Alternative Drug & Alcohol Counseling

324 E. Antietam St. Ste. 308
Hagerstown, MD. 21740

217 Glenn St, Ste 401.
Cumberland, MD. 21502

Patient Name:_____

Family and Recovery Environment Assessment

	Questions	Yes	No
1.	Would you like to receive information about how chemical dependency affects families?		
2.	Did you grow up in a household where 1 or more family member's substance use had a negative impact on the family?		
3.	Would you like to receive information about 12-Step programs and other self-help programs?		
4.	Do you have a family member who is currently in need of substance abuse treatment?		
5.	Do you believe that the support of your family members can help you refrain from alcohol and/or drug use?		
6.	Would you be interested in setting up a meeting with your primary counselor and family member about substance abuse?		
7.	Would you like to receive information about how to deal with family issues in recovery?		
8.	Did you grow up in a household where 1 or more family member's drug abuse had a negative impact on the family?		
9.	Do you currently reside with a family member or relative whose active drug and/or alcohol use has a negative impact on your efforts to maintain abstinence or sobriety?		
10.	Are your family members supportive of your efforts to abstain from alcohol and/or drug abuse?		
11.	Can you talk to your family members about your participation in Substance Abuse Treatment?		
12.	Have you ever suffered any type of physical, emotional, or sexual abuse by a family member that would make it unsafe for you to involve them in your treatment?		
13.	Would you like to set up a meeting with a family member(s) to discuss how substance use can impact the family?		
14.	Would you like to bring in a family member to discuss how your substance use may have impacted them?		
15.	If you have children under the age of 18, are you comfortable discussing your involvement in treatment?		
16.	Could your primary counselor of the treatment team be helpful in talking to your family members about your current involvement in treatment?		
17.	Are you currently interested in receiving family counseling and/or therapy?		
18.	Do you have any concerns about a family member's current drug or alcohol use?		
19.	Do you want your family or a member of your family involved in any aspect of your treatment?		
20.	Is there a need for interpreter and/or supports or special services needed to engage your family member in treatment?		
21.	Do you want or need support and/or treatment services to address how your substance misuse may have impacted your own children and loved ones?		

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ADAC FEE AGREEMENT

Patient Name: _____ DOB: _____
Patient Address: _____

FINANCIAL POLICY

Insurance Clients: Insurance Accepted: Maryland Medicaid. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. We will send information, including clinical information i.e., diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice. Should any changes occur, that will impact your insurance benefits or eligibility, please notify ADAC immediately for assistance. Maryland Medicaid clients shall not have any out of pocket fees for service.

Insurance Service Fees:

Evaluation: $220.65 Group: $60.62 1-hr Individual: $124.24 IOP: $194.23 U/A's: Covered

In the event that your insurance is canceled or benefits change, you will be responsible for any unpaid balance at the end of your treatment program.

Self-Pay Clients: Full payment is due at time of service (unless prior arrangements have been made). **Clients may not exceed an open balance of over $100 or a suspension in services could occur**. Should financial circumstances change due to lay off, unpaid medical leave, job changes, or any other reason to place patient into financial hardship, please discuss with an ADAC representative immediately so an equitable payment schedule or adjustment may be made, if appropriate Please feel free to ask if you have any questions about our financial policy.

Adjusted Self-Pay Fees for Service:

Evaluation: $150 Group: $40 Individual: $60 IOP: $75 Self-Pay Urinalysis: $20.00

In the event that you obtain insurance during treatment, you are responsible for immediately notifying staff. We are unable to provide refunds of past payments due to billing requirements

****All outstanding balances must be paid in full to receive letters or successfully complete your treatment program. Failure to pay balances could result in submission to collections****

(My signature below indicates that I have read, understand and agree to the full importance of this Fee Contract. Failure to comply may result in refusal of services, suspension from group and referral source being notified. Non-payment will result in unsuccessful termination and possible legal action)

Patient Signature: _____ Date: _____

ADAC Witness: _____Date: _____

Guardian/Responsible Party (if applicable) _____

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ADAC RULES & REGULATIONS

___ 1. The client is responsible for attending every group/individual meeting on time. If the client is more than 15 minutes late, they will not be permitted to attend the group

___ 2. Breathalyzer and urinalysis testing are a required part of the program. These tests are performed at client's expense, regardless of reason for admission. This is to verify that other chemicals are not being substituted and that another dependency does not exist. Any refusal or failure to show for testing is recognized as a positive.

