Please do not fill out the following forms without an existing appointment.

If you would like to make an appointment, please call our office at (702)258-5855.

If your call goes unanswered, please leave a voice message with your name and phone number, and we will get back to you as soon as possible.

Thank you.

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA
ASO INTAKE FACE SHEET

Date	Preferred Pronoun: Gender ☐ F ☐ M ☐ Other	First and Last Name		
Date of Birth	Age	Soc.Sec.Number	Current Occupation	Place of Employer
Street Address	City	State	Zip Code	Phone Number

Current Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Highest Level of Education

Relationship History: List all past marriages and major/long-term relationships

Name of Partner	Length or Dates of Relationship			
_____	_____	☐ Married	☐ Lived Together	☐ Neither
_____	_____	☐ Married	☐ Lived Together	☐ Neither
_____	_____	☐ Married	☐ Lived Together	☐ Neither

PSI/Investigation Report Submitted on: _____

Projected Probation/Parole Expiration Date: _____ Were you incarcerated for offense? ☐ Yes ☐ No If yes, how long? _____

Tier Level: (circle) ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 How did you plead? (circle one ☐ Guilty ☐ Not Guilty ☐ Alford Plea

Restrictions While on Probation: (example: Cannot be around minors without supervision, supervised visits with biological children, etc.)

_____
_____
_____

Please Describe Nature of the Offense: _____
_____
_____
_____

Household Information

(Includes: Immediate Family, Half/Step-Siblings, live-in Partners, Roomates, and Non-Relatives)

Name:	Age	Relationship	Living In Household?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Referral Source

Name/Title/Position	Contact info

Child Protective Services

Circle one: ☐ Past ☐ Present	Report #
Caseworkers Name:	Date Reported:
Case Plan:	

Criminal History

Crime	Date	Outcome

Treatment History

Have you ever participated in any type of therapy in the past? ☐ No ☐ Unknown ☐ Yes Where _____

If yes, what type of treatment was it?

What was the reason for treatment?

Describe your experience with previous treatment?

Substance Abuse History: List any and all past substance abuse related information, including choice of substances and previous treatment.

Additonal Information:

Official Use Only: Follow-up scheduled with_____ on_____ Check after client data is entered ☐ Titanium ☐ Delphi ☐ S Drive

Revised 08082018

FAMILY AND CHILD TREATMENT

8080 W. Sahara Ave., Suite D. Las Vegas, Nevada 89117
Phone: (702) 258-5855 Fax: (702) 258-9767

CONSENT FOR TREATMENT AND NOTICE OF PRACTICES

By signing this agreement, you are giving your voluntary consent to participate in treatment at Family and Child Treatment of Southern Nevada (FACT) and that you are not aware of any reason why you should not proceed with therapy.

As a client of FACT, you understand that this agency does not discriminate or refuse professional service to anyone based on race, gender, religion, natural origin, physical disability or sexual orientation.

The clinical staff is comprised of Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Marriage and Family Therapist Interns and Clinical Social Work Interns. Staff is expected to perform their services in accordance with their State Board's ethical standards and practices.

You should expect benefits from your treatment, but understand that individual results may vary. Your desired outcomes cannot be guaranteed. Progress happens at a different pace and level for each individual. If at any time you are unsatisfied with your progress, or the services you are receiving, you should address these concerns with your therapist before terminating treatment.

Termination Policy
By requesting counseling services from FACT you are entering into a treatment contract. Your appointment time has been reserved for you. If you are unable to keep your scheduled appointment time you must call 24 hours in advance. **If you fail to provide 24-hour notice for 2 consecutive sessions or you show a pattern of missing appointments, your case will be closed. Also if you miss or cancel an appointment and do not reschedule within a two-week time frame** (unless an agreement has been made between you and your therapist) **your case will be closed.** If in the future you wish to re-open your case, you may do so but please note that your case will have to be re-assigned to the next available therapist and you may be charged another intake fee.

The therapist/agency has the right to terminate treatment with a client if the therapist believes that a client is not benefiting from treatment or if the issues are beyond the therapist's professional expertise or scope of practice or the agency's mission. Referrals will be given to another resource.

