

SPIRIT 2 SPIRIT

Healing

Personal Information

Dates of Program: _____ Location: _____

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Female: _____ Male: _____ Trans: _____ Other: _____

Address: _____
Street City State Zip code

Email: _____ Home Phone: _____ Cell Phone: _____

Dietary Restrictions: (Food Allergies, Etc.) _____

Treatment History

Are you currently under the care of a therapist/psychiatrist/psychologist/counselor/life coach? Yes _____ No _____

Are you currently taking part in any 12 step programs? If so, please list all: _____

Are you currently under the care of a Physician for any major medical conditions? _____ Yes _____ No

If Yes: Dr's Name: _____ Phone: _____ Fax: _____

Email: _____ Illness: _____

Circle all types of Therapy and Treatments have you participated in (PHP, IOP, Residential, Psychotherapy, EMDR, DBT, SE, other/
name: _____

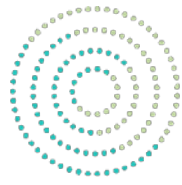
Are you currently on any medication? If yes, please list below: _____

Please let us know a little about what you hope to get out of this experience: _____

What was the first trauma or perceived trauma that you experienced? _____

Age? _____

Did you experience other traumatic events? If yes please describe: _____



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How do you cope with your emotions? _____

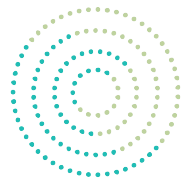
Have you ever felt suicidal? ___Yes or ___No If Yes, please describe: _____

Do you feel suicidal currently? ___Yes or ___No If Yes, please describe: _____

Are you currently using drugs or alcohol? _____ If Yes, please describe: _____

Please tell us anything else you would like us to know and feel free to type or write anything on an additional page:

How did you hear about Spirit to Spirit? _____
If referred by a professional, please provide us with their name and telephone # or email: _____



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I, _____ hereby authorize Spirit2Spirit Trauma Training & Treatment

(Check appropriate box) **To Release Information to:** **To Receive Information from:**

Persons/Facility/Agency/Relationship

The specific information indicated below regarding the services provided to me for the period of treatment

from _____ to _____ for the following purpose(s):

- Treatment at this facility
- Telephone updates (i.e., medical or clinical interaction)
- Written updates (i.e., medical or clinical interaction)
- Discharge Planning
- Discharges (Administrative, Transfer, AMA)
- Medical/psychiatric emergencies
- Processing of insurance, third party review, employee benefits claim, or other financial arrangements
- Other, Specify: _____

This disclosure authorization is specifically intended to include any references to diagnosis, testing, and/or treatment for communicable diseases, including sexually transmitted diseases (e.g. HIV/AIDS-related illness), mental health services and drug/alcohol services governed by 42 CFR Part 2.

PLEASE CHECK AND INITIAL REPORTS/INFORMATION YOU WISH TO BE FURNISHED: (YOU MUST COMPLETE THIS SECTION):

CHECK AND INITIAL

- _____/_____ Master Treatment Plan
- _____/_____ Counselor Discharge Summary
- _____/_____ Psychiatric Evaluation
- _____/_____ Laboratory Reports
- _____/_____ Discharge Plans
- _____/_____ Internal/External Consultations
- _____/_____ Psychological Evaluation Reports
- _____/_____ Progress Notes (medical, program, nursing)
- _____/_____ Letters and other correspondence (for Tx)
- _____/_____ Other, specify: _____

I understand that the above authorization is subject to revocation by me at any time, except to the extent that action has been taken in reliance on this authorization prior to revocation. In the event, if no expiration date is specified below, this authorization will automatically expire one year from the date signed noted below. The Federal Regulations of Confidentiality of Alcohol & Drug Abuse Records (42 CFR Part 2) and State law protecting the confidentiality of patient records have been explained to me.

Signature

Date



Client Responsibilities for Intensive Workshop

I UNDERSTAND THAT I AM EXPECTED TO:

- ❖ Be on time.
- ❖ Attend groups as scheduled per your treatment plan.
- ❖ Refrain from using tobacco products in buildings or non-smoking areas

I UNDERSTAND THAT I AM ASKED TO:

- ❖ Complete all assignments
- ❖ Complete Program Tasks and Treatment Plan Goals

I UNDERSTAND:

- ❖ That there is a procedure I may follow if I have a grievance
- ❖ That I may be searched and/or my property may be searched at any time during my participation in the program.

I UNDERSTAND THAT I AM RESPONSIBLE FOR APPROPRIATE BEHAVIOR and that when I act in an inappropriate way I am expected to be honest and own my behavior and its effects on myself and my peers. I will expect feedback from my peers and will expect appropriate consequences from the community. Some examples of behavior destructive to the program include:

- ❖ Unauthorized use of electronic equipment
- ❖ Conducting intimate relationships with another client
- ❖ Using Staff phones without permission
- ❖ Use of mood altering chemicals during treatment
- ❖ Contributing to the use of chemicals by another client
- ❖ Violation of Confidentiality

DRUG POLICY

Spirit2Spirit is an outpatient treatment program for people with trauma, alcoholism, process addictions or drug dependency problems. In order to maintain a therapeutic setting, THE USE OF INTOXICANTS WILL NOT BE TOLERATED. The following procedures are adhered to:

- ❖ A patient who is found to have any intoxicants shall be subjected to a Treatment Team decision for possible discharge.
- ❖ Visitors who are suspected or known to be intoxicated or who are suspected of bringing in intoxicants will be asked to leave the property promptly. They may be removed by staff if necessary. Police will be called if we suspect a visitor is operating a vehicle under the influence.
- ❖ The term ***intoxicants*** includes alcohol, marijuana, K2, Spice, all forms of synthetic drugs, barbiturates, opiates, benzodiazepines, cocaine, amphetamines, hallucinogens, glue and other vapors and any other mood altering substances.