___ 3. Any positive breathalyzers or urine tests will constitute the need for longer treatment, change of treatment modalities, or referral to a more intensive program. Abstinence from alcohol & drugs are the program goal and necessary for successful completion.

___ 4. A client is considered a "No Show" unless notification is given 24 hours before/after scheduled appointment. The client will then be assessed a fifteen (15) dollar No Show Fee.

___ 5. Attendance demonstrates commitment and responsibility. We identify poor attendance as missing two (2) consecutive sessions. This situation can result in an attendance contract being issued. Additionally, a letter of inadequate attendance may be sent to referring agency or probation monitor. Any exceptions will need to have validation from employer or medical personnel

___ 6. Clients are required to provide medication lists monthly for verification on urinalysis testing.

___ 7. Staff is required to have clients sign ROI's for any outside agency working with the client, if the client chooses not to participate in the coordination, they may sign the opt out option on ROI.

___ 8. All topics and conversations that take place during group/individual sessions will be held as confidential.

___ 9. The client is responsible for paying the agreed to amount for services rendered at the time of service, unless other official arrangements have been made. A successful completion cannot be issued while an outstanding fee balance exists. A fee balance that goes over the allowed $100 may result in non-admission to the program or the need to sign a revised fee contract.

___ 10. Any returned checks from clients will be assessed a thirty-three (33) dollar returned check fee. If a client has more than one returned check, they will be required to pay by cash or money order for their remaining time at ADAC.

___ 11. Cell phones and video recording devices are not permitted while in session.

___ 12. Clients shall present themselves in an appropriate manner. Clients shall refrain from all negative behaviors such as: walking out of group, non-participation, intended deceptions, disrespect toward ADAC staff or fellow group members, and other negative community behaviors.

____ 13. If clients have an odor of any drugs or alcohol, including marijuana (medicinal or recreational), they will be asked to leave. This is done for respect to other clients as it can be a trigger.

FAILURE TO COMPLY WITH THESE RULES/REGULATIONS CAN RESULT IN TERMINATION FROM THE PROGRAM.

Patient Signature: _____ Date: _____

ADAC Witness: _____ Date: _____

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ADAC CONFIDENTIALITY OF ALL PATIENTS

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of ADAC unless:

1. The Patient provides written consent, (with exception of telehealth releases which will be done with last 4 of social for verification on release, patient can also provide email permission as well)
2. The disclosure is required by law and/or court order
3. The disclosure is made for insurance claims
4. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation & supervision.

Information obtained from minors is not generally shared with parents without permission.

HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information with proper documented request.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person

CONSENT TO TREATMENT: I am voluntarily seeking outpatient counseling at ADAC. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at ADAC.

I, _____, have received and understand the above notice in reference to my confidentiality rights regarding my treatment with ADAC. All questions and concerns have been answered to my satisfaction and I have received a copy of this notice

Patient Signature: _____ Date: _____

ADAC Witness: _____ Date: _____

In case of emergency, I give ADAC permission to contact:

_____

_____

Name & Relationship & Phone Number

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Advanced Healthcare Directive:

The Advanced Healthcare Directive is a legal document giving a delegated individual the ability to make decisions on your behalf in case of incapacitation. Do you currently have an ADH in place?:

If yes, their name and number: _____

If no, would you like information regarding AHD? YES NO

In order for ADAC to provide the best services, please participate in the following questionnaire:

Sex Identified at Birth

- Male
- Female

Identifying Gender/Pronouns

- Male
- Female
- They/Them
- he/him
- she/her

Primary Language spoken: _____

Do you need an interpreter? ☐ YES ☐ NO

Race/Ethnicity

- American Indian / Alaskan Native
- Asian
- Black / African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

- Hispanic / Latino
- Non-Hispanic / Latino

Religious Identity:

Do you identify with any religion? YES / NO

(optional) if yes, which one? _____

Do you have any religious or cultural practiced that would need accommodated in order for treatment to be successful? YES / NO, If yes, please describe: _____

_____

Are you currently experiencing any of the following difficulties? (Check all that apply) **NONE**

◯ Hard of hearing or deaf

◯ Serious difficulty seeing (even w/glasses) or blind

◯ Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition (5 years or older)?

