____ Phone _____ - _____

Records to be released _____

I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on my consent, and that in any event this consent expires automatically on the date stated below or upon termination of the services for which the consent was granted, whichever comes first.

Date of expiration (One year from date signed) _____

Person signing authorization:

Client or Guardian (print please)

Signature

Date

Witness:

Name (print please)

Signature

Date

**Summit Family Counseling, LLC
Substance Abuse Intervention Project
AUTHORIZATION**

To Release Confidential Information Emergency Contact

Client Name: _____ Date of Birth: _____

I, hereby authorize Summit Family Counseling, LLC to contact the agency or person specifically listed on this form to exchange such information for the purpose of providing assessment, case management and/or treatment services for the client named above. The authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

Emergency contact authorized to release information:

Name _____ relationship: _____

Address _____

City _____ State _____ Zip _____ Phone _____ - _____

Records to be released _____

I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on my consent, and that in any event this consent expires automatically on the date stated below or upon termination of the services for which the consent was granted, whichever comes first.

Date of expiration (One year from date signed) _____

Person signing authorization:

Client or Guardian (print please)

Signature

Date

Witness:

Name (print please)

Signature

Date

Client Information

Today's Date: _____
 Client Name: _____ Date of Birth: _____
 Client's Soc. Sec. #: _____
 Client's Phone # Home: (____) _____ Cell/Work #: (____) _____
 Can a message be left? Yes _____ No _____
 Client's Address: _____
 City: _____ State: _____ Zip Code: _____
 Race: African American Asian Caucasian Hispanic Native American
 Other: _____
 Religion: Baptist Catholic LDS Lutheran Jewish Protestant None
 Other: _____

Relationships

Is Client Married? Yes _____ No _____ Length of Marriage: _____
 If Not Married, with Significant Other? Yes _____ No _____ Length of Relationship: _____
 Please list dates and lengths of any past marriages/significant relationships:

Type of Relationship:	Length:	From:	To:

Number of Children: _____

Names:

Ages:

If Client is a Minor:

Parent/Legal Guardian's Name(s): _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone #: (____) _____ Cell/Work #: (____) _____

Concerns

What concerns bring you to counseling at this time?

What would you like to gain from counseling?

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.