SOAP POLICIES

LOWELL HOUSE ADDICTION TREATMENT AND RECOVERY

ATTENDANCE/PUNCTUALITY:

- Clients are expected to attend SOAP Monday through Friday from 8:30am to 3:00pm
- Appointments that require a client to miss either partial or full day of SOAP must be written on the calendar & verified
- If a client needs to call out (sickness, family emergency, medical emergency, etc.), please call the main phone number at **978-459-8656** – ***always leave a message*** for the answering service & that message will be delivered to staff
- Clients are responsible for calling if running late – group facilitator has the right to not allow a client into group if that client is late and has not notified staff
- Consistent no call, no shows can result in discharge from the program
- Any client that is mandated to SOAP by probation will have weekly attendance reports and urine screens sent to his/her probation officer

GROUP EXPECTATIONS:

- *Spouses, family, relatives, and significant others are not allowed to enroll in SOAP at the same time due to conflict of interest*
- Refrain from eating food/bringing food into room during group time
- Participate in sessions
- Utilize break times wisely & arrive to group on time
- Remain alert & engaged during entire session
- Cell phones are to be kept on **silent mode or turned off** during group sessions – staff will assist clients with any phone calls in his/her office
- If a client is having difficulty remaining alert, group facilitator has the right to ask that client to step out of the room
- Be respectful of others – avoid interrupting/talking over others
- Be mindful of conversations - Avoid talk about glorifying drinking/drug use, personal conversations regarding medications
- Clothing must be appropriate – anything related to alcohol, drugs, or other illegal material (i.e. gang colors/symbolism) is not permitted
- ***All information discussed in group sessions is to remain confidential***

MEDICATIONS:

- Clients are responsible to bring in a copy of their prescriptions to staff
- Avoid taking any medications during group hours/in front of others – please notify staff of any medications that are taken during the day and take them in privacy of the restroom or a staff member's office
- **Medical Marijuana** – clients with a medical marijuana card are expected to bring in card/copy of card for his/her file. Clients are not allowed to use marijuana during SOAP hours or come to the program under the influence of marijuana.

_____ _____

client signature *date*

SOAP POLICIES

LOWELL HOUSE ADDICTION TREATMENT AND RECOVERY

URINE SCREENS:

- Urine screens are mandatory for **all** clients
- Staff are not allowed to give hard copies of urine screens to clients
- For court mandated clients – **All** urine screens will be faxed to appointed collateral
- Screens are supervised unless approved by staff
- Screens are collected by Ammon Labs 2-3x per week – randomized days
- Ammon Labs are present from **8:30am to 10:30am** – clients are responsible to give a urine screen during those hours
- If a client is not present during lab hours, staff may request a screen at a later time
- A positive urine screen does **not** constitute an automatic discharge – staff will meet privately with client to discuss screen. If a client continuously uses drugs/alcohol while in SOAP, staff may refer that client to another level of care before he/she can continue on with the program.

SAFETY:

- Staff emphasize a client's right to a safe and supportive environment. The following may result in immediate discharge:
  - Bringing alcohol/drugs into the facility
  - Selling or giving others drugs/alcohol – staff has the right to discharge a client if given enough evidence to believe client is selling/passing drugs/alcohol
  - Use of offensive language, remarks or abusive/threatening language (including references to race, culture or sexual orientation/preference)
  - Physical altercations
- Staff has the right to request a quick cup test or breathalyzer for client

VEHICLES/TRANSPORTATION:

- Parking validation will be provided to clients who drive to SOAP – please give staff parking ticket. Client may be asked to fill out paperwork for staff.
- If a client is under the influence of drugs/alcohol, staff will ask to hold onto car keys until client is deemed safe to drive (BAC reading of .08% or lower)
  - If a client refuses to give car keys to staff and gets into his/her car while impaired, staff are instructed to notify the police
- Clients are not allowed to leave treatment to provide transportation for another client. Everyone is responsible for obtaining his/her own means of transportation to outside appointments.
- Bus vouchers (when available) are given to those without any means of transportation **AND** income for transportation

_____ _____

client signature *date*

ESM#_____

LOWELL HOUSE, INC. SOAP
DAILY SAFETY CONTRACT

Substance Possession and Use Policy

(1) I must be alcohol and drug free for all sessions and appointments. In the event that you attend a session/appointment under the influence of alcohol and/or drugs, LHI will assess and determine your clinical need based upon medical necessity and level of care required.