Grievance
I understand that as a client, if I have a complaint, I have a right to due process. The following steps are needed to ensure proper resolution:

1. Schedule an appointment to meet with the therapist to discuss issues. (we will schedule within 10 business days).
2. If unsatisfied you may request, a meeting with the program manager (we will schedule within 10 business days).
3. If further action is requested, you may put your grievance in writing to the Executive Director. They will review the grievance and respond within 15 business days of our receipt of the grievance.

After Hours and Emergency Contact Numbers
For non-emergent after hours calls you may leave a message for your therapist by calling (702) 258-5855, they will return your call on **their** next workday. All emergency and crisis calls should be directed to your local emergency medical service center or by calling 911.

_____
Signature of Client **Date**

_____
Parent/Guardian/Representative Signature **Date**

_____
Signature of FACT Representative **Date**

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA
8080 W Sahara Ave, Suite D, Las Vegas, NV 89117
Phone: (702) 258-5855 Fax: (702) 258-9767

AUDIO-VISUAL CONSENT FORM

Client's Name: _____ Date: _____

Name of Parent or Guardian: _____
Address of Parent or Guardian: _____
City: _____State _____ Zip Code: _____
Phone Number: _____ Relationship:_____

Use of Audio-Visual Recordings

Family and Child Treatment (FACT) is considered a **training facility due to the close supervision of students and licensed interns at this site.** As a result, to provide quality services, video and/or audio recordings, or both, may be taken of the counseling sessions. These audio-visual materials are used as part of the supervisory process. The clients and FACT staff may review these materials as a means for exploring client and therapist interactions and therapy interventions to improve the quality of services provided and to monitor therapist development. **All audio and/or videotapes will be kept confidential and will be destroyed following the client's involvement in the program upon the family's or client's request.** Some audio and/or video recordings of counseling sessions may also be used for educational and research purposes with the client's identity concealed and only with their written permission. The audio and/or videotapes will not be used for any other purposes without the family's or client's written permission on a separate release form.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of FACT Representative: _____ Date: _____

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

NOTICE OF PRIVACY PRACTICE

Please Review This Notice Carefully

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website (www.factsnv.org).

Regarding access to the records of an un-emancipated minor. The agency is able to release PHI to a client's personal representative, who is defined as, an individual who is a parent, guardian, or other person acting in the place of a parent and who have documented authority to act on behalf of the client. However, in the following circumstances FACT **will not** treat a person as a personal representative;

1. When a parent, guardian, or other person who has the authority to act in place of the parent and they enter into an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
2. FACT has a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
3. Treating such person as the personal representative could endanger the individual; and FACT, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment, Care or Services. We may use protected health information about you to provide you with counseling treatment or services. We may disclose information about you to therapists, psychologists and, interns who are in employed by this agency. For example, any staff member may help schedule your appointment, the bookkeeper will process your billing or insurance claims and therapists and supervisors may discuss and strategize how to best meet your needs.

For Payment. We may use and disclose protected health information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party.

For Agency Operations. We may use and disclose protected health information about you for agency operations. These uses and disclosures are necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use information to review our treatment and services and to evaluate the performance of our staff in caring for you or your children. We may also disclose information to counselors, interns, social workers and other agency personnel for review and learning purposes.

RESEARCH-All clients who are seeking treatment for child sexual abuse, your information will be kept confidential and will not be released for research purposes. This does not apply to offender services.

Appointment Reminders. We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or care at the agency.

Treatment or Program Alternatives. We may use and disclose protected health information to tell you about or recommend possible treatment or program options or alternatives that may be of interest to you.

As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks. We may disclose protected health information about you for public health activities. These activities generally include the following: To prevent or control injury or disability; to report births and deaths; To report the abuse or neglect of children, elders and dependent adults.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a judge's order.

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official: However, Substance abuse treatment records cannot be released without a judge's order, all other records may be disclosed. In response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be

the result of criminal conduct; about criminal conduct in the agency; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. You may refuse to sign or revoke your authorization at any time. If you have been referred by the courts and your treatment progress and all other applicable information is required, your decision to revoke could lead to unsuccessful treatment discharge.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes billing records. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing to the Office Staff. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

However, we may deny your request to inspect psychotherapy notes. Psychotherapy notes are defined as notes recorded (in any medium) by a health care provider who is a mental health care professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record. Other portions of the record may be released. If you are denied access to this information, you may request in writing that the denial be reviewed. Another licensed professional chosen by the agency will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept the agency.

