Sierra County Health and Human Services

Social Services	Public Health	Behavioral Health	HHS Satellite Office
P.O. Box 1019	P.O. Box 7	P.O. Box 265	P.O. Box 38
Loyalton, CA 96118	Loyalton, CA 96118	Loyalton, CA 96118	Downieville, CA 95936
202 Front Street	202 Front Street	704 Mill Street	22 Maiden Lane
(530) 993-6720	(530) 993-6700	(530) 993-6746	(530) 289-3711
Fax (530) 993-6767	Fax (530) 993-6790	Fax (530) 993-6759	Fax (530) 289-3716
Lori McGee, INT Director	Rhonda Grandi, INT Director	Sheryll Prinz-McMillan, Director	

Thank you for making your first appointment with Sierra County Behavioral Health.

In order for us to provide services, please fill out the entire intake packet prior to your first appointment. At this time, please provide a valid picture ID, Sierra County Medi-Cal card and proof of residence such as a utility bill showing your physical address and your name. If the packet is not filled out in full or you have forgotten to bring it with you, we will need to reschedule your appointment. This may cause a delay in you receiving services.

Should you need assistance in filling out the paperwork, call our office at 530-993-6746 during normal business hours and we will be glad to assist you. You may request alternative formats. Our office is opened: M-F 8am-5pm; closed 12pm-1pm for lunch and on major holidays. For after-hours you can also call our toll free access line **1-888-840-8418.**

If you feel you are in crisis, please call our office during normal business hours. For after hours and weekends, call our 24-hour crisis line **1-833-723-2968 or 988** to speak with an on-call crisis worker.

Thank you for the opportunity to work with you,

Behavioral Health Front Desk.

Client #_____

Sierra County Behavioral Health Department
Demographic Form

Referral Source: Self Other_____ Referral Phone_____

Legal Name: Last Name:_____ First Name:_____ Middle:_____

Birth Name (If different from above) Last Name_____ First_____ MI_____

Alias (es): Last Name_____ First_____ Middle_____

Physical Address:_____

City: _____ State: _____ Zip+4: _____-_____

Mailing Address:_____

City: _____ State: _____ Zip+4: _____-_____

Home Phone: _____ **Cell Phone**:_____ **Work Phone**:_____

Driver's License/State Id: O Yes O No State_____ No._____

Social Security #:_____ Reason SSN Not Provided_____

Gender: _____ **DOB:**_____ O Actual O Estimated

Born in U.S. O Yes O No If No, what Country:_____

State:_____

County - if born in *California*:_____

Marital Status: O Married O Divorced O Separated O Widowed O Never Married

Mother's First Name:_____

Ethnicity: O Not Hispanic O Hispanic O Other Hispanic_____

Race: O Caucasian O African American O Native American O Other_____

Primary Language: O English O Spanish O Other_____

Communication Method: O Verbal O Translator O Sign Language O Other_____

Language Preferred (Individual):_____ (Caretaker):_____

Interpreter Needed? O Yes O No

Employment Status: O Full-time Job O Part-time Job O Actively looking for work O Homemaker
O Student O Volunteer Worker O Retired O Other_____

Living Arrangement: O House or Apartment O Foster Home O Adult Residential Facility
O Homeless O SNF/ICF/IMD for psych O Other_____

Number of Children under the age of 18 the Client cares for/responsible for 50% or more of the time_____

Number of Dependents age 18 or older the Client cares for/responsible for 50% or more of the time_____

Education: (highest grade completed)_____ **Special Education:** O Yes O No

Disability: O None O Developmentally Disabled O Mental Health O Hearing O Mobility
O Speech O Vision O Other Disability_____

Smoking Status: O Every Day O Some Days O Heavy O Light O Former O Never

Veteran: O Yes O No Branch:_____

Emergency Notification Information:

Name:_____ Relationship:_____

Address:_____ Home Phone:_____

Work Phone:_____ Employment Place:_____

Legal Information:

Responsible person:_____ Relationship:_____

Address:_____ Phone:_____

Medical Information:

Primary Care Physician:_____ Phone:_____ FAX:_____

Address:_____

Pharmacy:_____ Phone:_____ FAX:_____

Hospital Preference:_____

Advance Directive Given? O Yes O No

Notice of Privacy Practices Given? O Yes O No **Form Signed Date**:_____

Client Contact Information:

May we leave message at:
Home? O Yes O No
Work? O Yes O No
Cell? O Yes O No
Text? O Yes O No
May we leave message via **emergency contact**? O Yes O No
May we contact you by **email**? O Yes (email)_____ O No
May we contact you by **mail**? O Yes O No

Preferred Method of Contact:_____

Sierra County Health and Human Services

Notice of Behavioral Health Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES. PLEASE REVIEW THIS INFORMATION CAREFULLY.

