Copeland Ave.
COUNSELING
Helping Build A Better You. ®

24 Copeland Avenue Homer, NY 13077 • P 607.749.5711 • F 607.753.3165 • www.copelandavecounseling.com
220 S Warren St Suite 1002 Syracuse, NY 13202 • P315.476.3333 • F607.753.3165 • www.copelandavecounseling.com

Dear Client:

We have scheduled a DWI EVALUATION and/or substance abuse initial intake appointment for you at our facility. BEFORE your appointment, please make sure to fill out the following packet and bring the required information with you. Your appointment has been scheduled on:_____ with our therapist Janet Rider. Please be sure to be on time for this appointment and remember that someone needs to attend this appointment with you, as a collateral, such as a family member.

Should you have any questions, please be sure to call our office prior to your appointment date.

DRUG & ALCOHOL EVALUATION CHECKLIST

These forms for client to complete prior to interview appointment:

- ☐ CAC CLIENT DEMOGRAPHIC INFORMATION SHEET
- ☐ CAC BILLING FORM
- ☐ HIPAA INFORMATION FOR CLIENT
- ☐ CLIENT-SIGNED RECIEPT OF HIPPA INFORMATION
- ☐ MODIFIED MINI SCREEN (SCORED BY EVALUATOR)
- ☐ RIASI (SCORED &REVIEWED WITH CLIENT)

Client to supply:

- ☐ COPY OF POLICE/ARREST REPORT
- ☐ DRIVER'S LICENSE (to make a copy of)
- ☐ $220 PAYMENT OR INSURANCE INFORMATION (card to copy) TO BILL INSURANCE
- ☐ COLLATEROL REPORTER (MAY LEAVE SEPERATELY)

To be completed face-to-face:

- ☐ AGENCYCONSENT FOR RELEASE OF INFORMATION – DRINKING DRIVER PROGRAM
- ☐ AGENCY CONSENT FOR RELEASE OF INFORMATION – COLLATERAL SOURCES
- ☐ AGENCY CONSENT FOR RELEASE OF INFORMATION – ATTORNEY
- ☐ AGENCYCONSENT FOR RELEASE OF INFORMATION – LAB/UDS
- ☐ OASAS CONSENT FOR RELEASE OF INFORMATION – CRIMINAL JUSTICE, IF APPLIES
- ☐ OASAS CONSENT FOR RELEASE OF INFORMATION – IMPAIRED DRIVER SYSTEM (IDS)
- ☐ FACE-TO-FACE EVALUATION PERFORMED WITH BPS/AOD EVAL TOOL(DIAG; LOC)
- ☐ COLLATERAL INFORMATION (CLOSEST RELATIVE, SEEN ALONE)

Following interview, ASAP:

- ☐ PROGRESS NOTE INCLUDING SCREENINGS REVIEWED AND UDS ORDER CONFIRMED
- ☐ 80 HOUR (EtG)URINE ALCOHOL/DRUG SCREEN (LAB REPORT)
- ☐ ANY REQUESTED DISCHARGE REPORTS FROM PRIOR TREATMENT AGENCIES
- ☐ EVAL SUMMARY WITH DIAGNOSIS &RECOMMENDATION SENT TO REFERRAL SOURCE
- ☐ CLIENT INFORMED IN WRITING OF RECOMMENDATION& JUSTIFICATION
- ☐ FORM 449 FAXED TO ALBANY UNTIL IDS ONLINE IS WORKING

IF ADMITTED FOR DWI/ AOD TREATMENT:

- ☐ CAC INTAKE PAPERWORK, BILLING PREAUTHORIZATION
- ☐ TREATMENT PLAN ADDRESSING ALL AREAS OF SERVICE OUTLINED BY OASAS

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NEW CLIENT INFORMATION SHEET

****ALL FIELDS MUST BE PRINTED LEGIBLY****

CLIENT INFORMATION (PERSON FILLING OUT PAPERWORK: ☐ SELF ☐ PARENT ☐ GUARDIAN)			
Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Master ☐ Child			
Last Name:	First:	M.I.:	Date:
Street Address:		Apartment/Unit #:	
City:	State:	ZIP:	
E-mail Address:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security No:	Date of Birth:		

DEMOGRAPHICS (TO HELP THE THERAPIST KNOW YOU BETTER):		
Gender: ☐ Male ☐ Female ☐ Other	Race: ☐ Black ☐ Hispanic ☐ Native Am. ☐ White ☐ Other	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed ☐ Child ☐ Other		
Do you smoke:	☐ Yes ☐ No For how long:_____	Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Other

REMINDER CALLS: (PLEASE MAKE REMINDER CALLS TO):		
Name:	Phone #:	Type: ☐ Cell ☐ Home
Relation: ☐ Self ☐ Parent ☐ Guardian		

EMERGENCY CONTACT INFORMATION	
Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Master ☐ Other: Relation: ☐ Parent ☐ Spouse ☐ Friend ☐_____	
First Name:	Last Name:
Address:	City, State, Zip:
Phone:_____ ☐ Cell ☐ Home	Email:

****Please provide any additional information you deem necessary for the therapist to know on a separate sheet of paper.**

COPELAND AVE COUNSELING

Today's Date

PATIENT INFORMATION

First Name

Last Name

Street & #, PO Box, RR#, Apt # (Where you receive your mail)

City | State | Zip

Home Phone

Work Phone

Date of Birth			Age	Marital Status					Male ☐
Mo	Day	Yr		M	Single	Sep	D	W	Female ☐

Social Security Number

Employer Name & Address

Date of Injury or Onset of Symptoms					
Month	Day	Year	Is this a work related injury or illness?	Yes ☐	No ☐
			Is this an auto accident related injury?	Yes ☐	No ☐

RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

First Name

Last Name

Street & #, PO Box, RR#, Apt # (Where you receive your mail)

City | State | Zip

Home Phone

Work Phone

Date of Birth			Relationship to Patient
Mo	Day	Yr	

Social Security Number

Employer Name & Address

MEDICARE ID NUMBER	Is Medicare Your Primary Insurance?	NYS MEDICAID ID NUMBER	Do You Have A Medicaid HMO?	If yes, please list the information below
	Yes ☐ No ☐		Yes ☐ No ☐	

Primary Insurance (If not Medicare)

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male ☐
Month	Day	Year	Female ☐

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder	Co-Pay Amount

Employer Name If Through Employer

Secondary Insurance (Including Medicare Supplemental)

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male ☐
Month	Day	Year	Female ☐

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder	Co-Pay Amount

Employer Name If Through Employer

Additional Insurance

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male ☐
Month	Day	Year	Female ☐

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder	Co-Pay Amount

Employer Name If Through Employer

I authorize my insurance to be paid to the provider and acknowledge that I am financially responsible for any unpaid balance(s). I also authorize the release of any information required.

Signature

SAMEDICAL\NYPT fdb

State of New York
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONFIDENTIALITY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")* and the Confidentiality Law**. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency ;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

*** 42 U.S.C. § 130d et. seq., 45 C.F.R. Parts 160 & 164**
**** 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2**

CONFIDENTIALITY NOTICE

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.
- To make any of the above requests, you must fill out the appropriate form that will be provided by the program.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information at the program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

- Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.
- Communication with Business Associates such as clinical laboratories (blood work, urinalysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy) long term record storage.
- Reporting data to the NYS OASAS Client Data System.

The Program's Duties

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

CONFIDENTIALITY NOTICE

Complaints and Reporting Violations

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint form (on reverse side of this form) and submit the form to the:

- ATC Administrator;
- Bureau of Addictions Treatment Centers, 1450 Western Avenue, Albany, NY 12203; or
- OASAS Privacy Official. , 1450 Western Avenue, Albany, NY 12203.

The complaint will be reviewed by an appropriate individual, based on the nature of the complaint. That individual will complete the Privacy Complaint Resolution form. Copies will be forwarded to OASAS Privacy Official, 1450 Western Avenue, Albany, NY 12203.

The patient may also register a complaint with the:

Office for Civil Rights
U.S. Department of Health and Human Services,
Jacob Javits Federal Building
26 Federal Plaza--Suite 3313
New York, New York, 10278

Voice Phone (212) 264-3313.
FAX (212) 264-3039.
TDD (212) 264-2355
OCR Hotlines-Voice: 1-800-368-1019

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Effective Date: 4/14/03

State of New York
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONFIDENTIALITY NOTICE

I, _____ have received a copy of the Confidentiality Notice, and it has been explained to me.

_____

Signature Date

_____

Parent/Guardian Signature (if necessary) Date

Client Name_____ Date_____

Modified Mini Screen (MMS)

Section A

1. Have you been consistently depressed, or down, most of the day, nearly every day, for the past 2 weeks? Y N

2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Y N

3. Have you felt sad, low or depressed most of the time for the last 2 years? Y N

4. In the past month, did you think that you would be better off dead or wish you were dead? Y N

5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Not including times you were intoxicated on drugs or alcohol) Y N

6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? Y N

Total Yes /Section A: ___

Section B

7. (two parts) a- Have you had one or more occasions when you felt anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? Y N

b- If yes, did these intense feelings get to be their worst within 10 minutes? Y N

8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: Being in a crowd, standing in line, being alone away from home or alone at home, crossing a bridge, traveling in a bus or car, etc. Y N

9. Have you ever worried excessively or been anxious about several things over the past 6 months? Y N

10. Are these worries present most days? Y N

11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: Public speaking, eating in public or with others, writing while someone watches, being in social situations, etc. Y N

12. In the past month, have you been bothered by thoughts, impulses or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: acting on impulse in a shocking way, worry about being dirty/contaminated/germs, worry about contaminating

or harming others even though you didn't want to, fears or superstitions you would be responsible for things going wrong, obsessions with sexual thoughts/images/impulses, hoarding or excessive collecting, obsession with religious practices, etc. Y N

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: hand washing, cleaning, counting or checking things over & over, repeating, collecting or arranging things, superstitious rituals, etc. Y N

