

Kristopher Polak, M.S.
Registered Mental Health Counselor Intern
FL License# IMH 23239

CONSENT FOR TREATMENT I give my consent to voluntarily participate in Kristopher Polak's substance abuse/mental health treatment program. I understand that mental health/substance abuse treatment is not an exact science, and no guarantees are being made relative to the outcome of the treatment, recommendations and/or services provided. I agree to follow all program rules and guidelines, and I understand that failure to do so may result in my discharge. I agree to comply with treatment requirements for a medical history, physical examination, and recommended laboratory tests (if appropriate).

MANDATORY REPORTING, I have been informed that Kristopher Polak is a mandatory reporter by the State of Florida; as such, he is required to report any child or elder abuse. He is also required to initiate a Baker's Act (involuntary referral for a mental health assessment by a mental health facility) if you are a threat to yourself and/or others.

FINANCIAL AGREEMENT I understand that I am responsible for payment of my treatment and medical fees incurred while a Patient at K. Polak Counseling. The fees for treatment have been fully explained to me. Medications and medical appointments are not included in this fee. Payment is due at the time of admission unless other financial arrangements have been made. All payments are non-refundable.

PATIENT SAFETY I understand and will follow the instructions for patients regarding the safety of my well-being. I agree to hold Kristopher Polak harmless in the event of any loss and/or injury to my person and/or property while in treatment with K. Polak Counseling.

I consent to be transferred to the nearest hospital and to receive emergency medical treatment as is deemed appropriate by medical personnel. I agree to hold Kristopher Polak harmless in the event of the need for transfer or treatment.

COMMUNICABLE DISEASE REPORTING I have been informed of my need to report communicable diseases. I understand that Kristopher Polak must comply with the state of Florida requirements regarding the reporting of certain communicable diseases

PURPOSE OF IDENTIFICATION I agree to provide a picture of my driver's license or passport for the purpose of identification. These documents are protected as part of my clinical record.

Client's signature & date:

Client's signature & date

Therapist's signature & date:

K.Polak Counseling, LLC

Kristopher Polak, M.S.

Consent for Release of Confidential Information

Name:

MR#:

DOB:

I, _____, born on _____, Social Security
Number: _____ - _____, authorize **Kristopher Polak** to:



Disclose to



Obtain from



Electronic



Oral



Written

Name: _____ Relationship: _____

Phone: _____

The following information:



Presence in treatment



Medical history/current
status



Aftercare
recommendations



Progress in treatment



Biopsychosocial
assessment



Discharge planning



Treatment plans



Laboratory test results



Discharge summary



Psychological assessment



Employment information



Other:



Psychiatric history and
assessment



Legal status



Results of physical exam



Family information

Reason for release of information:

(Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure.)



Continuity of treatment - Patient history - Case Management services



Emergency contact - General Updates



Court services - Legal purposes - Probation - Disability claiming - Unemployment
claiming - Employment continuity

☐ Other:

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that I may revoke this authorization at any time upon written notice to Kristopher Polak. I acknowledge that such revocation will not be effective if Kristopher Polak has already acted in reliance upon this authorization.

This authorization is valid (if not previously revoked) this consent will terminate upon 365 days from the date of signature of this form.

Prohibition on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Signature of Client & Date:

Signature of Client & Date:

Signature of Therapist & Date:

Psychosocial Assessment

Current Living Situation

Where?

With whom?

Reason for Referral

Why are you seeking treatment now?

Number of attempts at recovery?

First serious attempt at recovery?

Reason for relapse (if applicable)?

Family / Social Supports

Family History

Family size : Brothers: Sisters:

Were you raised by both parents?

How many people lived in your household?

What was growing up like for you?

Did or does anyone in your immediate family drink alcohol and/or use illegal or prescription drugs?

Who in your immediate family do you feel closest to?

How often do you see or talk to your family supports?

How do you think they will support you in your recovery?

Can you describe your relationship with your parents/siblings?

Did you make friends easily growing up?

Were you able to have lasting friendships?

How many friends do you have today?

Will those friends be supportive of your recovery?

Marital Status / Family Lifestyle

Describe your current relationship

Describe any significant past relationships

Are there any events in your past you would describe as traumatic?