1. Your Rights under Federal Privacy Standards

Your agency health record typically contains your history, current symptoms, progress notes, examination and test results, diagnoses, treatment, and planned care or treatment. Although your record is the physical property of the agency, you have the following rights:

A. The right to request restriction on uses and disclosures of your health information for treatment, payment, and health care operations: We do not have to agree to a requested restriction on disclosures of information. If we do agree to the request, we will adhere to it unless you request otherwise or we give you advance notice.

B. The right to ask us to communicate with you by alternate means: If the method of communication is reasonable, we will grant the alternate communication request.

C. The right to obtain a copy of this Notice of Information Practices: You have a right to receive a copy of this Notice of Information Practices upon request.

D. The right to inspect and copy your health information: In certain situations, such as if access could cause harm to you or somebody else, we can deny access. If we deny access to your health information, we must provide you a review of our decision to deny access.

E. The right to request amendment/correction of your health information: We will be unable to grant the request if the record is accurate and complete, or we did not create the record. If the party that created the record amends or corrects the record, we will put the corrected information into our records.

   If your request is denied, you can attach a statement of disagreement to your records and you can appeal the decision. If we grant the request, we will make the correction and distribute the correction to those who need it.

F. The right to obtain an accounting of uses and disclosures of your information: We must provide the accounting within 60 days. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

G. The right to revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

2. Examples of How Your Information may be Disclosed

Sierra County Behavioral Health has an ethical and legal obligation to protect the confidentiality of your information; however there are situations in which information obtained during the course of your care may be disclosed without your permission.

A. Child or Elder Abuse: If we have reason to believe that a child below the age of 18 or elder person (age 65 or older) is subject to abuse, neglect, or exploitation we are mandated by law to notify the appropriate authorities.

B. Duty to Protect: If we have reason to believe somebody is in imminent danger of harm from themselves or another, we are required to take appropriate action necessary to protect somebody from harm. This can include notifying law enforcement or notifying an intended target.

C. Disclosure for Payment: With your consent, we will use your health information for payment. For example, we may send a bill to you or to a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis and treatment received.

D. Business Associates**:** We may at some time provide some services through contracts with business associates. Business associates are required to comply with the same federal security and privacy rules as we do.

E. Appointment Reminders: We may call you using contact information you provide to give appointment reminders or to attempt to schedule an appointment.

F. Public Health: Where required by law, we may disclose information to authorities charged with preventing or controlling disease.

G. Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents health information necessary for your health or the health and safety of other individuals.

H. Legal Entities: We may disclose health information as required by law or in response to a valid subpoena or court order.

I. Other Health Care Providers: We may share information with other health care providers as needed to coordinate your care.

Your signature below serves as acknowledgement that you have read this Notice of Information Practices and any questions you have about Sierra County Behavioral Health Information Practices have been adequately answered.

_____ _____

Signature Date

CLIENT NAME:_____

Date : _____ Client Name: _____

C.I.N. #: _____ SS#: _____ DOB: _____

Placer-Sierra County Systems of Care

Behavioral Health Services Financial Form

Information from: ☐ Patient ☐ Responsible Person ☐ New ☐ Readmit ☐ Update

Financial Type: : ☐ Individual ☐ Family Program: ☐ Mental Health ☐ Substance Abuse ☐ Both

Name: _____ Relationship: _____

Billing Address: _____ City/Zip: _____

Home Phone #:_____ Cell Phone :_____

Employer: _____ Work Telephone #: _____

Other Source of Income: _____

Primary Insurance Company: _____ Veteran: _____ Claim No.: _____

Secondary Insurance Company : _____

Family Members In Treatment:

