OneEighty

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Alcohol Education Program

Acknowledgment Form

____
AEP Program Participant Name (please print)

By signing below I acknowledge the following:

- ✓ I will pay $350.00 for the Alcohol Education Program (AEP). *Checks payable to **OneEighty***.
- ✓ I have received a copy of the education curriculum for the AEP.
- ✓ I have received the AEP program rules and or expectations.
- ✓ I have received the program's client rights and grievance procedures.
- ✓ I have received a written summary of the Federal Laws and regulations pertaining to the confidentiality of client records as required by 42 C.F.R., Part 2.
- ✓ I understand that OneEighty provides services to individuals and their families who have experienced problems due to alcohol and/or other drug use. I further understand that the staff members and AEP consultants are trained to provide appropriate services and treatment as needed in this area. My signature below indicates that I agree to services as offered by OneEighty.

____________________________________ ______________________________________
AEP Program Participant Signature Date

OFFICE USE ONLY:

Registered Program Date: ______________________________

OneEighty Client (former or current): ❐ Yes ❐ No

Dates of Service: ______________________________________

Case Number: _________________________________ Counselor: ______________________________

Fee paid: ❐ Yes ❐ No

Amount: _______________________________

Cash Check #: _________________________

Credit Card: ❐ VISA ❐MasterCard ❐Discover

Money Order #/Cashier's Check #: _________________

Date forwarded to CH&W Office: ____

____
Staff Signature Date

Intake Specialist/Support Staff: please retain this form for client file.

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Registration Form

Welcome to OneEighty! The Alcohol Education Program (AEP) is designed to provide an alternative to incarceration to individuals who have been arrested for drinking or drug related driving offenses while offering screening and education about alcohol and other drug use in a caring and professional environment. *We appreciate you selecting OneEighty for your Alcohol Education Program.*

Name: ________________________________ Gender: M F Today's Date: ____________________

Address: ____________________________ City: _______________ State: _____ Zip Code: ________

County: ___________________________ Age: ________ Date of Birth: ____________________

Home Phone: _______________________________ Cell Phone: _____________________________

SSN: ______________________________ Height: ________________ Weight: _________________

Education: High School Diploma (Year) ________ GED (Year) ________ College __________________

Employer: ____ Number of years: ____________

Work Phone: ____

Ethnicity- *Please check below:*

☐ Caucasian ☐ Asian Email Address: (optional) ______________________

☐ African American ☐ Native American

☐ Hispanic ☐ Other__________ Registered Program Date: ______________________

Emergency Contact Person: __________________________ Relationship: ______________________

Address: ______________________________ City: __________________ State: _____ Zip: ______

Home Phone: ___________________________ Cell Phone: _________________________________

The program will involve lectures, videos, group activities and individual questionnaires. Will you need reading and writing assistance during the program or interpretation services? ❐ Yes ❐ No

If Yes, Please explain: ____

____

____

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Alcohol Education Program

Court Information

Name of Court that referred you to this program: ____

Probation Officer's Name: ____

Phone Number: _______________________________ Fax Number: ___________________________

Date of Arrest: ____________________________ Time of Arrest: _________________________

Reason Law Enforcement stopped you: ____

Original Charge by Law Enforcement: ____

BAC at time of arrest: _____________________ Sentencing Date: ________________________

Court Case Number: _______________________ Final Charge:____________________________

Previous DUI charges: ❐ Yes ❐ No If yes, how many:________________________

Health History

Please describe any physical disabilities that so we may make your stay as comfortable as possible:
____

____

Dietary Restrictions: ❐ Yes ❐ No If yes, please explain: __________________________________

____

Please list any food allergies: ____

Are you a vegetarian: ❐ Yes ❐ No Are you vegan: ❐ Yes ❐ No Do you smoke: ❐ Yes ❐ No

Are you pregnant? ❐ Yes ❐ No If yes, please note the number of weeks and any other important health information about the status of your pregnancy: __________________________