◯ Are you currently having serious difficulty walking or climbing stairs (5 years or older)?

◯ Are you currently having difficulty dressing or bathing (5 years or older)?

◯ Because of a serious physical, mental, emotional condition, are you having serious difficulty doing errands such as doctors appts or errands alone?

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____

ADAC (Alternative Drug & Alcohol Counseling)

Release of Information

****CONSENT/AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION ****

I, ____, DOB: _______________________
{Client's Name, First, Middle Initial, Last} {Client's Date of Birth}

authorize Alternative Drug & Alcohol Counseling (ADAC) to Release & Obtain Information From

____

____
{Name & Contact Information of Program Information Released/Obtained}

For the purpose of:

____

The following information from my records (Precise description of Information/Please Initial):

____Assessment ____Recommendations ____Urinalysis Testing
____Progress in Treatment ____Attendance ____Discharge/Termination
____Other___________________________

I understand that my records are protected under Federal and State Confidentially Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These regulations do not restrict the disclosure of patient identify information related to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into cause of death. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance of it {e.g., probation, parole, and that any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations, etc.} and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires:

Executed this ______________ day of _____________________________________, 20______

Patient Signature ____

Witness/Counselor Signature ____

Parent/Guardian Signature ____
{Required for Minor and Incompetent patients}

**Per ADAC requirements, clients who participate in certain additional services (to include but not limited to – Mental Health, Pain Mgmt., etc.), or who are receiving certain Controlled Substance Prescriptions will be asked to sign a ROI for Coordination of Treatment Care. Clients have the right to deny participation, but must initial to consent refusal. ADAC also has the right to terminate services if client does not wish to participate in coordination of care if there are concerns that have already been addressed with the client.*

______ **I do NOT consent to collaboration with agency listed above**

**This form expires one year from the above dated signature. **

Special note *

This information has been disclosed to you from the records whose confidentiality is protected by HIPAA law. Federal regulations {42 CRF Part 2} prohibit you from asking any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. <u>A general authorization for the release of medical or other information is NOT sufficient for this purpose.</u> The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

This material contains confidential and subjective material, which is released for the professional use only. It should NOT be shared with ANYONE. Permission HAD NOT been granted to copy this material and/or to forward it to other professionals or agencies other than those named on the original release of information.

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Telehealth Informed Consent
Video/Audio

Name: _____ DOB: _____

The following information is our Telehealth Informed Consent. By consenting to receive telehealth services, you understand and agree to the following:

1. I understand that at the beginning of each Telehealth session, my telehealth provider is required to verify my full name and current location. Services must be provided in the state of Maryland.

2. I have a right to confidentiality under the same laws that govern in person sessions. However, staff are mandated reporters for reporting child abuse and neglect, and elderly abuse and neglect to authorities. Additionally, staff must contact authorities if I am at risk of hurting or killing myself or someone else.

3. I understand there are risks associated with Telehealth, including, but not limited to the possibility despite reasonable efforts on the part of my telehealth provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand there is a risk of being overhead by persons near me. I am responsible to use a location that is private and free from distractions.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
6. I understand that audio and/or video recording of telehealth sessions are prohibited.

7. I understand that I have the right to withhold or withdraw my consent to use of telehealth at any time, without it affecting my right to future services.

8. I understand that if I am experiencing a medical or mental health emergency, that I will be directed to contact 911 for emergency medical care, and that my telehealth provider is not able to connect me directly to any local emergency services.

_____ _____
Participant Signature Date

_____ _____
Witness Signature Date

☐ I DO NOT WISH TO PARTICIPATE IN TELEHEALTH SERVICES

AUTHORIZATION TO DISCLOSE SUBSTANCE USE TREATMENT INFORMATION FOR COORDINATION OF CARE

Name of Patient: _____DOB: _____
Address: _____
Phone Number: _____ Medical Assistance Number: _____

Section 1: Purpose of Authorization

This Authorization to disclose is for the purpose of permitting the Maryland Medical Assistance Program (the Medicaid program), my substance use treatment provider, and any other providers identified in this form to coordinate my care so that it is more beneficial to me. By giving my consent, my Medicaid Managed Care Organization and any other providers specifically identified on this form will have access to information about substance use treatment I am receiving, which will help avoid conflicts in medication or treatment and improve the care I am receiving. By giving this consent, I may also gain access to other case management services offered through the Medicaid program.