- _____
- _____
- _____

Income			Expenses		
Gross Monthly Income			**Allowable Expenses**		
Self	$	_____. 00	Court Ordered	$	_____. 00
Spouse	$	_____. 00	Child Care	$	_____. 00
Other: SS, Public Assist	$	_____. 00	Med. Exp. in excess of 3%	$	_____. 00
Unemployment, Disability			Mandated Deductible	$	_____. 00
Sub-Total (A)	$	_____. 00	Total (B)	$	_____. 00

Household Size (including self): _____

UMDAP Valid _____Through_____
(Uniform Method of Determining Ability to Pay)

Payment Plan Agreed Amount: $_____

Per : ☐ Month ☐ Visit

FOR OFFICE USE ONLY

Calculation of Annual Deductible Income

A. Subtotal - Gross Mo. Income	$	_____. 00
B. Total Allowable Expenses	$	_____. 00
E. Total Income (A-B)	$	_____. 00
F. MH Annual Liability	$	_____.00
G. Substance Abuse Sliding Scale	$	_____. 00

******Agreement to Pay Amount Due******

I affirm that the statements made herein are true to the best of my knowledge. I understand and accept my annual deductible and agree to pay the amount due on a timely basis.

******Assignment of Benefits-Release of Information******

I hereby assign all Behavioral Health Benefits to which I am entitled including Medi-Cal, Medicare, to Sierra County Department of Health and Human Services. This assignment will remain in effect until revoked by me in writing or until such time as I am no longer receiving Sierra County Behavioral Health Services. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible to pay any deductible amount referred to above if charges are not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ **DATE:** _____

Patient or Responsible Person

S.O.C. Representative: _____ **DATE:** _____

HEALTH QUESTIONNAIRE/MEDICAL HISTORY

Name:_____ Date:_____

Date of Birth:_____ Client ID#:_____

This questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.
   No ☐ Yes ☐ Date:
   Do you have any of the following symptoms?
   1. A cough lasting for 3 weeks or longer? No ☐ Yes ☐
   2. Coughing up Blood? No ☐ Yes ☐
   3. Fever or night sweats? No ☐ Yes ☐
   4. Unexplained weight loss? No ☐ Yes ☐
2. Have you ever had a stroke? If yes, please give details.
   No ☐ Yes ☐ Date:
3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.
   No ☐ Yes ☐ Date:
4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.
   No ☐ Yes ☐ Date:
5. Have you experienced or suffered any chest pains? If yes, please give details.
   No ☐ Yes ☐ Date:

Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.
   No ☐ Yes ☐ Date:
7. Do you take any medications for a heart condition? If yes, please give details.
   No ☐ Yes ☐ Date:
8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.
   No ☐ Yes ☐ Date:
9. Have you ever had high blood pressure or hypertension? If yes, please give details.
   No ☐ Yes ☐ Date:
10. Do you have a history of cancer? If yes, please give details.
    No ☐ Yes ☐
11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.
    No ☐ Yes ☐

Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.
    No ☐ Yes ☐ Date:
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
    No ☐ Yes ☐ Date:
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
    No ☐ Yes ☐ Date:
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
    No ☐ Yes ☐ Date:
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
    No ☐ Yes ☐ Date:
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
    No ☐ Yes ☐ Date:

18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If yes, please give details.
No ☐ Yes ☐ Date:

19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details including any ongoing pain or disabilities.
No ☐ Yes ☐ Date:

20. Please describe and date any surgeries or hospitalizations due to illness or injury that you have had.

_____

_____

_____

21. When was the last time you saw a physician? What was the purpose of the visit?

_____

22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
No ☐ Yes ☐

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.
No ☐ Yes ☐

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.
No ☐ Yes ☐

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.
No ☐ Yes ☐

26. When was your last dental exam? Date:_____

27. Are you in need of dental care? If yes, please give details.
No ☐ Yes ☐

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.
No ☐ Yes ☐

29. Are you pregnant? No ☐ Yes ☐ Due Date:

30. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

31. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

32. Please list current medications:

Type of Medication	Dosage

33. Do you have a Primary Care Physician? No ☐ Yes ☐ _____

Date of last visit and reason why _____

I declare that the above information is true and correct to the best of my knowledge:

Client Signature:_____ Today's Date:_____

Counselor Signature:_____ Today's Date:_____

Sierra County Drug & Alcohol Individual &Group Rules

- *Appropriate dress is required. No shirts with logos or drug/gang-related apparel, baggy pants, short shorts, sunglasses, or hats.*