- (a) Discuss and assist you with a detox
- (b) Call a family member to assist you home and to make them aware of your condition
- (c) Call for an ambulance and transport you to Lowell General Hospital, Emergency Room, due to medical risk and psychiatric evaluation.
- (d) In the event you are unsafe, threatening verbal or physical abuse, LHI will call the Lowell Police Department for assistance

(2) I will refrain from using or possessing any alcohol, drugs, as weapons while on LHI property. Violation of this may result in LHI calling the Lowell Police Department for assistance with the situation. Also, violation of this will result in termination from the program (with notification to the source/court referral).

(3) I will not sell, share, and dispense any illegal drugs, prescribed medication, and over the counter medication (i.e., aspirin, Tylenol, cough syrups, topical creams, ect.) with any persons associated with LHI on LHI property. Violation of this may result in LHI calling the Lowell Police Department for assistance with the situation. Also violation of this will result in termination from the program (with notification to the source/court of referral).

(4) I will refrain from assaultive or abusive behavior (verbal or abusive) toward any persons or property associated with LHI. Violation of this may result in LHI calling the Lowell Police Department for assistance with the situation. Also, violation of this will result in termination from the program (with notification to the source/court of referral).

I, _____, have read and understand the above
Print Name
policies. I agree to abide by the stated policies and understand the potential consequences stated above.

_____ _____
PERSON SERVED SIGNATURE DATE

_____ _____
STAFF SIGNATURE DATE

Client Name_____

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	NO	YES
Have you used drugs other than those required for medical reasons?	☐	☐
Do you abuse more than one drug at a time?	☐	☐
Are you always able to stop using drugs when you want to? (If never use drugs, answer Yes)	☐	☐
Have you had "blackouts" or "flashbacks" as a result of drug use?	☐	☐
Do you ever feel bad or guilty about your drug use? (If never use drugs, choose No)	☐	☐
Does your spouse (or parents) ever complain about your use of drugs?	☐	☐
Have you neglected your family because of your use of drugs?	☐	☐
Have you engaged in illegal activities in order to obtain drugs?	☐	☐
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, ect?	☐	☐

M.A.S.T. TEST

(Michigan Alcohol Screening Test)

(revised)

The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please circle the answers to the following YES or NO questions:

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people)
   ☐ YES or ☐ NO

2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
   ☐ YES or ☐ NO

3. Does any near relative or close friend ever worry or complain about your drinking?
   ☐ YES or ☐ NO

4. Can you stop drinking without difficulty after one or two drinks?
   ☐ YES or ☐ NO

5. Do you ever feel guilty about your drinking?
   ☐ YES or ☐ NO

6. Have you ever attended a meeting of Alcoholic Anonymous (AA)?
   ☐ YES or ☐ NO

7. Have you ever gotten into physical fights when drinking?
   ☐ YES or ☐ NO

8. Has drinking ever created problems between you and a near relative or close friend?
   ☐ YES or ☐ NO

9. Has any family member or close friend gone to anyone for help about your drinking?
   ☐ YES or ☐ NO

10. Have you ever lost friends because of your drinking?
    ☐ YES or ☐ NO

11. Have you ever gotten into trouble at work because of drinking?
    ☐ YES or ☐ NO

12. Have you ever lost a job because of drinking?
    ☐ YES or ☐ NO

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
    ☐ YES or ☐ NO

14. Do you drink before noon fairly often?
☐ YES or ☐ NO

15. Have you ever been told you have liver trouble such as cirrhosis?
☐ YES or ☐ NO

16. After heavy drinking, have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?
☐ YES or ☐ NO

17. Have you ever gone to anyone for help about your drinking?
☐ YES or ☐ NO

18. Have you ever been hospitalized because of drinking?
☐ YES or ☐ NO

19. Has your drinking ever resulted in you being hospitalized in a psychiatric ward?
☐ YES or ☐ NO

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?
☐ YES or ☐ NO

21. Have you been arrested more than once for drinking under the influence of alcohol?
☐ YES or ☐ NO

22. Have you ever been arrested, even for a few hours because of other behavior while drinking?
☐ YES or ☐ NO
If yes, how many times?____

C.A.G.E.