To request an amendment, your request must be made in writing and submitted to the Office Staff. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the protected health information kept by or for the agency; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we make of protected health information about you other than our own uses for treatment, payment and agency operations, as those functions are described above. This is available to records up to six years old. You must submit your request in writing to the office staff and must identify a specific time period. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or agency operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your case or the payment for your case, like a family member or friend. For example, you could ask that we not use or disclose information about appointment times.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Office Staff. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about agency matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Office Staff. We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice from office staff or from our website, www.factsnv.org.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Executive Director, Heather Campa, at Family and Child Treatment of Southern Nevada, 8080 West Sahara Ave., Suite D, Las Vegas, NV 89117, Phone: (702) 258-5855 ext. 232 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D. C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of FACT's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can discuss with my therapist.

Client Name_____**DOB**_____

_____ _____

Signature of Client or Guardian **Date** **Signature Staff Witness** **Date**

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

8080 W. Sahara Ave, Suite D, Las Vegas, Nevada 89117
Phone: (702) 258-5822 Fax: (702) 258-9767

NON-DISCRIMINATION POLICY

It is the continuing policy and commitment of FACT to provide equal opportunity for job applicants, to provide equal opportunity for advancement of employees, and to administer these policies in a manner that does not discriminate against any person because of race, religion, color, sex, sexual orientation, age, marital status, national origin, physical disability, or veteran status.

This policy applies to all agency operations and includes all types of employment practices such as but not limited to: Recruiting, hiring, training, wages, compensation, assignments, working conditions, promotions, reduction in work force, employee treatment, and all other terms and privileges of employment. Additionally, FACT will not discriminate in its delivery of services to clients because of race, religion, color, sex, sexual orientation, age, marital status, national origin, physical disability, or veteran status.

This document establishes written procedures as required by the **Nevada Office of the Attorney General (OAG) Grants Unit**, as sub-recipients, to follow when a complaint is received alleging discrimination from clients, customers, program participants, or consumers or of a sub-recipient of funding from the U.S. Department of Justice.

All individuals have the right to participate in programs and activities regardless of race, color, national origin, sex, religion, disability, and age. These classes are protected from discrimination in employment and in the provision of services. In addition to these, sub-recipients of grants under the Violence Against Women Act (VAWA) of 1994, as amended, are prohibited from discriminating on the basis of sexual orientation or gender identity.

FACT must comply with the nondiscrimination provisions within the applicable DOJ program statutes, which may include the following:

1. Omnibus Crime Control and Safe Streets Act (Safe Streets Act) of 1968, as amended, 34 U.S.C. §§ 10228(c) and 10221(a), and the DOJ implementing regulations, 28 CFR part 42, subparts D (prohibiting discrimination in programs funded under the statute, both in employment and in the delivery of services or benefits, based on race, color, national origin, sex, and religion) and E (requiring certain DOJ-funded programs subject to the administrative provisions of the statute to prepare, maintain, and submit an Equal Employment Opportunity Plan (EEOP));
2. Juvenile Justice and Delinquency Prevention Act (JJDPA) of 1974, as amended, 34 U.S.C. § 11182(b), and the DOJ implementing regulations, 28 CFR §§31.202, .403 and part 42, subpart D (prohibiting discrimination in programs funded under the statute, both in employment and the delivery of services or benefits, based on race, color, national origin, sex, and religion);
3. Victims of Crime Act (VOCA) of 1984, as amended, 34 U.S.C. § 20110(e) and the regulation implementing the Victim of Crime Act Victim Assistance Program, 28 CFR § 94.114 (prohibiting discrimination in programs funded under the statute, both in employment and in the delivery of services or benefits, based on race, color, national origin, sex, religion, and disability); and
4. Violence Against Women Act (VAWA) of 1994, as amended, 34 U.S.C. § 12291(b)(13) (prohibiting discrimination in programs either funded under the statute or administered by the Office on Violence Against Women, both in employment and in the delivery of services or benefits, based on actual or perceived race, color, national origin, sex, religion, disability, sexual orientation and gender identity).

These laws prohibit agencies from retaliating against an individual for taking action or participating in action to secure rights protected by these laws.

