

Welcome to His House Recovery Residence! Where Safety, Serenity, Sobriety and God's Word Are "THE WAY" of Life.



## Program Admission and Consent Documents

**"Our mission is to serve God in fulfilling Christ's Great Commission by raising up and equipping disciples out of the ranks of those afflicted by substance abuse and its related emotional disorders."**

**His House Recovery Residence, a faith based sober living** environment, serves those in **recovery** from drug and alcohol **addiction** by providing **transitional living** accommodations in the **Atlanta** area. We are not simply another **sober house** or **halfway house**. His House is "*A Place for New Beginnings*." We combine **sober living** and **transitional housing** with a **12 Step Program, addiction counseling**, through a **holistic** approach to **recovery living**.

**As a faith based recovery residence**, our foundation for recovery is a **faith based** upon trusting in *Jesus Christ* and His promises of a full and productive life one can only experience from **sober living**. **Sober living** involves much more than living in a **Sober House** or a **Halfway House** in **Atlanta**. True Sobriety requires sound thinking and a healthy lifestyle. His House promotes and facilitates **addiction recovery** by teaching what a **faith based** in God's Word, prayer, and meditation coupled with a healthy diet and exercise will accomplish. Living in recovery from addiction is freedom from destructive pasts, people, places and play things and the restoration of families, careers and relationships.

Our program for **transitional living** provides a holistic approach, engaging 12-Step community, working in conjunction with County Services and law enforcement agencies, educational institutions, employment services, healthcare providers, and counselors trained professional **addiction counselors, who utilize evidence based practice methods to facilitate a holistic recovery for the client to integrate into their personal recovery journey**.

Facilitating these resources through increasing our client's motivation and teaching new abilities within the **transitional living environment that can then be applied to a mainstream life** with productivity and enrichment through Christ is an attainable reality. Quality **faith based transitional housing** in **Atlanta** doesn't have to be cost prohibitive either. Our **recovery housing** program fees are among the most competitive in **Metro Atlanta**.

We would like to welcome you to the His House and look forward to walking with you in your recovery journey.

Sincerely,

Kevin Weikum  
Executive Director, CEO and Founder  
His House Recovery Residence Inc.

## Program

His House Recovery Residence has an open ended transitional living program where one has long term support for as long as one embraces sober living, remains current with program fees and gets along with the other House Members. Recovery takes time. Here is a sober living home where one can take all the time one needs to heal, gain strength and succeed.

His House begins the transitional living process by helping meet our client's basic needs such as food, clothing, personal hygiene, healthcare and employment. We then coordinate a wealth of programs, curriculum and services available at low to no cost that further engage our members in daily sober living practices and life skills like education, discipleship, goal setting, communication skills, career choices, personal finances and family living. We stress personal responsibility and pride of ownership of one's person, place and things by assigning household chores, responsibilities and time tables for completion.

Like many halfway house programs, our recovery residence engages clients in community outreach and recreational activities like Alcoholics Anonymous, Narcotics Anonymous and Celebrate Recovery meetings, attendance and involvement in church related activates, mid-week Bible study groups, and group outings with family and other clients. We encourage family involvement and permit day and overnight visits with family members. Our clients enjoy sleepovers here with their children. All of which are therapeutic and teach our clients how to enjoy sober living without the presence of destructive substances, addiction and high-risk activities.

Sober living is simply, "normal"! And so is *accountability*, especially when one lives in a sober house with other sober people. Every person living in our recovery residence is held accountable by everyone in our program to stay sober and carry out our mission. So we employ tools like rules, urine drug screens, schedules, and meetings to keep our environment safe and serene. Our ultimate goal is to transition our clients from a life of chaos and destructive consequences into mainstream life complete with beauty, freedom, spiritual victory, and success.

## **Limits of Confidentiality**

The contents of your personal file are considered part of your health record and as such are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client.

It is the policy of His House Recovery Residence, Inc. not to release any information about a client without a signed Release of Information form. Noted exceptions are as follows in accordance with G.:

### **1. Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, we are required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, we are required to notify legal authorities and make reasonable attempts to notify the family of the client.

### **2. Abuse of Children and Vulnerable Adults**

If adult states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, we are required to report this information to the appropriate social service and/or legal authorities.

### **3. Prenatal Exposure to Controlled Substances**

We are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### **4. In the Event of a Client's Death**

In the event of client's death, the spouse or parents of a deceased client has the right to access their child or spouse's records.