- *Cell phone use is not permitted in sessions. Please turn off cell phone before entering the session.*

- *Swearing, derogatory statements and /or abusive language is unacceptable.*

- *Tobacco use (including vaping/chewing tobacco) is allowed in designated areas only.*

- *If you are more than five (**5)** minutes late for your session/group, you will not be allowed to enter the session/group and will be charged an absence.*

- *You may only leave sessions to use the restroom (no other reason).*

- *Do not bring any visitors or children to sessions.*

- ***NO FOOD OR DRINK** in sessions, (bottled water acceptable).*

- ***If we suspect that you are under the influence, you will be asked to leave and face the possibility of being dismissed from the program.***

Group Protocol

- Confidentiality! Who you see here - What you hear here – STAYS here!
- Talk one at a time
- Address the Group
- Avoid giving advice- focus on SELF
- Participate!
- Respect each Group member
- Disruptive behavior will not be tolerated and you may be asked to leave the premises

I have read and understand the above rules and agree to the terms and conditions set forth.

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness Date

SIERRA COUNTY Health and Human Services

Social Services
P.O. Box 1019
Loyalton, California 96118
202 Front Street
530-993-6720
Fax 530-993-6767

Downieville, California
P.O. Box 38
Downieville, California 95936
22 Maiden Lane
530-289-3711
CPS 530-289-3720
Fax 530-289-3716

Mental Health/Drug/Alcohol
P.O. Box 265
Loyalton, California 96118
704 Mill Street
530-993-6746
Fax 530-993-6759

Health Department
P.O. Box 7
Loyalton, California 96118
202 Front Street
530-993-6700
Fax 530-993-6790

SIERRA COUNTY DRUG/ALCOHOL PROGRAMS
P.O. BOX 265
LOYALTON, CA 96118

CLIENT AGREEMENT AND CONSENT TO TREATMENT

I, _____, have been informed of treatment. I agree to participate in the counseling process and will aid to the formation and completion of my treatment plan. Appointments will be set up for me and I agree to attend as scheduled. If I am unable to make a scheduled appointment, I will call to cancel/reschedule as soon as possible (preferably 24 hours in advance). I further understand that I am obligated to pay for services according to the sliding scale as explained to me by my counselor. All counseling sessions are confidential, but I understand that my counselor is obligated by law to inform appropriate parties if I am in danger or I am causing DANGER TO SOMEONE ELSE.

_____ _____

Signature of Client Signature of Witness

_____ _____

Signature of Parent or Legal Guardian when applicable Date

Sierra County Substance Use Disorders

INFORMED CONSENT

Welcome! All of us at Sierra County Behavioral Health Substance Use Services want your experience with our agency to be positive and helpful. We want you to feel welcomed and comfortable here and encourage you to speak with your therapist/counselor or one of the supervisors if you have any concerns about your treatment.

CLIENT RIGHTS

As a client of Sierra County Health and Human Services Department you are entitled to be treated with respect and with dignity at all times by all staff at this agency. Sierra County AOD/Mental Health provides care to clients and does not discriminate based upon race, ethnicity, physical or mental disability, religious beliefs, economic circumstances, gender, age or sexual orientation. If at any time you feel you have been discriminated against, please do not hesitate to contact the Sierra County Quality Assurance, Jamie Franceschini at 530-993-6770.

You have the right to be accorded access to your file. If you should want to see your file, please speak to the Sierra County Director of Behavioral Health or the Administrative health assistant for AOD services, about the procedure regarding client access to files.

You have the right to fully understand your financial obligation and the billing process for your treatment here with us. If you have concerns or questions related to charges for services, please speak with the Drug & Alcohol Administrative Secretary.
Your treatment here is voluntary unless you are court-ordered to receive treatment from us. You may choose to discontinue your treatment at any time. If you do not feel comfortable with your counselor/therapist, you have the right to ask to be transferred to a different counselor/therapist; however, we encourage you to process your decision with your counselor/therapist or the Sierra County Clinical Director of Behavioral Health services.

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1. EFFECTIVENESS OF SERVICES

Treatment is most effective when there are occasional discussions about your progress and counseling experience. You will develop a treatment plan collaboratively with your counselor and participate in a review of your treatment and progress every thirty (30) days.