Written Procedures to Address Complaints Filed Against Sub-Recipients:

1. Complaints from any source are to be submitted on the Written Complaint Statement of Concern/Complaint with Grant Programs Form to the OAG Grants Manager.
2. The complaints are to be submitted to:
   Debbie Tanaka, Grants Manager Office of the Attorney
   General 100 North Carson Street
   Carson City, NV 89701
   Or dtanaka@ag.nv.gov
3. The OAG Grants Manager will review any and all complaints in an objective and impartial manner and provide the complainant with written acknowledgement of the complaint and how correspondence will be administered throughout the investigation as well as an explanation of how the complaint will be investigated upon and resolved.
4. Any person who submits a complaint of impermissible discrimination is notified promptly that a complaint also may be filed with the Office of Justice Programs' (OJP) Office for Civil Rights, by submitting a written complaint to the following address:
   Office for Civil Rights Office of Justice Programs, U.S. Department of Justice, 810 Seventh Street N.W. Washington, DC 2053

Signature of Client or Parent/Caregiver	**Date**	**Signature of FACT Representative**	**Date**

Revised 08082018

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA
8080 W Sahara Ave, Suite D, Las Vegas, NV 89117
Phone: (702) 258-5855 Fax: (702) 258-9767

CLIENT AUTHORIZATION TO RELEASE INFORMATION FORM

Client Name: _____ **Date of Birth:** _____

I hereby authorize Family and Child Treatment (FACT) of Southern Nevada to release and/or receive information to/from:

Clients Name

Organization: Adult Parole & Probation

Individual Name/Title: _____

Address: 218-5 E Bonanza Road. Las Vegas, Nevada 89101

Phone: (702) 486-3001 ext._____ Fax: _____

Email: _____@clarkcountynv.gov

Specific information to be released:

☐ Diagnosis	☐ Presence/Participation in Treatment	☐ Termination Summary
☐ Psychiatric Evaluation	☐ Demographic Information	☐ Current Treatment Update
☐ Psychosocial Assess	☐ Psychological Evaluation	☐ Progress in Treatment
☐ Treatment Plan/Summary	☐ Current Medications	☐ ABEL Results

The purpose of this information is to improve assessment and treatment planning, share information relevant to treatment, coordinate treatment services, promote community safety and maintain continuity of care.
If other purpose, please specify: _____.

I understand that I have a right to revoke or limit this authorization by **sending written notification** to my therapist at FACT. However, I further understand that if I choose to revoke or limit my consent and I am court mandated to receive services, FACT may discharge me as it impairs their ability to effectively treat me.
This consent expires: (PICK ONLY ONE)

- ☐ 30 days after the completion of treatment,
- ☐ On the following date _____,
- ☐ Or the following event _____.

NOTE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. It is FACT policy that psychotherapy notes are not released to any party, unless required by subpoena or court order.

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 I, the undersigned, also understand that a copy of this signed authorization form is as acceptable as the original.

_____ _____ _____ _____
Client Signature **Date** **Signature of FACT Representative** **Date**

_____ _____
Parent, Guardian or Personal Representative Signature **Date**

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA
Adult Offender Treatment Contract

Between: Family and Child Treatment (FACT)
8080 W. Sahara Ave., Suite D
Las Vegas, NV 89117

Main Office: (702) 258-5855
Fax: (702) 258-9767

AND

Client: _____ DOB:_____ Date: _____

GENERAL PROGRAM CONDITIONS:

1. I understand that by signing this agreement I am giving my voluntary consent to participate in the Sexual Offender Treatment Program at FACT.
2. I understand that my progress in treatment will be measured by my:
    a. Attendance
    b. Weekly participation in treatment
    c. Compliance with the treatment contract
    d. Openness in talking about my sexually abusive behavior
    e. Completion of homework assignments
    f. Keeping fees current
3. I have read the Notices of Privacy Practices and understand the exceptions involving court-mandated treatment. I understand that a weekly progress report will be sent to my appropriate referring agency in regard to my attendance, participation and treatment progress, etc.
4. I understand that I may at any time, withdraw my authorization to release information. I also understand that if I withdraw my authorization to release information to the courts/Probation-Parole, I will be terminated because it will prevent FACT from effectively treating me.
5. FEES:

    a. $50 – Initial Intake fee. Paid at first initial appointment prior to group.
    b. $25 - Weekly group fee. Paid prior to group.
    c. $25 - Scheduled meetings with therapist outside of group to:
        i. Discuss with therapist contract non-compliance issues.
        ii. Meet with probation/parole officer.
        iii. Individual therapy sessions.
    d. $20 -$400 - Psychological or psychophysiological testing requested by therapist. This is not typical in treatment but may be required if clinically necessary.
    e. $100 per hour- If I or my attorney request FACT to testify in court or request participation in court proceedings. Charge is portal to portal.
    f. $225 / $250- Polygraph paid to independent polygraph examiner.

NOTE: There is no funding to supplement sex offender treatment. You alone are responsible for your offense and your treatment. You may pay fees in advance but you may not get behind. If you fall behind in your fees your probation/parole officer or referring agency is immediately notified. If you become habitually delinquent, you will be removed from your main treatment program and placed in an

accountability group where you will work on budgeting and other related topics. You will be permitted to return to your main treatment program once you have paid your own fees. You could be terminated for nonpayment of fees. If FACT raises fees, you will be notified 14 days in advance.

6. I understand that I am required to introduce myself to any new group member, staff members, or observer by going through the formal "introduction exercise" where each group member discloses:
    a. First name
    b. The number of victims I have had
    c. What I did to my victim(s) using proper terms. I fondled my daughter using my hand, touching her vagina under her clothes.
7. I agree to complete all treatment homework assignments within the designated time frame as instructed by my group therapist.
8. I agree that unless approved by my FACT therapist I should not participate in any other type of treatment while in FACT. I will inform FACT if I have other court ordered treatment.
9. I agree, understand to pay for, and participate in additional treatment session if my therapist believes it is clinically necessary.
10. I understand, agree to pay for, and participate in at least one polygraph to help determine the number of victims of my sexual abuse and the extent of that abuse. If I passed the polygraph, I understand I will be moved into the next level of treatment. If I fail a polygraph, I understand that I may be required to repeat a part of a previous level, repeat an entire level, or I may be referred back to parole-probation, or the referring agency, because FACT is unable to determine the extent of my sexually abusive behavior. If I refuse a polygraph, I understand I will be immediately terminated at staff request. Therapists may require additional polygraphs as necessary or as part of the completion process.

ATTENDANCE CONDITIONS:

1. I will attend all treatment sessions required by FACT staff and I will be on time. I understand that if I am more than 10 minutes late, I will not be allowed to enter group, regardless of the reason, and I will receive an unexcused absence.
2. I understand that I will be given a total of 3 absences every six months. These will be defined either excused or unexcused.
    a. Excused Absence—
        i. I am not required to pay the weekly session fee.
        ii. I must notify my therapist at least 90 minutes before the group starts that I will be absent and why I will be absent
        iii. I do not have more than one absence in a 30-day time period.
    b. Unexcused Absence—
        i. I am required to pay the session fee, even though I am absent.
        ii. I did not contact my therapist at least 90 minutes before group.
        iii. I have more than one absence within a 30-day period.

NOTE: These absences can be used for illness, work issues, transportation issues or Parole and Probation approved vacations. Parole and Probation (or referring agency) is notified for each absence. You cannot miss more than 3 groups per level and you may only have one absence in a 30-day period. Any other absences are considered a treatment issue at which time you could be terminated or be required to repeat the level.

EMPLOYMENT/ VOLUNTEER WORK:

1. I will notify FACT staff immediately of any changes in my employment status. I will discuss any potential changes to my employment during my group sessions well in advance of taking any new employment or volunteer position to help determine any potential risks.

2. I will not apply for, accept, or keep any job / volunteer work that involve any potential for gaining access to victims or offense situations. I will not apply for any job that is in an area where children frequent or includes contact with children as part of my regular duties.

