Insights Educational and Treatment Services, Inc.
1441 St. Andrews **Road**, Columbia, SC 29210 Phone 803.750.8444 Fax 803.750.7744

Assessment Screening

IMPORTANT

In order to better understand your needs, it is important that you answer all questions completely and honestly. As you answer these questions, keep in mind that we are interested in your entire history and not just today. All of this information is confidential and will be protected in accordance with federal confidentiality and privacy laws.

In your own words, please specifically describe why you are here today.

_____

PERSONAL DATA

Email address _____

_____ _____
First Name Last Name Middle Initial Today's Date

_____
Street Address, City, State, ZIP Code (If student, use university student box # or local address)

_____ _____
☐ Home/ ☐Cell Phone Emergency Contact/Relationship/Phone Number

_____ _____
If Under the Age of 16, Responsible Party Relationship to self

_____ _____ _____ ☐ M ☐ F _____
Social Security Number Date of Birth (mm/dd/yy) Age Gender Race

Marital Status ☐ Not Married ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Current Living Arrangements ☐ Live alone ☐ Live with spouse/partner ☐ Live with parents
☐ Live with roommate(s) ☐ Live with other family ☐ Live in dorm

Do you have health insurance? ☐ No ☐ Yes, Company _____

EMPLOYMENT DATA

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Student
☐ Unemployed/looking ☐ Unemployed/Not Looking ☐ Disabled/Unable to work

Name of employer_____

Address of employer _____

Employer's Phone _____ Fax # _____

REFERRAL INFORMATION

Who referred you to Insights? _____

Why were you referred? _____

Have you been a client of Insights before? ☐ Yes, approximate dates _____ ☐ No

HEALTH/MEDICAL

Are you feeling well today? ☐ Yes ☐ No

If not, please describe problems. _____

Do you have a persistent cough that has lasted 3 weeks in duration or tested positive for T.B.? ☐ Yes ☐ No

Are you aware of risk factors for HIV? ☐ Yes ☐ No

Are you currently under a doctor's care? ☐ Yes ☐ No

If yes, why are you being treated? _____

When was the last time you were seen by a doctor? _____

Are you currently taking prescription medication(s) ☐ Yes ☐ No

If yes, please list. _____

Are you having any problems with your medication(s)? ☐ Yes ☐ No

What medical conditions do you have? _____

Is there a history of medical problems in your family? ☐ Yes ☐ No

If yes, please list all. _____

Do you sleep well at night? ☐ Yes ☐ No

If not, provide details. _____

Would you describe your appetite as good? ☐ Yes ☐ No

If not, please describe problems _____

Are you sexually active? ☐ Yes ☐ No

Do you regularly practice protected sex? ☐ Yes ☐ No

Are you comfortable with your sexuality? ☐ Yes ☐ No

PSYCHOLOGICAL

Have you ever been treated by a therapist, counselor, psychologist or psychiatrist for any reason? ☐ Yes ☐ No

If yes, please provide approximate dates, locations and the reason(s).

_____

Have you ever experienced mood swings, extreme highs or lows,
or felt depressed for more than a few days? ☐ Yes ☐ No

If yes, please explain. _____

Have you ever felt like you were crazy or losing your mind? ☐ Yes ☐ No

If yes, please explain. _____

Have you ever thought about killing yourself? ☐ Yes ☐ No

Have you ever attempted or planned to attempt suicide? ☐ Yes ☐ No

If yes, please tell us about that. _____

Do you currently have any thoughts of harming yourself? ☐ Yes ☐ No

If **yes**, please tell a staff member **IMMEDIATELY**.