Section 2: Name of Substance Use Treatment Provider:

ADAC (ALTERNATIVE DRUG & ALCOHOL COUNSELING)

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Section 3: Duration and Revocation of Authorization

This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying the Maryland Medicaid Program's Administrative Services Organization, Optum Maryland, either orally or in writing at the address below; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed. To revoke the authorization, notify Optum at:

Optum Maryland
10175 Little Patuxent Parkway Columbia, MD 21044
Phone: 800.888.1965
Fax: 855-293-5407

Section 4: Authorization

I hereby authorize my substance use treatment provider to disclose to the Maryland Medicaid Program (including its administrative services organization, Optum Maryland), claims and authorization data resulting from my treatment, for purposes of coordination of my care. If you want to identify the kind or amount of information that you are authorizing for disclosure, you may do so here:

_____.

I also authorize the Maryland Medicaid Program (including Optum Maryland) to re-disclose my claims and authorization data to the Medicaid Managed Care Organization in which I am enrolled, and with any additional health care providers listed on this form below, for purposes of coordinating my health care.

I further authorize my substance use treatment provider to disclose medical records requested by my MCO's patient care coordination team, for purposes of coordinating my care.

I understand that the information that may be disclosed as a result of this authorization may not be redisclosed to any entity other than those entities identified in this authorization.

I also understand that, for two years following the date of my signature, I have the right to find out who in the MCO actually saw my information.

I have been provided a copy of this Authorization.

Patient Signature_____ Date _____

Parent or Guardian Signature* (if applicable) _____Date _____

Additional health care provider(s) with whom information about my care may be shared:

Name: _____

Address: _____

Name: _____

Address: _____

* NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the legal document(s) granting you the authority to do so. Examples are a health care power of attorney, a court order, guardianship papers, etc. The following are the Maryland Medicaid Managed Care Organizations (MCOs).

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14201 Park Center Dr. Suite 407
Laurel, Maryland, 20707, USA
Phone: 301-498-0340
Fax: 301-542-0045
www.capitaltox.com
Dr. Ramneesh Bhatnagar

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:	DOB:
Ordering Provider: *Deanna Bailey, CAC-AD, NCAC II, SAP*	SS#:

I request and authorize my provider/facility named above, to release healthcare information, to Capital Diagnostics, for the purposes of obtaining reimbursement.

This request and authorization applies to: *urinalysis testing*

*Healthcare information relating to the following treatment, condition, or dates of service in which Urine Drug Testing, from my provider/facility that ordered the Urine Drug Test and Capital Diagnostics, who performed the testing.

_____

- All healthcare information
- Other

By signing below, I authorize Capital Diagnostics to release information to my insurance carrier to obtain reimbursement for the performed services.

By signing below, I authorize the release of any records regarding drug, alcohol, or mental health treatment to the provider/facility listed above

Patient Signature: _____ Date:_____

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Infectious Disease Risk Assessment

Yes No 1. Have you received a blood transfusion in the past 5 years?

Yes No 2. Have you been diagnosed with any STD (sexually transmitted disease) in the past year?

Yes No 3. Has your addiction involved intravenous use (needles?)

Yes No 4. Have you received a positive TB test?

Yes No 5. Have you been diagnosed for Hepatitis?

I have received the brochure regarding the warnings, symptoms, and dangers of infectious diseases.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

The information that is contained on this form is protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is released of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SERVICE RECIPIENT'S RIGHTS

Alternative Drug & Alcohol Counseling provides all participants; upon admission to its program, the complaint/grievance policy and procedures as well as notifying participants of their rights. If the service recipient/responsible person cannot read the statement of rights and responsibilities, it is read, and a copy is given to the service recipient/responsible person in a language he or she understands. For a minor or a service recipient needing assistance in understanding these rights and responsibilities, both the service recipient and the responsible person are fully informed of these rights and responsibilities. Alternative Drug and Alcohol Counseling also posts the Service Recipient's rights along with the Grievance Procedure in the office lobby.