Have you experienced past or current Physical Abuse or Trauma? (Any current abuse should be reported to Kristopher Polak immediately)

Have you experienced past or current Sexual Abuse or Trauma? (Any current abuse should be reported to Kristopher Polak immediately)

Have you experienced past or current Psychological Abuse or Trauma? (Any current abuse should be reported to Kristopher Polak immediately)

How would you describe your present sex life?

Has your lifestyle put you at risk for HIV or a STD?

Children

Name / Ages / Sex:

Number of dependent children?

Names:

Do you have any children under age 16 not living with you?

Do you have any specific cultural influences that may be a factor in your recovery?

How do your religious/spiritual beliefs affect your substance use or abuse?

**Did you experience or were you exposed to domestic violence as a child?
Was there domestic violence in your home?**

Is there domestic violence in your home now?

What do you like to do in your spare time?

When was the last time you engaged in recreational activities?

Who would you consider to be in your “support” network?

How will they support you in your recovery?

Educational / Vocational and Financial

Educational

Highest grade completed?: Year?:

How would you rate your reading ability?

Languages spoken?

Additional training?

Are you currently employed?

Can you tell me about your last four jobs?

Most current or most recent first, when, where, type, duration.

Do you have any specific vocational certifications?

Annual family income

Monthly family income / take home?

How do you support yourself / your family?

While employed, are you able to maintain a savings account?

How did you support your addiction (if applicable)?

Substance Abuse History

Use History

	Age of first use	Last use	Amount
Alcohol			
Marijuana			
Cocaine			
Crack			
Crystal Meth			
Heroin			
Oxy/Roxy/			
Methadone			
Other Opiates			
Xanax			
Klonopin			
Other Benzo (Ativan, Valium)			
Hallucinogens			
PCP			
Suboxone			

Amphetamine

Inhalants

Nicotine

Caffeine

Steroids

Other Pills

Other OTC

Other

Primary drug of choice

Secondary drug of choice

Type of use?

Time of use?

Lies to and/or hides use from others?

Has tolerance to drugs/alcohol increased?

What was your longest time of sobriety/clean date?

Please describe the consequences of your substance use in the competencies listed below

Physical consequences?

Emotional consequences?

Intellectual consequences?

Social consequences?

Spiritual consequences?

Legal consequences?

Legal Issues (Current/Past)

Date

Charges

Disposition or Court date

If more legal issues scan into evaluations tab

Treatment History

Previous Substance abuse treatment history

Other Hospitalizations

(Emergency rooms, accidents, minister, psychologist, counselors, psychiatrist, etc)(Emergency rooms, accidents, minister, psychologist, counselors, psychiatrist, etc)

MO/YR

Location

Length of stay

If clean/sober for any length of time following treatment, what can you attribute this to (what was different about that treatment?)

Vocational/Educational consequences?

Have you ever experienced any of the following?

Blackouts , DT's , Paranoia , Hallucinations , Suicidal Thoughts , Mood Swings , Depression , Anxiety

Have you ever tried to stop drinking/drugging?

Is Client stepping down from

Client's perception of previous treatment?

Client's perception of strengths and weaknesses related to potential for recovery or program completion?

Twelve Step Program Experience

If not, community support?

Recovery goals (eg: sponsorship, 12 steps, career, etc)

Risk factors, stressors (eg: unemployment, family conflict, cravings, unhealthy relationships)

Current risk for any of the following?

If any of the above were checked, please explain.

Mental Health History

Have you ever experienced mental health problems, such as anxiety, nervousness, depression, or bipolar disorder?

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Are there any mental health problems in your family, such as anxiety, nervousness, depression, or bipolar disorder?

Appearance

Behaviors

Mood

Affect

Thought process

Oriented

X4 , Time , Place , Person , Situation

Intellectual functioning

Insight

Judgment

Memory

Sleep

Appetite

Medications

Medication

Dose

Frequency

Allergies

Withdrawal symptoms

Narrative Summary

Diagnosis & Code

History

Additional comments

Clinical Summary of all information - Including an analysis and interpretation of the results of the assessment

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Trauma:

Level of Substance Abuse Impairment

Mild

☐

Moderate

☐

Severe

Chronic

☐

Treatment recommendations and Clinical Rationale for Level of Care

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