REFUND POLICY

In the event that you are unable to attend the retreat, Spirit2Spirit Healing will give you a refund as long as you provide two weeks-notice. If cancellation is due to an emergency, you will be refunded. In either case Spirit2Spirit Healing reserves the right to hold your deposit and apply it towards a future retreat. I fully understand that if canceling, I will be financially responsible for any fees incurred by Spirit2Spirit Healing, due to payment method chosen and acknowledge that Spirit2Spirit Healing does not offer refunds for treatment rendered.

CLIENT CONSENT

The client responsibilities, daily living guidelines, and drug policy have been explained to me, and I agree to act responsibly in meeting these treatment guidelines. I will seek help from staff and/or clients if I do not understand any of the guidelines. I further understand that possession or use of any intoxicants or drugs not prescribed to me may be cause for discharge from this program.

Client Signature: _____

Date: _____





CLIENT LEGAL RIGHTS / GRIEVANCE PROCEDURE

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status or national origin are assured that their lawful rights as Patients shall be guaranteed and protected. While being served, the Patient is assured and guaranteed the following rights:

1. To be treated with respect and dignity.
2. To receive timely treatment by qualified professionals.
 - A. Every effort will be made to use the least restrictive, most appropriate treatment available, based on Patient need.
 - B. Each Patient shall be afforded the opportunity to participate in activities designed to enhance self-image.
 - C. An individualized treatment plan shall be developed for each Patient in accordance with the provisions established for each program component as required by the 65D-30.
3. To receive quality treatment that is best suited to his/her needs and shall include appropriate services medical, vocational, social, educational, and/or rehabilitative services.
4. To express by signature an informed consent of the right to release information for communication purposes, with other agencies.
5. To receive communication and correspondence from individuals.
6. To privacy for interview/counseling sessions.
7. To report abuse by the following toll-free number: 1-800-962-2873
8. To confidentiality, except where noted in the Federal Law of Confidentiality.
9. To receive full information regarding the treatment process.
10. To refuse treatment.
11. To all other constitutional and legal rights, including the right to personal clothing and effects.
12. To be informed of the Patient grievance procedure upon request.



CLIENT LEGAL RIGHTS / GRIEVANCE PROCEDURE

It is the policy of Spirit2Spirit to treat our patients with dignity and respect and in a humanitarian manner, utilizing standard treatment practices applicable to each patient’s needs. If, despite these efforts of Spirit2Spirit staff, a patient feels that his/her rights have been violated in any way, he/she will have a right to seek a remedy by filing a grievance.

Register a grievance in the following manner:

- A. In the event that a patient grievance arises, the aggrieved party shall complete a Grievance Form and immediately discuss his/her concerns with his/her Primary Therapist toward working out an appropriate solution and resolving the problem.
- B. If the Patient is not satisfied with the results, the Patient will then have the opportunity to discuss his/her grievance with Spirir2Spirit Director. This will occur within three (3) working days of the circumstance, which gave rise to the grievance. If the Patient fails to adhere to this requirement, and does not file a Grievance Form, his/her right to appeal shall be abrogated.
- C. If the Patient is not satisfied with the above results, the Patient will meet with the CEO. The CEO will evaluate the problem and discuss with the Clinical Director and the Primary Therapist. Resolutions will be completed by the CEO. The decisions made at this point are considered final. If the Patient is not satisfied, the Patient has the right to contact the Abuse Registry at (800) 962-2873.
- D. In the event that the aggrieved Patient does not obtain a satisfactory resolution to the grievance by means of the process outlined above, he/she may choose to seek resolution of same by contacting the Assistant Secretary, Substance Abuse and Mental Health Services at the Department of Children and Families at (850) 414-9063

Any allegations of physical or sexual abuse by a Therapist shall immediately be brought to the attention of the Clinical Director. The Patient will be afforded the opportunity to contact the Abuse Hotline and DCF. The number of the hotline is posted in the program office.

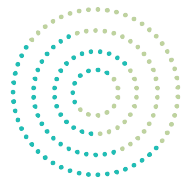
I hereby acknowledge receipt of and understand the “Patient Right” statement as indicated by my signature:

CLIENT SIGNATURE

DATE

STAFF SIGNATURE

DATE



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Consent for Treatment

- ❖ I give my consent to participate in Spirit2Spirit Trauma Healing Intensive and have received and understand Spirit2Spirit's rules. I agree to comply with the treatment program and the rules.
- ❖ I agree to follow Spirit2Spirit Workshop schedule and my individualized Treatment Plan.
- ❖ I agree to complete the Intensive Workshop for a minimum of 6 days.
- ❖ I understand that I must abstain from using alcohol and any other mind or mood altering substances throughout the duration of this program.
- ❖ I am capable of self-preservation. I can comprehend and respond to danger (such as prompt evacuation of a burning building).
- ❖ In case of emergency illness or accident, I authorize staff of Spirit2Spirit, IOP Staff or EMS to take me to the hospital of my choice, or, if I have no personal choice, to the closest hospital.
- ❖ I agree to follow the universal precaution:
 - o Program participants will allow staff to clean any toxic spills, blood, or other bodily fluids.
- ❖ I am entering Spirit2Spirit Intensive Workshop at my own request. I agree not to hold Spirit2Spirit, The Guest House Ocala, any of its Board of Directors and/or staff liable for any loss and/or injury to my person or property suffered by me while I am in or about the premises of the workshop facility.

THIS AGREEMENT SIGNED BY:

Client Name _____

Client Signature _____ Date _____

Staff Signature _____ Date _____