____

Please describe any allergies besides the food allergies, including drug reactions, above: _____________

____

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Alcohol Education Program

Please describe any history of serious health problems (illnesses, accidents, operations): ______________

____

Please describe any health conditions for which you are currently being treated: ____________________

____

Please list any prescription and over-the-counter medications you currently take: ___________________

____

Please describe your sleeping habits (Number of hours, loud snoring, and difficulty getting to sleep, etc.)
____

____

Do you have any other special needs? ❒ Yes ❒ No If yes, please describe them: _______________
____

____

Psychological

Have you ever been treated for emotional or mental problems?	Yes______	No ______
Have you ever been to a Psychologist or Psychiatrist?	Yes______	No ______
Do you get severely anxious?	Yes______	No ______
Do you have difficulty controlling emotions such as anger?	Yes ______	No ______
Do you ever get seriously depressed?	Yes ______	No ______
Have you ever attempted to take your own life?	Yes ______	No ______
Are you currently taking medications for any of the above?	Yes ______	No ______

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Alcohol Education Program

Emergency Medical Contact Information

In the event a medical emergency occurs while you are attending the Alcohol Education Program, staff will call 911 for assistance if deemed appropriate. The program is required to have a name, address and phone number of a person they should contact on your behalf in the event of a medical emergency. Staff will only provide the necessary information to qualified medical/911 personnel for a medical emergency and will notify your emergency contact person if you were transferred for outside medical care.

If you experience a medical emergency that requires treatment outside of the Alcohol Education Program during your 72 hour program, staff will discuss with you the alternatives in order to complete the 72 hour program.

Emergency Contact Name:____

Contact Street Address:____

City: ____ State: ____________ Zip: ______________

Home Phone: _________________________________ Cell Phone:___________________________

I affirm the information above is true and accurate. I authorize the staff of the Alcohol Education Program to notify my Emergency Contact Person listed above in the event of a medical emergency.

____

Signature Date

OneEighty

CONSENT FOR THE RELEASE OF INFORMATION

Client Name:_________________________________ Date of Birth: _____________________

I, ____, hereby consent to communication from and between OneEighty, Inc.

And ____ (_____) _____ - _____ (_____) _____ - _____
(Name of entity to whom information is to be released) (phone) (fax)

Purpose and need for disclosure: Order of the Court_______________________________________

Information to be released:

____ Attendance ____ Treatment History ____ Housing Coordination Plan
____ Treatment Plan ____ Treatment Recommendations ____ Housing Status
____ Diagnosis ____ Progress Notes __X__ Other AEP Report_____
____ Diagnostic Assessment ____ Participation ___________________________

Amount of information to be disclosed:

____ Information covering the most recent admission
____ All treatment
_X__ Other: Information from most recent AEP Program_______________________________________

I understand that this consent will remain in effect until:

_____ 180 days from my signature
_____ ____

(Specify other time period or condition/event when consent can be revoked or expires)

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as other authorized by law; however, I understand that OneEighty, Inc. cannot control the above entity's use of the information. I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information FOR ANY OTHER PURPOSE.

____ _____________________________________
Signature of Client **Date**

____ _____________________________________
If appropriate, signature of Parent/Guardian/Personal Representative (with description of relationship and authority to act on behalf of client. Required for all minors) **Date**

____ _____________________________________
Signature of Staff **Date**

REVOCATION: This authorization is subject to revocation at any time except to the extent the program or person who is making the disclosure has already acted in reliance upon it. The consent can be revoked either verbally or in writing.
I hereby revoke consent ____ in writing ____ verbally Time if verbally revoked: _________ Date:____________
Signature of client/parent/guardian or staff witness to verbal revocation:____

Client given copy ____________ (Client initials) **Client declined copy** _____________ (client initials)

Prohibition against re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 F.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol/drug abuse or mentally ill client.