### **5. Professional Misconduct**

Our team members must report professional misconduct by any of the other team members. In cases in which a professional or legal disciplinary meeting is being held regarding the actions of team member, related records may be released in order to substantiate disciplinary concerns.

### **6. Court Orders**

We are required to release records of clients when a court order has been placed. Clients who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the County Juvenile Court may have waived certain rights to confidentiality when entering into services.

### **7. Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records **except in the case of substance abuse records when the consent of a minor, regardless of age, is required to release the minor's record.**

### **8. Audio/Video Taping**

In the event it becomes necessary to audio and/or video tape a client for treatment or supervision purposes, a specific consent form for the purpose of audio and/or video will be required. No recordings of any kind will be conducted without the expressed consent of the client.

### **9. Drugs & Weapons in client's home**

Our clinicians are required to report any illicit drugs or weapons that they notice at client's home.

### **10. Other Provisions & Research**

His House Recovery Residence, Inc. does not conduct research on any of their clients. Outcome measures, pertaining to the effectiveness of the Agency's Programs, are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any client is disclosed, nor can any client be identified by any of outcome information collected by external entities. Information about clients may be disclosed in consultations with other

professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in file in the form of case notes. In the event in which we must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

Clients are informed of their responsibility to maintain confidentiality of all information seen, observed, or heard upon entering a group and agree to keep the confidentiality of all group members. A copy of the Consent for Services is given to the client. Any breach of confidentiality by a group member is grounds for immediate dismissal from group.

#### **Client's Rights and Responsibilities Information Disclosure**

Clients have the right to receive accurate, easily understood information. We will make any reasonable effort to accommodate Clients that might require assistance in making informed mental health care decisions about their services and professionals serving them.

#### **Choice of Providers**

Clients have the right to a choice of provider, in order to ensure access to appropriate high quality care. If you would like to contact another provider, with the approval of the court, you will be furnished a list of other providers providing similar services.

#### **Access to Emergency Services**

Clients have the right to access our services 24 hours/day, 7 days/week in case of an emergency. The therapist/paraprofessional are available on call at the phone number given to the consumer between 7 a.m. and 10 p.m. On-call staff member provides coverage, when the therapist or paraprofessional is off-duty. The emergency phone number is: (770.312.2598). The supervisor on call will have access to the on call psychiatrist for any psychiatric emergencies. For clients with hearing or speech disabilities, the services of Georgia Relay can be used by dialing 711.

#### **Participation in Treatment Decisions**

Clients and guardians have the right and responsibility to fully participate in all decisions related to services and to ensure that the client's preferences are included in all decision making processes. Clients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other legal entities. Clients have the right to discuss any treatment concerns with therapist, paraprofessional, or clinical director.

#### **Respect and Nondiscrimination**

Clients must not be discriminated against in the delivery of services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Clients and their families have the right to be treated with courtesy, respect and dignity at all times. Limitations to access to service do not infer or result in discrimination. These limitations (i.e. inability to effectively treat psychotic participants with active hallucinations, delusions, patients under the influence of drugs during the majority face-to-face contacts, families without stable housing, autistic patients and children and adolescents without parent/guardian, sexual offenders who are predatory) are discussed with referring agencies and clients/families. HIS HOUSE RECOVERY RESIDENCE Inc. will not discharge client because of the inability to get reimbursed for services due to lapse in Medicaid or PeachCare insurance coverage.

#### **Complaints and Appeals**

Clients have the right to a fair and efficient process for resolving disputes and differences with provider. Clients have the right to communicate freely with the therapist, paraprofessional, supervisor and clinical director. Client's complaint form is available upon request from the therapist or paraprofessional. If therapist or paraprofessional refuses to provide client with the complaint form, please contact one of the Clinical Directors Kevin Weikum

#### **Other client's rights**

Clients and their families have the right to have all program rules conveyed in an understandable manner. Clients have the right to have rights explained to them in a language they understand

## **His House Recovery Residence Rules & Regulations**

**INSTRUCTIONS: Forms Must Be Completed In Black Ink ONLY.** Read and initial in the blank provided for each rule. Do not sign the Rules Agreement without a staff member present.