If you feel your treatment is not helping you, please inform your counselor/therapist so that your treatment plan can be revised. Revision may include an increase in services, if that is what you need for your recovery services.

2. ATTENDANCE

Your time is reserved for you. If you must cancel, please provide 24-hour notice or call in before or by 8 am, the day of appointment. Otherwise, you may be charged a maximum fee of $15.00 for a no show/no call.

Individual sessions generally last for fifty (50) to sixty (60) minutes. If you are five (5) minutes late for a session, this will be considered a “no show”, and your appointment will be considered an absence. You may reschedule your appointment. If you arrive late for an appointment, your appointment will still end at the designated time. You are expected to arrive to all appointments on time.

Repeated absences/failure to participate in treatment will result in a re-evaluation of your treatment plan and may result in discontinuation of services.

3. COMMUNITY RESOURCES

A list of community resources is available. If you would like a copy of Sierra County’s Resource Guide, you may obtain one at the front desk.

4. TB/HIV TESTING AND COUNSELING

Confidential TB and/or HIV testing is available through Sierra County Public Health. If you would like testing and/or counseling, inform your counselor.

5. ALCOHOL AND DRUG TESTING

The Sierra County AOD program does not perform drug and alcohol tests. If you are mandated to be tested contact your probation officer to identify those testing services available to you.

6. ABSTINENCE

Participants are expected to abstain from mind-altering substances while accessing treatment services, including alcohol. Use of prescription medications as prescribed is allowed. The need to explore alternative medications with your doctor may be addressed on an individual basis where there is risk of cross addiction or relapse related to prescription drug use.

7. RELAPSE

It is recognized that relapse can be a part of the recovery and treatment process. If you are unable to abstain, inform your counselor/therapist so your treatment plan can be revised to meet your recovery needs. If you are a participant in a drug diversion program and undergo a relapse episode, your recovery needs will be discussed with the appropriate personnel (Drug Court team, Probation Officers, treating psychiatrist) and a treatment plan will be constructed which addresses both your legal requirements and treatment needs.

8. DISCONTINUATION OF SERVICES

If you are not seen for a face-to-face counseling session in a thirty (30) day period, we are obligated to close your file, per state regulations. Should your file be closed, you will be eligible to participate in another intake and assessment process, and this would be considered a new admission.

9. CAUSE FOR DISCHARGE

Refusal to follow the rules of the program can be cause for discharge.

Any violence or threats of physical violence will result in immediate discharge from treatment. Individuals are prohibited from possessing guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers acting in the line of duty) at Sierra County Behavioral Health.

Failure to make progress in treatment despite all treatment plan revisions increases in level of care and supportive services offered can be cause for discharge from program services.

Failure to treat other clients and staff with respect can result in discharge from program services.

If a client is suspected of being under the influence of any mind-altering substance at the time of treatment, the client will be asked to submit to a breathalyzer in addition to being excused from the session. Clients will not be permitted to drive if there is reason to suspect or if a breathalyzer test confirms the client is under the influence.

Sierra County Alcohol and Other Drug Treatment services reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without good cause.
In the event of discharge from program services, clients will be given referrals to other resources.

10. READMISSION TO PROGRAM

If you have been discharged for any of the aforementioned reasons and have participated in the Sierra County AOD program under voluntary circumstances you may request to be readmitted to services. You will be required to participate in another intake and assessment process. If the assessment reflects you will benefit from a continuation of services, this process will be considered a new admission.

If you are discharged for any of the aforementioned reasons and are a participant of a drug diversion program, your counselor will communicate with the drug diversion team said reasons. Your successful participation in a recovery and treatment program is the preferred course of your AOD and drug diversion team. If appropriate you will be offered the opportunity to participate in a reassessment process and a revised treatment plan will be recommended to the drug diversion team for their approval.

11. CONFIDENTIALITY

Participants are expected to maintain the confidentiality of others participating in treatment services.

STATEMENT OF CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

According to the California Association for Marriage and Family Therapy Ethics code 2.1, and U.S. federal regulation regarding confidentiality of drug and alcohol treatment records, all clients are entitled to confidentiality in regard to their relationship with their therapist, including the nature and content of sessions and written records of client/therapist sessions. This means that your therapist will not disclose the fact that

there is a client/therapist relationship, nor will they disclose any information about that relationship without the client's express written consent on a "Sierra County Health and Human Services- Release of Confidential Information," form unless one of the four limits of confidentiality explained below apply.