Service Recipient's rights while receiving services at ADAC are as follows:

1. Service Recipients have the right to non-discriminatory treatment; to be treated with consideration, respect and full recognition of human dignity and individuality.
2. Service Recipients have the right to be free from mistreatment, neglect, or verbal, mental, sexual, emotional and physical abuse, including injuries of unknown source and misappropriation of service recipient property in a healthy, comfortable and physically safe environment.
3. Service Recipients have the right to have confidentiality and privacy of all treatment services and information contained in the service recipient record, the right to be advised of discloser of clinical records and of importance Protected Health Information (PHI).
4. Service Recipients have the right to an accounting of all disclosures of the service recipient Protected Health Information made by ADAC.
5. Service Recipients have the right to be informed, both orally and in writing, in advance of services being provided, of the charges, including payment expected from third parties and any charges for which the service recipient will be responsible.
6. Service Recipients have the right to be treated by qualified personal who provides care and services that are adequate, appropriate and in compliance with relevant State, Local and Federal Laws and Regulations.
7. Service Recipients have the right to identify personnel members through proper identification.
8. Service Recipients have the right to full information about treatment options and resources open in advance about the services to be provided.
9. Service Recipients have the right to have all rules, regulations and procedures explained to his/her full satisfaction.
10. Service Recipients have the right to participate in the development of his/her own treatment plan and the periodic revision of the treatment plan.
11. Service Recipients have the right to refuse care or treatment after the consequences of refusing care or treatment are fully presented.
12. Service Recipients have the right to refuse participation in any experimental research.
13. Service Recipients have the right to be informed of any financial benefits the treating organization may have when it refers the patient to another organization.
14. Service Recipients have the right to file complaints/grievances regarding services; lack of respect of property or recommend changes in policy, personnel or service without interference, coercion, discrimination or reprisal with ADAC and/or the U.S. Department of Health and Human Services if a Service Recipient feels that ADAC has Violated his/her rights under HIPAA.
15. Service Recipients have the right to use the grievance procedure outlined in the Patient Grievance Policy to grieve any program decisions including discharge or change in status or services without fear of interference in his/her treatment.
16. Service Recipients have the right to be free from all physical restraints; physical restraints are prohibited.
17. Service Recipients have the right to formulate an Advance Directive.
18. Service Recipients have the right to be fully informed of one's responsibilities.

All Service Recipients have the right to fair and equal treatment without discrimination, no person will be subjected to discrimination by a facility because of race, color, national origin, gender, religion, sexual

orientation, age creed, marital status, military status or presence of any physical, mental or sensory disability.
All Service Recipients have the right to fair treatment which prohibits physical abuse and punishment, sexual abuse and punishment, psychological abuse and punishment, including humiliation, neglect, threats, retaliation and exploitation; financial or otherwise.
Any Service Recipient who feels that their rights have been violated or they have been discriminated against or treated unfairly in any manner will be enabled to complain and/or file a formal written grievance. Facility staff will be equipped to accept verbal or have written complaint and grievance forms available and will assist with further instructions to complete.

Service Recipients have the responsibility to:

- Provide accurate and honest information about their mental health, substance use and medical issues as well as other circumstances which might impact treatment planning.
- Attend scheduled appointments and arrive on time. Attendance demonstrates commitment and responsibility.
- To keep all topics and conversations that take place during group/individual sessions strictly confidential.
- To pay all service fees in full or to ensure insurance coverage.
- Follow all rules and regulations to keep a safe and comfortable environment for everyone.
- Cooperate with staff in planning, reviewing and revising individual treatment plans.

PROGRAM RULES AND EXPECTATIONS

1. Client agrees to communicate in an appropriate manner to all staff, peers and guests.
2. Client agrees to the smoking/vaping polices.
3. Client agrees to follow schedule and attend all scheduled appointments arriving on time.
4. Client agrees to dress in an appropriate manner and refrain from possessing all prohibited/non-allowable items on the premises of ADAC.
5. Client agrees to respect the property of ADAC maintaining a safe, healthy and clean facility and refraining from causing property damage.
6. Client agrees to keep staff informed of the inability to attend scheduled sessions within a 24 hour notice if possible.
7. Client agrees to respect and abide to confidentiality for all peers in group sessions.
8. Client agrees to respect the personal space of all other individuals and refrain from physical contact. This includes both aggressive and non-aggressive behaviors.
9. Client understands that in order to have a successful completion, they need to participate in completing their treatment goals for the recommended level of care. This includes any changes of level of care during the time services are provided.
10. Client agrees to follow all the rules and expectations set in the handbook.