It is reasonable to expect and encourage Clients to assume reasonable responsibilities. Greater individual involvement by Clients in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

### **Those responsibilities include:**

1. Clients have the responsibility to be a full participant in the formulation of their Holistic Recovery Plan.
2. Clients, have the responsibility to follow their Holistic Recovery Plan.
3. Clients have the responsibility to provide the service delivery staff with all required information to maintain proper and correct records.
4. Clients have the responsibility to attend required group/individual counseling sessions and be on time to groups and individual counseling sessions.
5. Clients have the responsibility to treat their therapist or paraprofessional with dignity and respect.
6. Client's performance during the treatment will be reported to the referral source, when it is required for treatment compliance with court orders.
7. Clients will not possess any drug without prescription, or alcohol including mouthwash and medications containing alcohol.
8. Clients will be required to take random drug / alcohol tests. Refusal is grounds for immediate termination from the program and premises.
9. Clients are responsible for any keys issued them. Replacement keys are \$5.00 each
10. No Pets Allowed.
11. Clients will be fully dressed in the common areas at all times
12. Violence, or threats of violence, emotional or physical, will not be tolerated. Conditions requiring contacting authorities will result in the immediate dismissal of the person(s) involved.
13. No weapons are allowed on premises or in vehicles.
14. All vehicles must be approved with the submission of proof of insurance and ownership. Vehicles must be in operating condition.
15. NO gambling of any kind.
16. Clients are not permitted to frequent environments detrimental to their recovery such as, bars, lounges, liquor stores, taverns, etc.
17. No smoking in the house
18. No pornographic materials or media.
19. Common areas are for relaxation and community interaction. No sleeping on the couches.
20. Laundry hours are 7:00 A.M. until 10:00 P.M. daily.
21. Clients are not permitted to loan money or automobiles to other clients.
22. All Clients will participate in chores. Chore List will be posted.

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### **Schedule of Program Fees**

23. Payment for participation is \$175 per week or \$700 per month. A \$30.00 Late Fee will be assessed if not paid by 10:00 A.M. Saturday.
24. There will be no pro-rated refunds for any dismissal for rule violation. (This means if you pay on Friday and are dismissed on Saturday there will be no money given back. No Exceptions)
25. Urine Drug Screen, \$10.00
26. Transportation Fees, 54c/mile
27. Missed Meeting Fee, \$20.00
28. Incident Fees, \$10.00
29. Intake Fee, \$400.00
30. Relapse Assessment and Re-Entry, \$150.00
31. Missed Work Day, \$50.00

**Court Ordered Clients: Non-Payment Is A Violation of The Court's Order!**

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## **Recovery**

32. All Clients must have a counselor or sponsor whose name and number will remain on file. Clients are expected to have regular contact with their counselor or sponsor at least once a week. House personnel are not admissible as sponsors.
33. All Clients are required to attend recovery meetings: 12 step programs, church or therapeutic counseling are permitted. 3 meetings per week is required. Meetings are documented with the signature of the chairperson. Forms are available.
34. If the Client is transitioning from a treatment facility all aftercare recommendations must be followed.
35. If on probation with a legal agency, the resident must adhere to all requirements made of them. This includes informing their probation officer of their current participation at His House.
36. All scheduled in-house Group Meetings, Wednesday's Bible Study, Emergency House Meetings, Sunday morning Church Services at God's Rolling Thunder Church (unless otherwise approved by Director) and at least 2 outside recovery meetings are mandatory and attendance is unconditionally required unless an exception is made by a staff member. Failure to attend a mandatory meeting will result in a \$20.00 sanction for each missed meeting and will be due with the following week's program fees. Failure to pay sanction fees when due will result in a \$30.00 Late Fee.

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## **Urine Drug Screen Policy**

37. Random urine drug and alcohol screening is a significant aide in the recovery process and is practiced at His House for the benefit of everyone participating here. Random screens are administered and supervised by staff. There is a \$10.00 fee for the screen. A list of banned substances is available from the Director.
38. A positive screen may result in a minimum 5 day expulsion from the program. During which time all fees must be kept current and no refunds will be given. Client will be referred to an agency for evaluation and counseling.
39. The cost of an Alcohol and UDS at Cherokee County's Lab is \$35.00 and is your responsibility.
40. Re-admittance to the program may require you to report to the Cherokee County DUI / Drug Court Lab no later than the following business day and submit to a drug and alcohol screen. Then after 5 days you must return to the same Lab for a follow up screen and the 2nd screen must indicate a lower presence of the banned substance before you will be allowed to return to the premises.
41. Failure to pass 3 urine drug screens at any time may result in immediate termination from the program.
42. Re-admission to His House will be considered after 7 days and will require an additional \$300.00 deposit. All failed screens will result in the forfeiture of off premises privileges, except for home, work, church, and supervised recovery meetings, or accompaniment by a house member with at least 30 days of sobriety.