1. Have you ever thought about cutting down on drinking?
☐ YES or ☐ NO

2. Have you ever felt annoyed when friends or members of your family expressed concerned about your drinking?
☐ YES or ☐ NO

3. Have you ever felt bad or guilty about drinking?
☐ YES or ☐ NO

4. Do you ever drink in the morning before breakfast or before going to work?
☐ YES or ☐ NO

ALLERGY IDENTIFIER Date:_____

Lowell House, Inc.
Person Served Emergency/Contact Sheet

Name_____ DOB_____ SS#_____

Address_____
Street Name City State Zip Code

Telephone: Home_____ Cell_____ Work_____

Email Address_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Interpreter Needed: ☐ Yes ☐ No

Health Insurance_____ Policy_____

Adolescents – If you are under the age of 18, please fill out this section:

Parent/Guardian's Name_____

Address_____

Telephone: Home_____ Cell_____ Work_____

Medical Information

Physician's Name/PCC _____

Physician's Address _____

Physician's Telephone _____

Blood Type _____

Allergies _____

Medication/Dosages _____ _____

_____ _____

_____ _____

Psychiatrist's Name _____

Psychiatrist's Address _____

Psychiatrist's Telephone _____

Emergency Contact – Person to contact in case of Emergency

Name_____ Relationship_____

Address_____

Telephone: Home_____ Cell_____ Work_____

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name: LOWELL HOUSE, INC.	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

(Check all that apply below)

1. What drugs do you usually use? ☐ N/A
☐ Heroin ☐ Other Opiates ☐ Cocaine ☐ Alcohol ☐ Methadone ☐ Benzodiazepines
☐ Inhalants ☐ Marijuana ☐ Amphetamines ☐ Other: _____

2. How do you use your drugs? ☐ N/A
☐ Inject ☐ Oral ☐ Smoke ☐ Snort ☐ Other: _____

3. If you inject drugs, how often do you use new needles? ☐ N/A
☐ Sometimes ☐ Always ☐ Never

4. If you use new needles, where do you get them? ☐ N/A
☐ Pharmacy ☐ Friends ☐ Needle Exchange ☐ Other _____

5. If you use needles, how do you dispose of them? ☐ N/A
☐ Throw Away ☐ Needle Exchange ☐ Bring to Pharmacy ☐ Disposal Site ☐ Other _____

6. Do you ever share needles/injection equipment? ☐ N/A
☐ Yes ☐ No

7. In the last five years, about how many people have you had sex with?
☐ 20 or more ☐ 10-19 ☐ 3-9 ☐ 0-2

8. How often do you use protection against infections? ☐ N/A
☐ Sometimes ☐ Never ☐ Always

9. Have you had sex for money, drugs or something you needed?
☐ Yes ☐ No

10. When was the last time you were tested for HIV?
☐ _____ ☐ Never

11. Did you receive your results? ☐ N/A
☐ Yes ☐ No

12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

Please check what was provided to Person Served below:
☐ HIV Fact Sheet ☐ Discussion Only ☐ Referral ☐ Viral Hepatitis Information
☐ Other STI Information ☐ Other: _____

Other Notes / Recommendations:

Person's Name (First MI Last):	Record #:

Person's Signature (Optional, if clinically appropriate)	Date:	Parent/Guardian Signature (If appropriate):	Date:
Clinician/Provider - Print Name/Credential:	Date:	Supervisor - Print Name/Credential (if needed):	Date:
Clinician/Provider Signature:	Date:	Supervisor Signature (if needed):	Date:
Psychiatrist/MD/DO (If required):	Date:		

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name: LOWELL HOUSE, INC	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

ASK – Systematically identify all tobacco users at every visit.

☐ Never used tobacco → Encourage continued abstinence / Proceed to the signature section.

☐ Recovering tobacco user → Do you need any further help at this time? ☐ No, Proceed to the signature section. ☐ Yes - Proceed to the Assist section

☐ Average number of Cigarettes _____ / Cigars _____ / Pipe Bowls _____ smoked per day?

☐ Average use of Snuff _____ / Chew _____ / Other: _____ - _____ per day?

How soon after waking do you use tobacco? _____

ADVISE – Strongly urge all tobacco users to quit.

☐ This program cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for tobacco users with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.

ASSESS – Determine willingness and readiness to make an attempt to quit.