Do you have any thoughts of harming someone else? ☐ Yes ☐ No

Has anyone close to you ever attempted or committed suicide? ☐ Yes ☐ No

Please tell us about that. _____

Is there a history of depression/other mental illness in your family? ☐ Yes ☐ No

Please tell us about that. _____

Have you ever been sexually assaulted? ☐ Yes ☐ No

If yes, did you seek assistance? ☐ Yes ☐ No

Is it important for you to feel that you are always in control? ☐ Yes ☐ No

Do you often feel worried or anxious? ☐ Yes ☐ No
Do you often feel fearful? ☐ Yes ☐ No
Has your fearfulness kept you from doing things that you enjoy? ☐ Yes ☐ No

If yes, describe. _____
Do you often feel angry? ☐ Yes ☐ No
Has your anger (temper) ever caused you problems? ☐ Yes ☐ No

If yes, explain. _____
Have you ever experienced a violent or emotional outburst? ☐ Yes ☐ No

If yes, explain. _____
Do you own weapons/have access to them? ☐ Yes ☐ No
Have you noticed problems with your thoughts/thinking?
(Remembering things, confusion orientation to time and place) ☐ Yes ☐ No
Do you often feel guilty or ashamed? ☐ Yes ☐ No
If yes, describe. _____
Do you often feel stressed out? ☐ Yes ☐ No
On a scale of 1 to 10 (lowest to highest stress), describe your stress level. _____

What are your biggest stressors? _____

FAMILY / SOCIAL

Describe your current living arrangement. _____
Are you currently in a significant relationship? ☐ Yes ☐ No
Are you having any problems with the relationship? ☐ Yes ☐ No
If yes, describe. _____
Do you have any children? ☐ Yes ☐ No

How many? _____ What are their ages? _____
Are you experiencing problems with your children? ☐ Yes ☐ No
If yes, describe. _____
Describe your family of origin: ☐ Raised by two parents/same household
☐ Raised by two parents/separate households ☐ Raised by single parent
☐ Raised by grandparents/other relatives ☐ Raised by foster family(s)
☐ Raised in group home ☐ Other, please describe _____
Do you have brothers/sisters? ☐ Yes ☐ No
If yes, describe. _____
Do you have a good relationship with them? ☐ Yes ☐ No
Did you feel loved growing up? ☐ Yes ☐ No
Were you raised in a particular religion/faith? ☐ Yes ☐ No
Do you believe in God/Higher Power? ☐ Yes ☐ No
Do you currently attend church/worship? ☐ Yes ☐ No
Do you feel you are a spiritual person? ☐ Yes ☐ No
Do you worry about religious issues? ☐ Yes ☐ No
Was there violence in your home while you were growing up? ☐ Yes ☐ No
Did you witness violence between family members? ☐ Yes ☐ No
Have you ever been the victim of violence? ☐ Yes ☐ No
If yes, explain. _____
Were you ever touched inappropriately by a family member? ☐ Yes ☐ No
Would you say that you have a lot of friends? ☐ Yes ☐ No
Do you have at least one family member or friend in whom you can confide? ☐ Yes ☐ No

VOCATION/EDUCATION

Are you currently employed? ☐ Yes (Choose one: ☐ Full time ☐ Part time) ☐ No

Describe the type of work you do. _____

How long have you been with your present employer? _____

Do you enjoy what you do? ☐ Yes ☐ No

Where did you work before? _____

What would you like to be doing in five (5) years? _____

Are you a high school graduate? ☐ Yes ☐ No ☐ GED ☐ Currently enrolled

Highest level of education _____ grade ☐ High School ☐ Some college ☐ Associates' Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ PhD

Are you interested in pursuing education or training? ☐ Yes ☐ No

Have you served in the military? ☐ Yes ☐ No

Are you a combat veteran? ☐ Yes ☐ No

If yes, describe. _____

STRENGTHS/NEEDS/ABILITIES/PREFERENCES

What do you consider to be personal strengths? _____

What are some skills/abilities you have? _____

What are your hobbies/leisure time activities? _____

What do you do for recreation? _____

Do you have financial concerns? ☐ Yes ☐ No

If yes, describe your plans to address them. _____

What do you see as your needs at this time? _____

LEGAL HISTORY (LIST ALL CHARGES, ARRESTS and CONVICTIONS)

Month/Year	Reason for Arrest/Charge	Convicted?	If yes, date of conviction	Check if Alcohol or Drug Related
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug
		☐ Yes ☐ No		☐ Alcohol ☐ Drug