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## **Off Premises Policy**

43. Off premises passes are allowed after 30 days with written authorization verifying the purpose and place of leave, Client is in compliance with program policies and program fees are current. House Members, during their 1st 30 days Clients are not allowed to leave the premises except for home, work, church, and supervised recovery meetings, or accompaniment by a house member with at least 30 days of sobriety.
44. Weekend passes are allowed after 30 days with 5 days prior approval and must include at least 1 recovery meeting while on pass and are subject to a UDS before and after the pass is granted.

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## **Phones and Computers**

45. House phones may be available for Client's use. Common courtesy is expected when others are waiting. No calls longer than 15 minutes.
46. Cell phones are permitted in Recovery Residences as a privilege which may be revoked if abused. Cell phones are not permitted at Bear Mountain Recovery in Ranger, GA. Conversations should be restricted to common areas out of respect for your neighbor. All ringers must be off by 10:00 P.M.  
**His House Recovery Residence Consent Agreement | Page 6 | Revised September 1, 2014**
47. Calls after lights out should be kept to a minimum out of courtesy to others. Phone use for illegal purposes will result in the loss of this privilege.  
The computer is provided for Client's use in job search activities and checking email. No game playing browsing adult websites, chat rooms etc.. No Downloading! Computer use for illegal purposes will result in the loss of this privilege.

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## **Personal Living Area**

48. Bedrooms are the sole domain of its occupants.
49. No guests, except family by blood or marriage, are allowed in bedrooms.
50. All rooms are to be kept clean and beds made daily prior to leaving the house.
51. His House is not responsible for losses or theft of personal property, including money, jewelry, clothing, etc.
52. No storage space is available for personal belongings beyond that which can fit in one's bedroom, however, bicycles and work tools may be stored with prior approval and is contingent upon availability of space.
53. Bedrooms are subject to daily inspections.
54. Staff Members Rooms are Off Limits, except by the expressed permission of that Staff Member.
55. A \$10.00 Fee will be assessed for each Sanction. Multiple sanctions can be assessed for failure to keep one's area in compliance with rules.
56. House Chores are assigned bi-weekly and must be completed to Staff's satisfaction. Failure to satisfactorily complete weekly chores by Sunday will result in the following sanctions: First Offense will result in the assessment of 1 house workday (8 Hrs.) to be satisfactorily completed within 2 weeks of assessment date. Second Consecutive Offense will result in a sanction fee of \$50.00 and 1 additional house work day.
57. No swimming pool privileges or off premises passes will be allowed until your area is in compliance and chores are satisfactorily completed. Third Offense will result in immediate termination from the program.

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## **Kitchen**

58. Paper towels, cleaning products, light bulbs and trash bags are provided.
59. All Clients are expected to clean up after themselves when cooking. Pots and pans are to be cleaned and put away. Plates, glasses, and silverware are to be put in the dishwasher.
60. Each Client will be assigned a separate cabinet for personal food storage.
61. Refrigerated items are to be labeled with Client's name. Unidentified items are fair game.

**Initial\_\_\_\_\_**

## **Visitors**

62. Guests of the opposite sex are not allowed on the premises between the hours of 10:30 P.M. and 7:00A.M. This includes sitting in a car talking in the driveway.
63. Visitors are allowed in common areas only. No visitors are allowed in bedrooms.
64. Clients are responsible for their guests and must ensure that they behave in accordance with the same rules as the Client.
65. House management must be informed of all overnight leave from the house.

**Initial\_\_\_\_\_**

## **Significant Others**

66. One of the most frequent causes of relapse is getting involved or reconnecting with a significant other early in recovery. Because of this we strongly discourage Clients from dating while in recovery at His House for a minimum of 1 year. Clients residing at His House are expressly prohibited from collaborating with one another. Pairing off with His House members of the opposite or same sex will not be permitted and is grounds for dismissal from the program. Contact with Clients of the opposite sex outside or apart from supervised group functions is expressly prohibited. If, however, a Client is married or formerly engaged with proof of engagement prior to occupancy, one is required to identify that person and the status of the relationship to house management by the time of acceptance into occupancy. Adultery and fornication (sexual acts outside of marriage) will not be tolerated.