14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: serious accidents, sexual or physical assault, terrorist attack, being held hostage, kidnapping, fire, discovering a body, sudden death of someone close to you, war, natural disaster, etc. Y N

15. Have you re-experienced the awful event in a distressing way in the past month? Y N

Total Yes /Section B: ___

Section C

16. Have you ever believed that people were spying on you, or that someone was plotting against you or trying to hurt you? Y N

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? Y N

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self> Or, have you ever felt that you were possessed? Y N

19. Have you ever believed that you were being sent messages through the TV, radio, electronic devices or newspaper? Did you believe that someone you did not personally know was particularly interested in you? Y N

20. Have your relatives or friends ever considered any of your beliefs strange or unusual? Y N

21. Have you ever heard things other people couldn't hear, such as voices? Y N

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see? Y N

Total Yes /Section C: ___

Total Yes /all sections: ___

Further assessment recommended? _____

:: +14+15, (>6), >10

RIA SELF INVENTORY

Please circle **T** if the statement is true and **F** if the statement is false.

Name_____

T F 1. I smoke or use tobacco products.

T F 2. I have no problem telling a companion that he or she has done something to hurt my feelings.

T F 3. I often feel so restless I can't sit still.

T F 4. When I drink 7 or more drinks, I become aggressive.

T F 5. I like people who are sharp and witty even though they may sometimes hurt other peoples' feelings.

T F 6. When the alcohol runs out, I leave a party.

T F 7. When I make plans I am almost certain to make them work.

T F 8. I have relatives who have had problems with alcohol or drugs.

T F 9. I have been arrested for crimes other than drinking and driving.

T F 10. My hand often shakes when I try to do something.

T F 11. I am irritated a great deal more than people are aware of.

T F 12. Since the age of 18, I have been accidentally cut, or cut in a fight or burned badly enough to leave a scar.

T F 13. A family member was arrested for drinking and driving.

T F 14. When I don't get my own way, I sulk or pout.

T F 15. I slow down when a traffic light turns yellow.

T F 16. I often feel like a powder keg ready to explode.

T F 17. When I have a problem, I try to make it go away by drinking.

T F 18. I have no trouble sleeping or staying asleep.

T F 19. I sometimes do dangerous or risky things just for fun.

T F 20. I have experienced a major stressful life event in the past 12 months.

T F 21. I feel that I have lived the right kind of life.

T F 22. It is easy for me to turn down an unreasonable request from a friend.

T F 23. I have feelings that something bad will happen to me.

T F 24. I feel like I have lost energy. I am fatigued and tired.

T F 25. I often have feelings of nervousness.

T F 26. I often feel sad or blue.

T F 27. A drink or two gives me energy to get started.

T F 28. I am probably not capable of slapping someone, even when I lose my temper.

T F 29. When I get beyond a certain point, I don't stop drinking until all the booze is gone or I pass out.

T F 30. I don't like to break Rules, even if I think they are wrong.

T F 31. I hardly ever drink more than I plan to.

T F 32. I am not interested in surprising or upsetting others by doing something that might shock them.

T F 33. It depresses me that I did not do more for my parents.

T F 34. I like to gamble for money.

T F 35. After 7 or more drinks, I feel happier.

T F 36. I often acted without thinking as a child.

T F 37. I was referred for a liver test, or a blood test for liver enzymes.

T F 38. Since the age of 18, I have needed emergency treatment for an injury of some kind.

T F 39. I skipped school as a child.

T F 40. When I am drinking, I make sure I do not skip any meals.

T F 41. I often feel hopeless about the future.

Please answer the following questions by writing in your response on the line provided next to each question.

_____ 42. In the past five years, how many jobs have you had?

_____ 43. How many traffic tickets for moving violations have you ever received (i.e., speeding, running a red light or stop sign).

_____ 44. How much money do you usually spend on alcohol in a week? Include the cost of drinking at home, at friends' or relatives' houses, and in bars and restaurants.

_____ 45. If you go out drinking, how many places do you drink at in one evening? Include friends' end relatives' homes, as well as bars and restaurants.

_____ 46. What is the largest number of drinks you ever consumed in a 24 hour period. (one drink = a 12 ounce beer, or a one ounce shot of liquor, or a mixed drink, or a 4 ounce glass of wine, or a 12 ounce wine cooler.)

_____ 47. How many days of the week do you usually drink? If you drink less than once a week put in 1.

_____ 48. When you are drinking, how many drinks do you usually have?

_____ 49. How many drinks does it take before you begin to feel the effects of alcohol? (If currently not drinking Answer for period before the current DWI arrest).

Age

Date of Birth

Please Circle Your Sex. Male Female

Listed below are a few statements about your relationships with others. Please circle the number to indicate how much each statement is TRUE or FALSE for you.

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
50. I am always courteous even to people who are disagreeable.	1	2	3	4	5
51. I sometimes feel resentful I don't get my way.	1	2	3	4	5
52. No matter who I'm talking to, I'm always a good listener.	1	2	3	4	5

For Office Use Only.

Date

Course No.

Course Location

Total Score