1. On a scale of 1-10, with 1 being not at all important and 10 being extremely important, how important would you say it is for you to stop using tobacco?	*Not at all* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *Extremely*
2. On the same scale, how interested are you in quitting?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
If uninterested, ask: What would make you more interested?	
If you decided to be tobacco free, on a scale of 1-10, how confident are you that you could successfully do it?	*Not at all* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *Extremely*
If unconfident, ask: How could the program help you become more confident?	
If you were to quit, what would be some reasons?	

STAGE OF CHANGE

☐ Not considering quitting *(Pre-contemplation)*
☐ Thinking about quitting *(Contemplation)*
☐ Ready to quit in next 30 days *(Preparation)*
☐ Tobacco Free 1 day to 6 months *(Action)*
☐ Tobacco Free 6 mos or more *(Maintenance)*

If in preparation, ask: What steps have you taken to prepare for your attempt to quit?

ASSIST – Aid the person served in quitting or planning for the future.

☐ Evaluate past quitting experience:
How many times have you tried to quit using tobacco?
What kinds of Nicotine Replacement Therapy (NRT) have you tried? (gum, patches, inhaler, Zyban/Wellbutrin)

☐ Discuss available programs: * Individual counseling and NRT on site * Referral to local tobacco treatment specialist off-site * Support for tapering * Support for going "cold turkey" * Self-help materials * Nicotine Anonymous Information

Give materials and encourage support including the use of telephone counseling at.
Tobacco-Free Helpline 1-800-QUIT-NOW or website www.makesmokinghistory.org

ARRANGE – Schedule follow-up contact.

☐ Offered referral for on-site tobacco treatment:	☐ The person served would like to be referred ☐ The person served does not want to be referred
☐ Will follow-up as part of regular treatment planning.	

Person's Name (First MI Last):			Record #:
Person's Signature (Optional, if clinically appropriate)	Date:	Parent/Guardian Signature (If appropriate):	Date:
Clinician/Provider - Print Name/Credential:	Date:	Supervisor - Print Name/Credential (if needed):	Date:
Clinician/Provider Signature:	Date:	Supervisor Signature (if needed):	Date:
Psychiatrist/MD/DO (If required):	Date:		

Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: _____ DOB: _____ Date: _____

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____	☐	☐
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐	☐
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	☐	☐
4) Do you have (or have you had) any of these medical conditions? Diabetes — Kidney disease HIV infection — Colitis Cancer — Stomach or intestine surgery Rheumatoid arthritis	☐	☐
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐	☐
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	☐	☐
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)	☐	☐

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?	☐	☐
2) Coughing up blood?	☐	☐
3) Weight loss of more than 10 pounds for no known reason?	☐	☐
4) Fever of 100°F (or 38°C) for over 2 weeks?	☐	☐
5) Unusual or heavy sweating at night?	☐	☐
6) Unusual weakness or extreme fatigue?	☐	☐

If you answer "yes" to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.

101 Jackson St 4th floor Lowell, MA 01852

LHATR
LOWELL HOUSE ADDICTION
TREATMENT *AND* RECOVERY

I, _____ authorize Lowell House Inc and its affiliate to
(person served)

disclose to and/or receive from :

_____ _____
(provider) (email/phone)

The following information:

- ☐ Attendance
- ☐ Urine screen
- ☐ Breathalyzers
- ☐ Assessment
- ☐ Evaluation results
- ☐ Treatment status
- ☐ Completions
- ☐ Discharge summary
- ☐ Other _____

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I agree that this release is set to expire on _____.
(date)

_____ _____
(date) (client signature)

_____ _____
(date) (staff signature)

101 Jackson St 4th floor Lowell, MA 01852

LHATR

LOWELL HOUSE ADDICTION
TREATMENT *AND* RECOVERY

I, _____ authorize Lowell House Inc and its affiliate to
(person served)

disclose to and/or receive from :

_____ _____
(provider) (email/phone)

The following information:

- ☐ Attendance
- ☐ Urine screen
- ☐ Breathalyzers
- ☐ Assessment
- ☐ Evaluation results
- ☐ Treatment status
- ☐ Completions
- ☐ Discharge summary
- ☐ Other _____

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I agree that this release is set to expire on _____.
(date)

_____ _____
(date) (client signature)

_____ _____
(date) (staff signature)

101 Jackson St 4th floor Lowell, MA 01852

LHATR
LOWELL HOUSE ADDICTION
TREATMENT *AND* RECOVERY

I, _____ authorize Lowell House Inc and its affiliate to
(person served)

disclose to and/or receive from :

_____ _____
(provider) (email/phone)

The following information:

- ☐ Attendance
- ☐ Urine screen
- ☐ Breathalyzers
- ☐ Assessment
- ☐ Evaluation results
- ☐ Treatment status
- ☐ Completions
- ☐ Discharge summary
- ☐ Other _____

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I agree that this release is set to expire on _____.
(date)

_____ _____
(date) (client signature)

_____ _____
(date) (staff signature)

APPENDIX C

SELF-DECLARATION OF INCOME REPORT / FY2018-19

(Effective May, 2018)

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether or not they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PLEASE NOTE: ALL FOUR SECTIONS OF THIS FORM MUST BE COMPLETED TO RECEIVE REIMBURSEMSENT

PARTICIPANT INFORMATION

1. PARTICIPANT STATUS: ☐ FAMILY ☐ INDIVIDUAL

Participant Name: _____

Address: _____ City, State, Zip Code: _____

2. ETHNICITY *(please select only one):*

☐ Hispanic or Latino ☐ Not Hispanic or Latino

3. RACE *(please select only one):*

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native *and* White
☐ Asian *and* White
☐ Black/African American *and* White
☐ American Indian/Alaskan Native *and* Black/African American
☐ Other Multi-Racial: _____

4. HOUSEHOLD INFORMATION

1) Circle the number of family and non-family members living in your household below.

2) Circle the corresponding income level (FY2018-19 Median Family Income) Note: Does not need to be on same row as number of household size – should be accurate yearly household income.

Household Size		#1 (0% - 30%)	#2 (31% - 50%)	#3 (51% - 80%)	#4 (81% and above)
1		$0-$22,150	$22,151-$36,900	$36,901-$50,350	$50,351+
2		$0-$25,300	$25,301-$42,200	$42,201-$57,550	$57,551+
3		$0-$28,450	$28,451-$47,450	$47,451-$64,750	$64,751+
4		$0-$31,600	$31,601-$52,700	$52,701-$71,900	$71,901+
5		$0-$34,150	$34,151-$56,950	$56,951-$77,700	$77,701+
6		$0-$36,700	$36,701-$61,150	$61,151-$83,450	$83,451+
7		$0-$39,200	$39,201-$65,350	$65,351-$89,200	$89,201+
8		$0-$42,380	$42,381-$69,600	$69,601-$94,950	$94,951+

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____ Date: _____

(Original signature is required)

☐ New Client

☐ Insurance Update

☐ OP ☐ EVAL ☐ 24Q ☐ SMOA ☐ SOAP

☐ Out of State Eval ☐RC ☐ JUV ☐ GAM

☐ MBHP ☐ UNISYS ☐ NET ☐ Always-Optum ☐ GIC

☐ FALLON ☐ BMC ☐ UNICARE ☐ TUFTS NAVIGATOR

☐ SELF PAY ☐ FREE CARE ☐ Commonwealth Care Alliance

****

NAME_____DOB_____INTAKE DATE_____

MMIS MEMBER ID#_____

AUTH DATES_____OR ☐ CY # SESSIONS_____

AUTHORIZATION #_____ CO-PAY ☐ NO ☐ YES $_____

Confirmation/Ref #_____

☐ Uploaded waiting to receive file _____

LOWELL HOUSE ADDICTION
TREATMENT *AND* RECOVERY

Client Telehealth Consent Form

I, _____(client name), hereby consent to participate in telemental health with Lowell House Addiction and Recovery _____(program) as part of my treatment. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that I have voluntarily entered telemental health services and that if I am under the supervision of a court or another agency (identified as "Collateral" below), they have already approved my accommodation to participate in the above mentioned services remotely.

3) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

4) I understand that any disruptions, breaches, and/or situations that impact my ability to virtually attend or remain present during a session may impact my attendance record, and it is my responsibility to communicate these situations to Lowell House and seek to rectify, potentially through a make up session. This may result in me having to pay a missed session fee or make up fee.

5) I understand it is an expectation that I make personal accommodations with my own technology to ensure I can be visible and heard (a working camera and microphone on the technology I am using) throughout the sessions, and that I am able to locate myself physically in a location which protects my own and others' (if in a group setting) confidentiality.

6) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

7) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies

(i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

8) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a more intensive or alternative level of care is required.

I have read the information provided above and discussed it with my collateral/referral source. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Client signature	Date
Collateral signature	Date
Lowell House Staff signature	Date