SUBSTANCE USE HISTORY – THIS APPLIES TO **BOTH** ALCOHOL AND OTHER DRUG USE

Have you ever been diagnosed with substance dependence? ☐ Yes ☐ No

Have you had medical problems/illnesses resulting from use? ☐ Yes ☐ No

If yes, describe. _____

Have you ever experienced memory loss during or after use? ☐ Yes ☐ No

Have you ever experienced cravings to use? ☐ Yes ☐ No

Has your sex life suffered due to your use? ☐ Yes ☐ No

Have you ever felt guilty or remorseful after using? ☐ Yes ☐ No

Are you more impulsive when using? ☐ Yes ☐ No

Do you become angry during or after use? ☐ Yes ☐ No

Do you become fearful during or after use?	☐ Yes	☐ No
Has your family expressed concern about your use?	☐ Yes	☐ No
Do you feel annoyed when others criticize/confront your use?	☐ Yes	☐ No
Are your parents/grandparents substance dependent?	☐ Yes	☐ No
Have your friends expressed concern about your use?	☐ Yes	☐ No
Have you ever harmed anyone while using?	☐ Yes	☐ No
Have you ever had a car accident while using?	☐ Yes	☐ No
Have you damaged property while using?	☐ Yes	☐ No
Have you ever done anything while using for which you were later ashamed?	☐ Yes	☐ No
Have you ever attempted to cut down or control you use?	☐ Yes	☐ No
Have you ever used more than you intended?	☐ Yes	☐ No
Have you ever used when you planned no to use?	☐ Yes	☐ No
Do you ever drink/use first thing in the morning?	☐ Yes	☐ No
Have you ever promised others that you would not use and then used anyway?	☐ Yes	☐ No
Do you need to use more now than you used to use to get the same effect?	☐ Yes	☐ No
Have you ever received treatment for your use?	☐ Yes	☐ No
Have you ever attended NA or AA meetings?	☐ Yes	☐ No
Have you ever abused medications?	☐ Yes	☐ No

If yes, please list. _____

How often did you use them and for how long? _____

Do you attribute your substance use/abuse to a major loss/trauma?	☐ Yes	☐ No

If yes, please provide information you are comfortable sharing.

_____

Do you smoke cigarettes?	☐ Yes	☐ No

If yes, how much do you smoke? _____

Do you believe you have a problem with alcohol/other drugs?	☐ Yes	☐ No
Do you feel you may be addicted to other things (gambling, sex, eating)?	☐ Yes	☐ No

_____ _____

Client's signature Date

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Notice of Privacy Practices

Please read and Sign

Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

How we use your patient health information We use health information about you for treatment, to obtain payment, for administrative purposes, for evaluation of the quality of care and so forth. Under some circumstances we may be required to use or disclose information even without your consent.

Treatment We will use and disclose your health information to provide you with medical treatment or services. We may also disclose the information to other health care providers who are participating in you treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment We will use and disclose your health information for payment purposes.

Operation We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to perform various routine functions (e.g. quality evaluations or records analysis). We may use your information to contact you. We may also contact you to provide information about referrals for follow-up with lab results, to inquire about your health or for other reasons. We may share your information with business associates who assist us in performing routine operational functions but we will always obtain assurance from them to protect your information the same as we do.

Special Situations We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information for audits and similar activities. In response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for workers compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization. Insights Education and Treatment Services, Inc. does not sale PHI or use PHI for marketing purposes.

Individual Rights You have certain rights with regard to your health information, for example

You may request restrictions on certain uses and disclosures of your health information. We are not required to accept all restrictions. If you pay in full for treatment or service immediately, you can request that we not share this information with your medical insurance providers or our business associates.

We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your health information. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information.

You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

If your unsecured PHI is breached, you will be notified via mail/email.

Our Legal Duty We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect.