Limits of Confidentiality – Please read below the four limits to this confidential relationship which shall necessitate disclosure of your identity by your therapist (to be read out loud by the therapist to the client in the initial session)

1) If I have reasonable suspicion or you disclose to me that there is abuse occurring at the present time toward a child in your home or that abuse has occurred in the past, I am mandated by California State Law to report abuse to the proper child welfare agency.
2) If I have a reasonable suspicion or you disclose to me that a dependent adult or an elder adult (66 years or older) in your home or in your care is being physically, sexually, or financially abused, or is being isolated, neglected or abandoned, I am mandated by California State Law to report elder abuse to Adult Protective services and/or the police.
3) If you communicate to me a serious threat of physical violence toward a reasonably identifiable victim or victims, I am mandated by California State Law to inform your intended victim and the police.
4) If a court compels me or if you give written consent.

I am permitted by law to break confidentiality under the following circumstances:

1) If I have reason to believe that your mental or physical condition is such that you present a threat of harm to yourself or another person or property, I will disclose information to whatever extent necessary to keep you and other people or property free from harm.
2) There are circumstances where I may be contacted by a client's attorney, or an attorney involved in a case which involves a client. If I am subpoenaed, I will claim privilege and will seek the client's counsel and legal counsel before responding to a subpoena.

12. MANDATED REPORTING

If an employee of Sierra County Behavioral Health has reason to suspect any of the following are occurring or may occur, they are legally obligated to make a report to the appropriate authorities:

Child abuse or neglect,
Elder abuse or neglect, including financial abuse,
Imminent danger to self, and/or
Imminent danger to others.

13. SOCIALIZING WITH CLIENTS

Note; it is against counselor codes of ethics to engage in social relationships with clients or former clients. If your counselor sees you in public, you are welcome to initiate a conversation. They may avoid initiating a conversation with you, in order to protect your privacy. If you wish to discuss your case, you are encouraged to contact your counselor at the office during regular business hours.

14. FOLLOW-UP

Upon discharge from the program, a member of Sierra County Human Services AOD staff may attempt to contact you for the purpose of follow-up, with your permission. Please initial one of the following statements to indicate whether or not you are willing to participate in a follow-up contact (note the follow-up contact assists us in monitoring the effectiveness of our services):

a. **Yes**, I am willing to participate in a follow up contact, following discharge _____ .

b. **No**, I do not wish to participate in a follow-up contact. Please do **not** _____ contact me for this purpose.

15. GRIEVANCE

If you have a complaint about services, feel free to contact the Behavioral Health Director at 993-6746 or the Quality Assurance Coordinator at 993-6770.

_____

Sign whichever consent statement is applicable to your situation below (adult consent or guardian consent for minor):

ADULT CONSENT

I have read and agree with all conditions set forth in the Informed Consent. I agree to participate in services with Sierra County Department of Alcohol and Drug Programs.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

GUARDIAN CONSENT FOR MINOR

I have read and agree with the conditions set forth in the Informed Consent. I agree to

allow my minor child, _____ (name of minor) to participate in alcohol and/or other drug treatment services with Sierra County Department of Alcohol and Other Drug Programs.

_____ _____
Parent Signature Date

_____ _____
Minor Signature Date

_____ _____
Witness Signature Date

Sierra County Behavioral Health Services
Consent for Treatment Using Teleconferencing Equipment

Your Sierra County Behavioral Health program has agreed to provide Mental Health and Substance Use services utilizing teleconferencing equipment.

Nature of Telehealth Consultation: Teleconferencing is a simple technology. It requires the use of a monitor and/or television and a small camera to talk to another person over secured data lines, much like a face-to-face contact and in real time. This service is confidential. This is not a satellite or broadcast service; it is a video signal sent over dedicated data lines in what is referred to as a "site-to-site connection." This is a standard considered the most secure and confidential.

Tele-counseling will use this same technology to provide you with your MH/SUD care. You will see your counselor for regular visits, crisis evaluations, and treatment planning, just as you would if your counselor were in the office. You will sit and talk with the counselor as you would if the counselor were in the office. Your treatment should not change significantly, except to receive more trained, specialized, and accurate treatment without waiting or driving for significant periods of time. You would have the opportunity to discuss your needs and have them resolved to the best of our ability.

