

# **Intensive Outpatient Treatment Contract**

## **Consent to treatment/patient rights**

### **I. Admission**

To be admitted you must complete an initial phone interview and an intake questionnaire. The interview is to gather information about your history and reasons for seeking treatment. If Dr. Stark cannot provide you with the most appropriate treatment, an agency that can better meet your needs will be recommended. Admission to treatment is never based on religion, race, ethnicity, sexual preference, sex, or age.

We rely entirely on payment for treatment services to pay for ongoing costs. Therefore, each client is fully responsible for payment of all costs associated with their treatment. A client without the means to pay for treatment will not be admitted.

### **II. Confidentiality**

I understand that only authorized persons will have access to my file and that no records, statements or data contained therein may be used to prosecute, charge, or otherwise infringe upon my civil rights. Thus, the confidentiality of my records has been assured to me as stipulated by:

42 CFR, Part 2 and Article 7 (commencing with Section 5325) or Subchapter 2, Part 1 of Division 5 of the Welfare and Institution Code.

I understand that my written permission is needed before any confidential information is released, EXCEPT under the following conditions:

1. To juvenile authorities when child abuse is observed or suspected (from Penal Code Section 11165.)
2. To prevent bodily harm to another person (Tarasoff vs. Regents of the University of California, 1976.)
3. To prevent self-induced harm or death (Johnson vs. County of Los Angeles, 1983.)

### **III. Treatment**

The experience of the individual who is attempting to discontinue alcohol or drug use is more likely to be successful if s/he participates in a comprehensive treatment program. The first twelve weeks of treatment focus on craving recognition and management through the use of behavioral tools that modify cravings and the compulsion to use drugs. Four treatment components are suggested: Relapse Prevention Workshop, individual counseling, medically supervised detoxification, and family counseling.

\_\_\_ I understand that medication alone is not sufficient treatment for my disease and I agree to participate fully in the education and relapse prevention program, as provided, to assist me in my treatment.

Medical Assessment: Dr. Stark will review the medical records and conduct a screening physical examination. The purpose of this assessment is to determine if the individual is sufficiently healthy to participate in outpatient treatment. Medications are used to relieve distress and alleviate symptoms of early abstinence that interfere with function and increase craving. Before medications are prescribed, the use of non-pharmacologic measures to treat withdrawal symptoms will be discussed. The individual patient will make the final decision regarding the use of medications.

\_\_\_ I agree to have a physical examination, screening laboratory tests, and to submit to urine drug testing when requested.

\_\_\_ I agree to have an active cell phone or contact number with an empty voice mail while in treatment.

Relapse Prevention Workshop: The goals of the Workshop are:

- \*Skilled use of avoidance strategies to manage environmental cues

- \*development of a structured, daily lifestyle

- \*recognition and management of craving episodes

Relapse Prevention Workshops meet twice weekly (except holidays) evenings in this office. The fee for Relapse Prevention Workshop is \$250 for the first month. The first month is included in the initial treatment fee and includes a one hour intake with a counselor. Additional months will be \$200 for 8 meetings.

\_\_\_ I agree to attend Relapse Prevention Workshop at least twice weekly for at least 3 months.

\_\_\_ I agree to conduct myself in a courteous manner, to be respectful of the rights of others, and to maintain the confidentiality of the other Workshop participants.

\_\_\_ I agree to be on time for all Workshop sessions.

\_\_\_ I agree not to seek or engage in intimate relationships with other Workshop participants because this is unsafe for my recovery.

\_\_\_ I agree not to deal, steal, or conduct any other illegal or disruptive activities and I understand that such behavior is grounds for immediate dismissal without recourse for appeal.

\_\_\_ I agree not to arrive intoxicated or under the influence of drugs. I understand that if I am intoxicated I may not be seen and I will not be given any medication or prescriptions until my next scheduled appointment.

Medication Monitoring: Medical detoxification is defined as the use of medications to treat drug withdrawal symptoms. Medications are used to relieve distress and promote recovery by alleviating symptoms of early abstinence that interfere with function and increase craving. Before medications are prescribed, you will complete a standard medical history and physical assessment.

Brandan Stark D.O. provides the medical services, which are billed separately from the Relapse Prevention Workshop.

\_\_\_ I agree that my medication prescriptions can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

\_\_\_ I agree to take my medications as the doctor has instructed and not to alter the way I take my medications without first consulting the doctor.

\_\_\_ I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reason for such loss.

\_\_\_ I agree to keep and to be on time for my scheduled appointments with the doctor or assistant.

\_\_\_ I understand that using legal drugs or street drugs while I am taking medications to help with drug withdrawal symptoms may cause serious medical problems and may cause death.

\_\_\_ I agree not to obtain medications from any physicians, pharmacies, or other sources without informing Dr. Stark

\_\_\_ I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

#### IV. FEES

The fee for the first four weeks of treatment is \$435 payable in advance. This includes 2 office visits and all group counseling sessions.

If you have insurance we can, as a courtesy, bill them. Office visits are usually covered, but at this time counseling is not. Any insurance payments received will be refunded back to you, but the ultimate responsibility is yours.

The four weeks start on the day of your medical assessment. Failure to attend recommended treatment sessions, regardless of the reason, will not result in a refund. **This fee is not refundable under any circumstance.**

Subsequent four week periods will be negotiated based on our assessment of your needs and generally will not exceed \$300, unless additional medical/psychological evaluation is needed. **This fee is not refundable under any circumstance.**

\_\_\_ If there is a persistent problem with attendance or payment of fees, I understand that my treatment may be terminated, and I will be referred to another provider or agency for follow-up care.

\_\_\_ Detoxification medications must be paid for separately, at the pharmacy of your choice. This fee does not cover inpatient treatment or psychiatric care.

**V. Discharge**

1. I understand that follow-up interviews are conducted following discharge. The interviews are confidential and have no bearing on re-admission or referral to other services. I recognize that by cooperating I am making a contribution to improve services and to better understanding of the treatment of addictive disease overall.
2. I fully understand that Dr. Stark reserves the right to terminate my treatment when the conditions of this contract are violated. In case of termination, I will receive a referral to another source of care.
3. I understand that Dr. Stark does not release medical records directly to the patient. Records are released to any designated treatment provider or to legal counsel upon receipt of a signed and witnessed consent form. A fee is required to pay the costs of duplicating and mailing the record. Alternatively, an appointment may be scheduled and the record reviewed in consultation with a designated clinician. A fee is required to pay for clinician time.

I \_\_\_\_\_ have reviewed and understand the above policies and give my consent to receive treatment from Dr. Stark.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
date

\_\_\_\_\_  
Signature of representative of Dr. Stark

\_\_\_\_\_  
date

## **FEE SCHEDULE**

Intensive Outpatient Program First Month Set FEE of \$435

This includes:

Initial medical assessment and one follow up visit

Relapse Prevention Workshops twice weekly

Drug testing

Second Month's set Fees for service minimum \$269. This includes:

One office visit

Relapse Prevention workshops twice weekly

Drug testing

Third Month's set fees for service minimum \$269. This includes:

One office visit

Relapse prevention workshops twice weekly

### **Drug Testing**

Extra costs: personal psychotherapy (recommended), medical evaluation of other coexisting medical problems, no show for extra scheduled medical visits (without 24 hour notice). Treatment needs beyond 3 months will be negotiated.

### **Your Personal Rights**

You have the right to confidentiality; to be treated with dignity; to be safe, healthful and comfortable; to be free from intellectual, emotional and/or physical abuse.