**Initial\_\_\_\_\_**

## **67. His House Recovery Residence Consent Agreement |Page 7| Revised September 1, 2014 Employment**

68. All Clients are required to work or volunteer unless disabled. (30 hrs. minimum).
69. Clients must inform house management of job changes.

## **Warnings and Eviction**

73. Violations of any of the following will result in a warning. Accumulation of more than two warnings in a four-week period will be grounds for termination from the program.

- a. Failure to do assigned chores.
- b. Illicit use of computer or phone.
- c. Failure to maintain personal living area.
- d. Disturbing others after lights out.
- e. Smoking or use of candles or incense inside the house.
- f. Possession of pornography.
- g. Littering or improper disposal of cigarette butts.
- h. Pairing off or unauthorized contact with members of the opposite sex.
- i. Any failure to cooperate with house management.
- j. Failure to document meetings.
- k. Any violation of a Court Order, ie. Pre-Trial, Probation, Parole including non-payment of program fees.

70. Violation of any of the following may result in immediate termination from the program or relocation to the induction facility located at Ranger, Georgia.

- a. Use of illicit drugs prescribed to someone other than resident or any abuse of prescription, illegal or banned drugs including any use of over the counter energy supplements or beverages.
- b. Consumption of Alcohol or Energy Drinks.
- c. Leaving the premises for periods longer than 24 hours without informing house management.
- d. Threatening behavior of any kind or perpetuating violence or discord.
- e. Admitting visitors under the influence of mood altering substance.
- f. Stealing
- g. Adultery or Fornication
- h. Failure to pay program fees.
- i. Positive results from drug or alcohol screen administered by house management.
- j. Refusal to submit to the above tests when requested by house management.

**Initial \_\_\_\_\_**

## **Confidentiality**

71. Confidentiality and anonymity are foundational principals in recovery environments and must be safeguarded in order to protect the interests and future success of our clients. By signing this document I attest that I have read and agreed to the terms and conditions set forth in this program's official Confidentiality Agreement. I furthermore attest, under penalty of law, that I will not disclose the names, locations, policies and procedures, materials, discussion content, trade secrets or any other information disclosed to me, which may endanger, inconvenience, threaten, or cause any harm to any individual participant in this program or its facilities unless failure to disclose such information has or may result in felonious harm or injury to myself or another individual.

**Initial \_\_\_\_\_**

If mail must be received while you are our guest mail must be directed to our Corporate Office c/o His House Recovery Residence, Inc.

Addresses: Your Name  
c/o His House Ministries  
P.O. Box 701  
Kennesaw, GA 30144

Initial \_\_\_\_\_

### **His House Recovery Residence Rules and Regulations**

By initialing and signing these statements, I acknowledge that I have read, understand, and agree to comply by all His House rules and regulations. I further agree that the His House Recovery Residence Staff may implement additional rules or regulations for the community, or specifically for myself, if needed. I further agree to accept any consequences assigned by His House Recovery Residence Staff if I violate any rule or regulation of the program, including discharge from the program. I understand that if I am aware of any violation by another resident that I am to disclose such to a staff member or I become subject to the same sanctions as the guilty party. I also understand that there is an appeal procedure for any grievance that I may have with a consequence assigned, but that I am to adhere to this consequence until my appeal can be heard.

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**By Order of the Court:** By signing and initialing these statements. I acknowledge that if my participation in this program is by order of the court, ie. pre-trial sentencing, probation, parole etc., I will comply with all terms and conditions of the court's order and / or the rules, regulations and policies set forth in this agreement including, but not limited to, paying my program fees as scheduled and in full. I understand that failure to comply with any of the terms and conditions set forth by the court and / or the rules, regulations and policies set forth in this agreement; that I will be held in violation of the court's order and I will then be subject to immediate discharge from this program and or arrest and return to the custody of the court's appointed officials.

Initial \_\_\_\_\_

By signing and initialing these statements. I acknowledge that successful completion of this program of recovery will be attained upon completing a minimum of 12 months of clean and sober residential participation in this program as evidenced by consecutive clean urine drug and alcohol screens. A confirmed failed drug or alcohol screen will extend the successful completion date to 12 months after the date of the last failed drug or alcohol screen. Payment for said extension of time and services will be the responsibility of the Client and/or Client's Guarantor(s) for payment.