GENERAL BEHAVIOR CONDITIONS:

1. I will have absolutely no contact with any victims of my sexually abusive behavior unless approved by my PO and FACT staff. I also agree I will not be in the vicinity or any location where I know my victim may be at or frequents. Having contact with victims requires a reunification agreement and is not considered until I am in level 3. I understand that contact includes physical, visual, written, and telephone contact, relaying messages through a third party and gift giving directly or indirectly. This does not include child support payments that are court ordered.
2. I will not be abusive or excessively controlling in any way towards others including my family. I will discuss in group problems I am having with changing my behavior. I understand that attempting to control others or coercing others do what I want is part of my sexually abusive behavior.
3. I agree to discuss with my therapist any thoughts or plans I may be having of suicide, harming myself or thought or plans of harming others.
4. I will not own, view, have in my possession, or use erotic materials, at any time, including but not limited to: erotic movies, 900 numbers, Internet, magazines, photographs or anything else that could be considered erotic. I will not post any profiles on dating sites or on social sites such as My Space.
5. I will completely avoid adult entertainment, including but not limited to: massage parlors, adult bookstores, strip clubs or <u>any</u> form of involvement with prostitutes.
6. I understand that I am prohibited from using any alcohol, illicit drugs or prescription drugs unless I can provide a doctor's prescription in my name. I may be required to have a substance abuse evaluation and be required to submit and to treatment recommendations such as inpatient treatment, outpatient treatment or 12 step meetings. I understand this requirement would then be added as a special condition in this contract.
7. I will not have any weapons in my possession while attending FACT group meetings (including in any vehicles I drive or ride in).
8. I understand I am required to have a full time job, or be in school fulltime or a combination. I am required to pay my fees with money earned from <u>my</u> income. If I have a lapse of 4 weeks or more in employment or if my employment history is erratic, I understand I will be taken out of my regular treatment program and placed in the accountability group to address my issues with employment, work on changing my perceptions, and improve my employment searching skills until I have secured permanent employment. Temporary employment agency assignments will not be considered permanent employment unless it is a temp to perm job placement.

9. I will practice safe boundaries including but not limited to locking doors to bathrooms and bedrooms that I occupy, or any place where I may be unclothed or partially unclothed. I will maintain conservative dress when others are present. I will always knock on closed doors before entering and I will not use coercion or force to enter. I will respect the rights and dignity of others.
10. I understand that my victim's needs and desires come before my own in any situation or activity where there is a potential conflict.
11. I will avoid public restrooms if possible. I will never use open stalls or urinals in a public restrooms. I will exit as quickly as possible if a child is present.

GROUP SESSION BEHAVIOR:

1. I understand I am required to actively participate in group sessions. Active participation includes; talking about my daily life, my thoughts, my behaviors, how I am applying what I am learning, asking questions of staff and other group members and presenting my assignments. I understand that active participation is the only way therapists can evaluate my progress. I understand I cannot progress if I do not participate.
2. I will use only first names when referring to my victim(s). I understand that victims are entitled to confidentiality.
3. I will not attend groups or treatment while under the influence of alcohol or drugs. I will not have in my possession any intoxicating substances or drug paraphernalia.
4. I will respect others. I will not yell at others, become verbally insulting, threatening or physically assaulting towards any FACT staff member or client whether inside or outside of the office. I understand charges will be filed against me if I assault someone connected to the FACT program.
5. I agree to discuss deviant sexual fantasies and deviant sexual urges. I understand these urges or fantasies are not uncommon and to get better I must talk about them.
6. I agree to be honest during all treatment sessions and assume full responsibility for my offenses and my behavior. I understand that being dishonest includes giving false information as well as leaving information out. I understand the importance of these principles of honesty and will make every effort to apply them in my daily life.
7. I understand that I need to be honest with my spouse, partner, and family and reveal my sexual history. I will invite my spouse or significant others to participate in planned sessions to disclose all information about my offense(s).
8. I will not disclose the identity of, or any information regarding another client to anyone outside this program unless it is to an appropriate authority in an emergency situation and therapist are not available. If I see someone in public or in a photograph that is in my treatment program, I am not to reveal how I know that person. Confidentiality is important to building trust in group.
9. I understand that I am not permitted to have social contact with other members who are in this or any other sex offender treatment program. I will discuss in group any accidental contact with other members. I may not exchange phone numbers or socialize in any way.

RELATIONSHIPS AND DATING:

1. I understand and agree that my dating and sexual activity must be openly discussed in group as it is related to learning healthy boundaries and how to have healthy, age appropriate relationships.
2. I will always respect my sexual partner's (or potential sexual partner's) right to say "no" to engaging in any social or sexual contact with me. I further understand that "no" includes any verbal or physical resistance.
3. I will immediately inform FACT of any change in my relationship situation (i.e., if I start or end any new relationship, plan to move in or out of living with a person, or if I plan to marry, divorce, or separate).