_____ _____

Service Recipient Signature Date

CLIENT COMPLAINT AND GRIEVANCE PROCEDURE

Alternative Drug and Alcohol Counseling informs each service recipient/responsible person at the initiation of service how to report/file a complaint/grievance and how the compliant/grievance is investigated and resolved.
Any patient who feels that their rights have been violated or they have been discriminated against or treated unfairly in any manner will be enabled to complain and/or file formal written grievance. Facility staff will have written complaint and grievance forms available and will assist with further instructions to complete.

Patient Complaint Form
Alternative Drug and Alcohol Counseling strives to always provide the best possible treatment available for its service recipients and in doing so encourages service recipients to participate in complaint forms when not satisfied. A complaint is an objection to something that is unfair, unacceptable or otherwise not up to normal standards and it is imperative that Alternative Drug and Alcohol Counseling be aware of any of these deficiencies to be informed, make corrections and to improve services.
To file a complaint a service recipient may contact any of the individuals/agencies below or may ask any personnel of Alternative Drug and Alcohol Counseling for a complaint form. Alternative Drug and Alcohol Counseling requests and encourages any individual wishing to file a complaint/grievance to first attempt to resolve the issue with Alternative Drug and Alcohol Counseling. Once the complaint is completed it will be delivered to the appropriate Supervisor or Manager of the office. The Supervisor or Manager of the office will attempt to resolve the problem/complaint and will document the problem and/or solution reached and inform the service recipient within five (5) business days. If the service recipient is not satisfied with the solution reached from the appropriate Supervisor or Manager arrangements will be made for the complaint form to reach the Director or the service recipient may file for grievance if not satisfied.

Patient Grievance Procedure
Patients of ADAC are guaranteed certain rights while utilizing our services. ADAC strives to maintain a professional and ethical level of service however if there may be a time when patients wish to file a grievance against the Program and/or its personnel they may do so by using the following steps:
1. Service recipients may report a grievance to his/her counselor. The counselor will attempt to resolve the problem and will document the problem and/or solution reached in the case notes and report the incident to the counselor's immediate supervisor in writing as soon as possible;
2. The service recipient may document grievance in writing if not satisfied with solutions reached by counselor and can submit a grievance in writing to the counselor's immediate supervisor and can expect a response within a reasonable time, no more than 5 business days;
3. If the service recipient is not satisfied with the solutions reached by the supervisor It will be the responsibility of the Director to evaluate the severity of the grievance. The Director will carefully assess professional, ethical and/or legal aspects of the report in coordination with Alternative Drug and Alcohol Counseling's governing body;
4. At each level, detailed documentation will be produced of all activities, investigations and action taken. All individual reports will indicate who, what, where, why and how of the incident including the investigation, analysis and resolution process.
5. The patient will be informed of the disposition of his/her grievance by the Director.

Alternative Drug and Alcohol Counseling attempts to resolve all service recipient complaints/grievances and documents the results within a reasonable time frame (no more than five (5) business days. ADAC maintains records of all complaints/grievances and their outcomes by submitting a summary report quarterly to the Governing Body/Owner. The summary reports are also included in the Performance Improvement Annual Report. All personnel of Alternative Drug and Alcohol Counseling are oriented and familiar with the complaint/grievance policies and procedures. Personnel may be invited assist in implementing the resolution process when needed.
All staff of ADAC must make no retaliation against any participant who presents a complaint or grievance.
Office managers must inform each participant of any revisions made to the grievance policy and the nature and extent of the revisions.