We may update or change our privacy practices and policies at any time. Before we make a significant change of our policies, we will change our Notice and post the new Notice on our website. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

Richard M. Cole, MS, LPC, MAC, SAP, CCS, CEAP
Insights Educational and Treatment Services, Inc.
1441 Saint Andrews Road
Columbia, SC 29210
P 803-750-8444
F 803-750-7744
HIPAA South Carolina
US DHHS
Atlanta Federal Center, Suite 3870
61 Forsyth Street
Atlanta, GA 30303-8909

Patient Acknowledgement

☐ I understand that a health information is private and confidential. I understand that Insights Educational and Treatment Services, Inc. has Procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Insights Educational and Treatment Services, Inc. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

☐ This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of another Patient's private health matters, I will not disclose them to others, and will treat any such knowledge as strictly confidential and private.

☐ My signature verifies that I understand how Insights Educational and Treatment Services, Inc. may use my patient information, that I have read The "Notice of Privacy Practices" and agree to be seen and treated under stipulations as described.

Patient's Name	Date of Birth	Social Security Number
Signature	Witness	Today's date

Insights Educational and Treatment Services, Inc.
1441 St. Andrews **Road**, Columbia, SC 29210 Phone 803.750.8444 Fax 803.750.7744

Statement of Client Rights / Consent for Treatment

_____ _____
Client Name (Last, First, Middle Initial) Social Security Number

Client Rights

As a client of Insights Educational and Treatment Services, (Insights), you have the following rights

- The opportunity to participate in the ITP;
- Informed consent for treatment;
- Grievance/complaint procedures, including the address and phone number of the Department, and a provision prohibiting retaliation should the grievance right be exercised;
- Confidentiality of client's records;
- Respect for the client's property;
- Freedom from abuse, neglect, and exploitation;
- Privacy in visits unless contraindicated in the recovery and treatment process or as ordered by a physician or other authorized healthcare provider;
- Privacy during treatment and while receiving personal care;
- Respect and dignity in receiving care/treatment/services.

Confidentiality of Alcohol and Drug Abuse Records

Federal laws and regulations protect the confidentiality of alcohol and drug abuse client records. Generally, a program may not disclose information about clients or their care unless

1. The client consents in writing
2. The disclosure is allowed by a valid court order
3. The disclosure is made under the research and evaluation exception
4. In the event of a medical emergency
5. In the case of reported child abuse/neglect
6. The client commits/threatens to commit a crime against the program/against program personnel

*Withdrawal from services may cause a delay in readmission. If your participation in the program is the result of involvement with the criminal justice system, your legal status may be jeopardized by withdrawing from services or by failure to comply with program requirements.

My signature below indicates that my rights have been explained to me and that I understand all requirements, expectations and conditions of participating in services at Insights and I am desirous of services

_____ _____
Client's signature Date

_____ _____
Parent, Guardian or Authorized Representative Date

_____ _____
Witness signature Date

Revocation of Consent

_____ _____
Client/Parent/Guardian signature Date

Insights Educational and Treatment Services, Inc.
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Acknowledgement of Receipt of Notice of Privacy Practices

Insights has the responsibility to

- **Maintain the privacy of an individual's health information;**
- **Provide individuals with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about the individual;**
- **Abide by the terms of this notice;**
- **Notify the individual if we are unable to agree to a requested restriction; and**
- **Accommodate reasonable requests the individual may have to communicate health information by alternative means or an alternative location.**

Insights will not use or disclose an individual's health information without his or her written consent except as described in the notice.

Insights reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should Insights' protected health information practices change, a revised notice will be made available to you.

Please acknowledge receipt of the Notice of Privacy Practices by signing below.