CONTACT WITH CHILDREN:

If you have had an offense against a child, you are required to abide by the following conditions. Initial one of the following

This section DOES _____ or DOES NOT _____ apply to me.

1. I will follow the sex offender conditions as stipulated in NRS 176A.410-416. I am to avoid locations frequented by children unless a Judge determines I can engage in these activities (FACT requires a copy of the order).
2. If I have legal permission to be with my own children, I will not take my children to movie theaters, bowling alleys, parks, birthday parties, water parks, or schools or any other location that is frequented by children without permission from FACT and my PO or a written order by a judge.
3. I will not date or live with anyone who has children in the home or who frequently interacts with children such as a parent with custody, partial custody or visitation, teachers etc.
4. If I am legally allowed to interact with children, I may be required by FACT to have an approved adult supervise my contact with authorized children in the form of a chaperone agreement.

VIOLATING THIS CONTRACT:

1. I understand that my probation/parole officer and/or FACT group therapist will be notified immediately of any violation of this contract. I also understand that local or state police departments may be contacted if necessary to maintain victim or community safety.
2. I understand that any violation of the conditions of this contract may be grounds for termination from the program at the discretion of FACT staff. I understand FACT may terminate my treatment for any problem behavior deemed disruptive. I may receive a termination for non-compliance or maximum benefit reached if my therapist believes it is in my and / or other clients' best interest to do so.

SPECIAL CONDITIONS:

Check, initial and complete only those that apply. Leave the items blank if they do not apply.

_____1. Substance Abuse Evaluation: I will participate and pay for a substance abuse evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance reports released to FACT.

_____2. Alcohol Anonymous or Narcotics Anonymous: I will attend AA or NA meetings _____ per week and provide written verification to include the first name and telephone number of the person conducting the meeting who can verify my attendance at each meeting.

_____3. Psychiatric Evaluation: I will participate and pay for a psychiatric evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance reports released to FACT.

_____4. Gambling Evaluation: I will participate and pay for a gambling evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance reports released to FACT.

OTHER CONDITIONS:

_____1. _____

_____

_____

_____2. _____

_____

_____

SIGNATURES:

I hereby enter into this treatment contract with FACT Sex Offender Treatment to allow their staff to provide me with a specialized treatment program for my sexually aggressive behavior. I have read this contract. I understand and acknowledge that I am required to follow all of the conditions listed above regarding my treatment behavior. I acknowledge I have received a copy of this treatment contract and agree to refer to it as needed.

_____	_____	_____	_____
Client	Date	FACT Staff Witness	Date

Revised 07/18

FAMILY AND CHILD TREATMENT
OF SOUTHERN NEVADA

POLYGRAPH EXAMINATION REQUIREMENT

I understand that participation in the Adult Sex Offender Treatment Program at Family and Child Treatment (FACT) involves taking a polygraph examination. The polygraph examination is to be completed prior to the end of any Adult Level I (12 week) course and I am responsible for the cost of this test. Information about my offense and myself will be provided to the polygraph examiner prior to taking the polygraph.

I understand that treatment cannot be effective if I am not truthful. I further understand that the polygraph test in sex offender treatment at FACT will be used to verify my truthfulness about my sexual history, as well as to validate if I am complying with the conditions of my treatment.

The results of any polygraph test I complete while in treatment at FACT will be shared with my Probation / Parole Officer. I understand that my Probation / Parole Officer may take action against me based on the result of my polygraph test.

I understand that I must pass the polygraph test in order to be considered for movement from Level I to Level II. I will not be considered for movement to Level II if I make a full admission of my sexual history ***after*** failing a polygraph test. It is the position of The Association for the Treatment of Sexual Abusers (ATSA) that "community-based treatment is not appropriate for a client who continues to demonstrate complete denial (ATSA, 1997)." FACT abides by ATSA standards and has adopted the policy not to treat deniers for longer than 12 weeks. This policy is based on the ethical reasons there are no concrete treatment goals to work on when a person continues to deny their behavior. Therefore, I understand that if I fail a polygraph test, and continue to deny responsibility for my offense, I will be terminated from the Adult Sex Offender Treatment Program at FACT.