Associated Risks: Reasonable and appropriate efforts have been made to reduce the risks associated with Telehealth consultation, and all existing confidentiality protections in compliance with CFR 42, and under Federal and California laws apply to information disclosed during this Telehealth consultation. Despite these measures and protections, there remains a risk that: the transmission of information could be disrupted or distorted by technical failures in transmission; the transmission of information could be intercepted by unauthorized persons; and/or the electronic storage information generated by this Telehealth consultation in one or more databases could be accessed by unauthorized persons. In addition, Telehealth consultation may not be as complete as face-to-face care.

Rights: Using Telehealth consultation is voluntary and in no way diminishes your rights as a client and you continue to have the right to withhold or withdraw your consent to Telehealth consultation at any time without affecting your right to future care or treatment and without risking the loss of your health insurance coverage. You have the option of using a face-to-face visit with a counselor/clinician/doctor. You will need to ask your agency for this information if you wish to pursue this option. As a Medi-Cal beneficiary, you have the right to request transportation to and from your appointments when other available resources have been exhausted.

The laws which protect the confidentiality of Mental Health and Substance Use Disorders information apply to Telehealth consultation. No information or images from the Telehealth consultation which identify you will be disclosed to researchers or other entities without your consent.

I have read and understand the above and give my consent to participate in Telehealth services using teleconferencing equipment.

Client Name (PLEASE PRINT)	Guardian Name (PLEASE PRINT)
Signature of Client or Guardian	Date

I **do not agree** to participate in Telehealth treatment using teleconferencing equipment.

Client Name (PLEASE PRINT)	Guardian Name (PLEASE PRINT)
Signature of Client or Guardian	Date

Sierra County Behavioral Health Services
Medical Marijuana Treatment Agreement

Clients are required to abstain from ALL mood-altering substances while in outpatient treatment for substance use disorders. Exceptions to this requirement are those clients who are taking prescribed medications and/or those individuals providing the required documentation for the se of medical marijuana under local and California Medical Marijuana Laws.

____ N/A-I do not use medical marijuana.

As a medical marijuana user, in order to be admitted and to remain in outpatient treatment, I agree to comply with all of the following:

____ I will provide a valid copy of my medical marijuana card verifying my medical need.
____ I will present a letter signed by my prescribing physician verifying the medical necessity for my use of medical marijuana.
____ I will sign a Release of Information to my physician allowing my primary therapist/counselor and/or Program Clinical Director to discuss the reasons for and the appropriate use of marijuana for medical purposes.
____ I will discuss and explore alternatives to medical marijuana with my physician/primary therapist/primary counselor and Program Director.
____ I will not use marijuana 4 hours prior to coming to treatment sessions.
____ I will not use marijuana for other than its prescribed purpose.
____ I will not bring marijuana in any form, or drug paraphernalia, onto program premises except prescribed dronabinol (Marinol), a marijuana substitute.
____ I understand it is my responsibility to assure that I am not impaired or unable to participate in my treatment sessions.
____ I understand that if I appear impaired, my counselor/therapist may ask me to leave the session.
____ Being asked to leave may be considered a failure to comply with my treatment agreement and may result in my being discharged from the program.
____ I further acknowledge that the program has the right to refuse treatment if I am unable or unwilling to comply with any provision of this agreement.

_____ _____
Client Signature Date

_____ _____
Staff Member Signature Date

SIERRA COUNTY SUBSTANCE USE DISORDERS

PARTICIPANT'S BILL OF RIGHTS

Sierra County's bill of rights ensures that individuals receiving treatment for a SUD have the right to all of the following:

1. To be treated for the life-threatening, chronic disease of substance use disorder with honesty, respect, and dignity, including privacy in treatment and in care of personal needs.
2. To be informed by the treatment provider of all the aspects of treatment recommended to the client, including the option of no treatment, risks of treatment, and expected result or results.
3. To be treated by treatment providers with qualified staff.
4. To receive evidence-based treatment.
5. To be treated simultaneously for co-occurring behavioral health conditions, when medically appropriate and the treatment provider is authorized to treat co-occurring conditions.
6. To receive an individualized, outcome-driven treatment plan.
7. To remain in treatment for as long as the treatment provider is authorized to treat the client.
8. To receive support education, and treatment for their families and loved ones, if the treatment provider is authorized to provide these services.
9. To receive care in a treatment setting that is safe and ethical.
10. To be free from mental and physical abuse, exploitation, coercion, and physical restraint.
11. To be informed of these rights once enrolled to receive treatment, as evidenced by written acknowledgment or by documentation by staff in the clinical record that a written copy of these rights were given.
12. To be informed by the treatment provider of the law regarding complaints, including, but not limited to, to be informed of the address and telephone number of DHCS.
13. To receive ethical care that covers and ensures full compliance with the requirements set forth in Chapter 5 (commencing with Section 10500) of Division 4 of Title 9 of the California Code of Regulations and the alcohol and other drug program certification standards adopted in accordance with Section 11830.1, if applicable.

I have read and understood the above rights.

_____ _____

Signature Date

Sierra County
Substance Use Services
TB~ HIV ~ STD Information

Tuberculosis (TB) is a disease that affects the lungs. It can also affect the brain, kidneys or spine and can lead to death if untreated. TB is spread through the air, NOT by sharing dishes or kissing. A person can have a TB infection (TB Positive), but if you take medicine can prevent the disease from developing.

Risk of Acquiring TB
HIV infection
With an infected TB person
You injected illegal drugs
You're from another country
You visited another country

Symptoms of TB Disease
Bad cough for 3 weeks or longer
Pain in chest
cough up blood
Night sweats/fever/chills
weakness/tired/weight loss

TB testing is available at the Public Health Department.
TB can be treated with medicine. See your Public Health Nurse or your Physician.
For more information see the Public Health Department.

SEXUALLY TRANSMITTED DISEASES (STDS)

There many Sexually Transmitted Diseases that are either bacterial or viral which are acquired by unprotected oral, anal or vaginal sex. Some STDS are passed from mother to child during pregnancy.

SYPHILIS- Bacteria that if not treated can cause brain damage, heart disease and other major health problems. Can cause serious problems with babies if you are pregnant.

HERPES- A virus, Not life threatening but can increase your chances of getting HIV during unprotected sex. No cure but medicine can reduce outbreaks of sores.

HUMAN PAPILLOMA VIRUSES (HPV) - A virus which is most common in United States. HPV can be a precursor to cervical cancer in women. Men carry the virus on their penis; women carry the virus in the vagina. No cure at this time, but women need continuous monitoring with pap smears to watch for cervical cancer. Gardasil vaccine is available at the health dept to help prevent HPV, but will not cure it.

CHLAMYDIA/GONORRHEA- Both are a bacteria which can cause serious infections leaving a person (man or women) sterile, unable to have children. Medicine can kill the bacteria and both partners need to take the medicine.

Other STDS are Trichomonas, Molluscum Contagiosum, NGU, Chrancroid, and Hepatitis C which can all be acquired from unprotected sexual contact.

ALWAYS USE A CONDOM DURING SEXUAL ACTIVITY AND SEE A PHYSICIAN OR HEALTH DEPARTMENT FOR ANY PROBLEMS.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

HIV/AIDS is a disease that is spread from person to person by direct contact with infected body fluids (blood, semen, vaginal fluids and breast milk). Not by sneezing, shaking hands, sharing toilets or mosquitoes.

HIV destroys white blood cells which destroys the body's ability to fight off germs. HIV causes AIDS which makes a person very ill and can eventually kill them. HIV/AIDS is obtained by:

1. Sharing needles (IV drug users)
2. Exchange of body fluids (blood, semen, vaginal fluids, breast milk).
3. Mother passes HIV to infant during pregnancy.

A person can have HIV for 10 years and not know it, but is carrying the virus and passing it on to others by sharing needles or having unprotected sex. The only way to know if you have HIV is to get an HIV test.

HIV RAPID Testing is available at the Health Department.
Results are kept confidential. Test is done in 20 minutes.

FOR MORE INFORMATION ABOUT TB, STDS AND HIV/AIDS ASK FOR BROCHURES AT THE HEALTH DEPARTMENT.

I have read this information and have had all my concerns and questions answered.
I am aware of the testing for TB, HIV and STDS at the Health Department.

Clients Signature_____**Date**_____

Witness_____**Date**_____

Sierra County Human Services
Original Copy to be kept in chart