Complaints/Grievances Should Be Directed To:

Alternative Drug and Alcohol Counseling (ADAC)
Deanna K. Bailey Program Director and Owner
324 E. Antietam St. Suite 308. Hagerstown, MD 21740
301-766-0065

Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Baltimore, MD 21201
Phone: 410-767-6500 Toll Free: 1-877-463-3464
E-Mail: dhmh.healthmd@maryland.gov
DHMH After Hours/Emergency: 410-795-7365

Accreditation Commission for Health Care (ACHC)
139 Weston Oaks Ct.
Cary, NC 27513
Phone: 855-937-2242 Local: 919-785-1214 Fax: 919-785-3011
customerservice@achc.org

Service Recipient Signature

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Hagerstown, MD. 21740

217 Glenn St, Ste 401.
Cumberland, MD. 21502

HIPAA NOTICE

ADAC is committed to full compliance with the **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 and therefore, to the protection, security and confidentiality of protected health information (PHI) as defined by the Act.

HIPAA provides each patient of ADAC with specific rights regarding their health information, including the right to file a complaint if the confidentiality of their protected health information has been compromised. Patients are also entitled to receive a copy of the organization's "Notice to Privacy Practices."

If you desire to file a complaint under the provisions of HIPAA, need additional information about the Act, or would like a copy of the organization's privacy practices, please contact:

ADAC (Alternative Drug & Alcohol Counseling)

324 E. Antietam St., Suite 308
Hagerstown, MD. 21740
Phone: 301-766-0065
Fax: 301-766-9594

217 Glenn St. Suite 401
Cumberland, MD. 21502
Phone: 301-729-0340
Fax: 301-729-0341

Acknowledgment:

By signing below, I acknowledge that I have received the Notice of Privacy and have been offered an opportunity to request restrictions on certain uses and disclosures of my protected information.

_____ _____

Signature of patient/patient's representative Date:

_____

Printed name of patient/patient's representative

Alternative Drug & Alcohol Counseling

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Urinalysis testing is a **MANDATORY** part of your program at ADAC, done on a random basis. The following are the rules for testing:

1. Any refusal to take a test is considered "Behavioral Positive" urine. (Not remaining for your test after being requested to do so is considered a refusal).
2. Diluted urines indicate altered intake of fluids. Altered urines indicate tampering or an attempt to flush the system and will be considered a "Behavioral Positive".
3. Any dip test that has questionable results may be sent to the lab for confirmation.
4. Urinalysis testing will be monitored (observed). If failure to comply with this, specimen will not be sent to lab and will be considered "Behavioral Positive".
5. Clients who test positive for THC and identify that it's medical marijuana must provide both a receipt and MMC id for validation, or the tests will be documented as positive.
6. Clients who are prescribed medication need to provide documentation monthly of prescriptions to validate urine testing or tests will be documented as positive.

If you are aware that your test will be inappropriate, notify your counselor or collector.

Urinalysis is a tool for clinical purposes to determine the level of problem that may exist. It provides a means to determine if more treatment recommendations are needed. Results are handled confidentially until it is determined that legal agencies need to be notified. You are given a chance to establish abstinence by increasing the urinalysis schedule to verify a length of abstinence. This may mean increasing your length of treatment to allow you to attain and maintain abstinence of sufficient duration to demonstrate treatment success.

Patient Signature:_____ Date:_____

Witness Signature: _____ Date:_____

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Alternative Drug & Alcohol Counseling

Service Recipient Handbook Acknowledgement Form

RECEIPT OF AND UNDERSTANDING OF INFORMATION CONTAINED IN THE CLIENT HANDBOOK

I have read and understand all of the information referenced in the handbook provided to me or someone who has read and explained it all to me. I am aware and informed of the nature and purpose of the services, possible alternatives options and approximate length of care. I understand that, while there are clear benefits of receiving services, desired outcomes are not guaranteed. I have been provided the opportunity to ask questions throughout this process. I agree to follow all of the rues described and am aware of my rights and responsibilities in the program and have received a copy of grievance procedures and policies and procedures in the program. I understand that I can revoke my agreement with any and all of the conditions listed in this document, but understand that it may result in being transferred or referred to another facility.

Upon signing this, I also provide consent to treatment services with ADAC (Alternative Drug & Alcohol Counseling).

_____ _____

Service Recipient's Signature Date

_____ _____

Signature of Person signing form if not client (Parent/Guardian) Date

I have reviewed the contents of this handbook with the individual seeking services and have offered opportunities for clarification and explanation of contents.

_____ _____

Signature of ADAC Personnel Date