_____ _____
Client's signature Date

_____ _____
Parent, Guardian or Authorized Representative (if required) Date

_____ _____
Witness signature Date

FOR INSIGHTS' STAFF USE ONLY
Insights attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An Emergency situation prevented us from obtaining the acknowledgement
☐ Other (specify) _____

_____ _____
Signature of Staff Member Date

Insights Educational and Treatment Services, Inc.
1441 St. Andrews **Road**, Columbia, SC 29210 Phone 803.750.8444 Fax 803.750.7744

Consent for the Release of Confidential Information

_____ _____
Client Name (Last, First, Middle Initial) Social Security Number

I, _____, authorize **Insights Educational and Treatment Services**
(name of client)
to disclose to _____,
(person or organization to whom disclosure is to be made)
the following information: Recommendations, Participation, Progress Reports, Treatment Plans, Reason for admission, attendance and discharge date, drug screen results and other information as indicated
_____.

The purpose of the disclosure is to coordinate treatment services including referrals and to obtain outcomes and follow up data.

I understand that my records are protected under the federal regulations governing Confidentiality, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows

12 months after discharge from services or upon written revocation
(specification of the date, event or condition upon which this consent expires)

I understand that, generally, this company may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign consent form.

_____ _____
Client's signature Date

_____ _____
Parent, Guardian or Authorized Representative* Date

_____ _____
Witness signature Date

Revocation of Consent

_____ _____
Client/Parent/Guardian signature Date

*Authorized representatives must demonstrate legal authority to sign

Continuity of Services

The continuity of services is very important in the therapeutic value of treatment. Treatment begins with the comprehensive bio-psychosocial assessment and continues with the Clinical Director staffing your case with your referent in order to formalize your Individual Treatment Plan.

Staffing your case may take a couple of days in the normal course of business. Once your case has been staffed, the Clinical Director will contact you to review your Individual Treatment Plan. If you do not review your Individual Treatment Plan with the Clinical Director for whatever reason within a week of your assessment, you are obligated to call Insights immediately in order to review your treatment plan.

Beginning groups/classes in a timely manner is essential in the course of treatment. Regular and uninterrupted attendance of groups/classes is required in order to complete services in a timely manner and to receive the most therapeutic value of treatment. If you miss more than one group/class, you must contact Treatment Staff to review attendance requirements.

If at any time you accumulate three absences, your case will be reviewed by the Clinical Director to determine if services will be continued.

_____ _____
Client's signature Date

_____ _____
Parent, Guardian or Authorized Representative Date

_____ _____
Witness signature Date

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New Client

Client First Name Last Name Middle Initial Today's Date

Street Address, City, State, ZIP Code (If student, use university student box # or local address)

☐ Home ☐Cell Phone Emergency Contact/Relationship/Phone Number

Email address If Under the Age of 16, Parent Name

Social Security Number Date of Birth (mm/dd/yy) Age ☐ M ☐ F Gender Race

Marital Status ☐ Not Married ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Name of Employer_____ Employer's Phone _____

☐ Retired ☐ Student ☐ Unemployed/looking ☐ Unemployed/Not Looking ☐ Disabled/Unable to work

INSURANCE INFORMATION	
Primary Insurance	Secondary Insurance
Policy Holder's Name	Policy Holder's Name
Policy Holder's Address	Policy Holder's Address
Policy Holder's DOB and Social Security #	Policy Holder's DOB and Social Security #
Policy Holder's Phone	Policy Holder's Phone

I hereby authorize assignment of benefits for all medical claims pertaining to Insights Educational and Treatment Services to be made to Insights Educational and Treatment Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release of all medical information necessary to secure the payment from said insurance companies. If this account has to be turned over for collection, the undersigned guarantor agrees to pay attorney fees if necessary and all collection fees, which is an additional charge above your normal charge. There will be a $35.00 charge added to your account on all returned checks. There will be a $35 charge added to your account for any balances that are 90 days past due and not paid in full. I have read and fully understand Insights Educational and Treatment Services Financial Policy given to me. I guarantee that I am of legal age.

Signature of client or responsible party if client is under 18 or disabled Date

Person financially responsible for balance not covered by insurance ☐ Client ☐ Spouse ☐ Guardian

I acknowledge that if I miss an appointment, or do not give a minimum of 24 hours notice of cancellation, that I will pay the cost of the session missed.

Signature of Client, Parent, Guardian or Authorized Representative Date

Reason for visit _____

How did you hear about us? _____