Client: _____ Date: _____

FACT Representative: _____ Date: _____

Adult Offender Treatment Program
And Fee Scale

LEVEL 1

Level 1 focuses on denial, talking about the abuse, being accountable for your offense and looking at the effect abuse has had on others.

- Education about the process of sexual abuse and preventing future abuse
- Journaling
- Understanding denial and how it influences behavior
- Effects of abuse on others / Victim Empathy
- Dynamics of Abuse
    - Reservoir of motivation
    - Triggers, releasers
    - Thinking errors, cognitive distortions
    - Deviant thoughts
    - Environmental opportunities
    - Attributes of the victim
    - Describing abuse of all victims
- Presentation of Abuse Dynamics
- Passes a polygraph revealing all victims
- Completion of treatment expectations, becoming a healthy person
- Caught up on all fees

LEVEL 2

Level 2 focuses on victim empathy, skill building and continuing the focus on accountability.

- Expanding self awareness, Johari window
- Boundaries
- Victim Empathy
- Anger awareness and management
- Assertiveness
- Sexual Inventory
- Sexual history
- Presenting sexual history
- Family history and dynamics, genograms
- Transition to Level 3
- Caught up on all fees

LEVEL 3

Level 3 This level requires weekly participation and self-disclosure. Individuals who do not participate will remain in the group until they show consistent participation.

- Able to openly talk about abuse in group and to family
- Demonstrates a clear understanding of his responsibility for his offenses and is accountable for the consequences
- Talks about and intervenes when deviant thoughts or fantasies arise and does not minimize the risk of reoffending.
- Takes full responsibility for offense and does not minimize or blame others for his behavior.
- Identifies and understands the emotional needs that were met through offending and has learned to meet emotional needs in a healthy way.
- Has made serious lifestyle changes to minimize risk and does not put self in situations that are risky or could be perceived by others as risky.
- Has learned how to handle problems appropriately and has adequate social skills to address problems in an open and honest manner.
- Has developed a sense of self-awareness.
- Practices anger management, assertiveness skills inside and outside of group. Talks about how he uses them outside of group.
- Completes updated dynamics of abuse diagram.

FAMILY AND CHILD TREATMENT CENTER OF SOUTHERN NEVADA
8080 W. Sahara Ave., Suite D, Las Vegas, NV 89117
Main Office: (702) 258-5855, Fax: (702) 258-9767

Sex Offender Program
AUTHORIZATION FOR RELEASE OF INFORMATION

Client: _____ _____ _____
Date of Birth Social Security Number

I hereby authorize Family and Child Treatment (FACT) of Southern Nevada to release and/or receive information to:

Ron Slay, Western Security Consultants, 1920 S Maryland Pkwy, LV NV 89104, 796-1183, 796-7513
Individual/Organization Address Phone Fax

Specific information to be released:

_____ Diagnosis
_____ Psychiatric Evaluation
_____ Psychosocial Assess
_____ Treatment Plan/Summary
_____ Presence/Participation in Treatment
_____ Demographic Information
_____ Psychological Evaluation
_____ Current Medications
_____ Termination Summary
_____ Current Treatment Update
_____ Progress in Treatment
_____ ABEL Results
_____ Sexual Offenses and History

The purpose of this information is to improve assessment and treatment planning, share information relevant to treatment, coordinate treatment services, promote community safety and maintain continuity of care. If other purpose, please specify: _____.

I understand that I have a right to revoke or limit this authorization by **sending written notification** to my therapist at FACT. However, I further understand that if I choose to revoke my consent, FACT will discharge me for reasons of community safety. This consent expires: (PICK ONLY ONE)

☐ 30days after the completion of treatment,
☐ On the following date _____.
☐ Or the following event _____.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to which disclosure is made from making any further disclosure to another entity. Any information that is generated by FACT can only be released by FACT upon the authorization of the above client. FACT will not release documents generated by another entity as part of this authorization. request a copy of this authorization for my records.

_____ _____ _____ _____
Client Signature **Date** **FACT Staff Witness** **Date**

_____ _____
Parent, Guardian or Personal Representative Signature **Date**