Initial \_\_\_\_\_

Client Signature Date \_\_\_\_\_

Staff Signature Date \_\_\_\_\_

## **HIPAA**

This section of the document contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. At any time, you may revoke this Agreement by submitting a written letter of revocation.

## **Professional Records**

The laws and standards of our profession require that we keep Protected Health Information about you and your family in your Clinical Record. Except in unusual circumstances that involve danger to yourself and others and we believe that access is reasonably likely to cause substantial harm to you or other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing, within 3 business days of receipt of written request.

## **Client's Right**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we

- 1)** Amend your record;
- 2)** Allow you to place restrictions on what information from your Clinical Record is disclosed to others;
- 3)** Provide you with accounting of most disclosures of protected health information that you have neither consented to nor authorized;
- 4)** Provide you with accounting of locations to which protected information disclosures are sent;
- 5)** Include any complaints you make about our policies and procedures in your records;
- 6)** Provide you with a paper copy of this Agreement and the attached Notice form, and our privacy policies and procedures.
- 7)** The client has a right to choose a provider. A list of Providers will be provided to client relevant to their location

## **Court Requirements for Mandated Clients**

His House Recovery Residence, Inc. is not a Law Enforcement or Court Agency. His House Recovery Residence, Inc. is a private contractor for Mental Health and Substance Abuse Treatment. His House Recovery Residence , Inc. does however, have a Memorandum of Understanding with all referral sources to report any illegal behaviors, including drug use, deprivation, neglect or abuse, and any other violations of probation or protective orders to the court or other appropriate authorities

## **Substance Abuse and Co-occurring Disorder Clients**

Positive Urine Drug Screen (UDS), Hair Follicle, and Blood panel results used to test for substance abuse will be reported in accordance with the terms of probation for court mandated clients.

## **Hours of Operation:**

His House Recovery Residence, Inc., Office hours are Monday – Friday from 8:00AM to 5:00PM.  
Emergencies: Clinicians/House Staff are available 24 hours a Day, 7 days a week through an on-call service. The on call phone, (770.312.2598), can be used during times when Recovery Staff cannot be reached.

Client: \_\_\_\_\_ Complainant: \_\_\_\_\_  
Relationship to the client: Self Guardian Parent Foster Parent (Circle One)  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Describe complaint, giving all facts (add pages if necessary/write on back):

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Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_  
Reported to : \_\_\_\_\_  
House Manager/Staff on Duty at Time of Incident:

Witnesses or others involved (names):

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Specific action requested by complainant:

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Complainant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

The completed form can be faxed to (678.445.1456) or mailed to our office address. You can call the Clinical Director in confidence, at (770.516.8638) to discuss your complaint. Grievances are reviewed by a executive board, originating information of complaint is not released in an effort to secure the anonymity of the individual filing the grievance.

# **Client Advocacy**

An intricate part of working with your family is gaining an ability to foster independence post your stay with His House Recovery Residence Inc. As part of that process His House Recovery Residence Inc, will facilitate open exchange of information pertaining to your rights while in our program and provide direction in location of agencies and organizations that can assist you in protecting those rights.

As a client of His House Recovery Residence, Inc., you have a right to expect advocacy in the following client rights categories:

## **1. Abuse and Neglect**

- a. Physical Abuse
- b. Verbal Abuse
- c. Sexual abuse
- d. Neglect

## **3. Admission and Discharge**

- a. Voluntary Admission
- b. Involuntary Admission
- c. Periodic Review
- d. Discharge
- e. Community Placement

## **5. Confidentiality**

- a. Confidentiality
- b. Disclosure of information
- c. Access to Media

## **7. Rights of the Person**

- a. Dignity and Privacy
- b. Education
- c. Entitlements
- d. Marriage and Divorce
- e. Religion
- f. Search
- g. Sexuality/Birth Control
- h. Smoking and Drinking

## **9. Consent**

- a. Competency
- b. Substitute Consent/Guardianship
- c. Obtaining Consent
- d. What Needs Consent
- e. Treatment

## **2. Freedom of Movement**

- a. Freedom of movement
- b. Seclusion
- c. Restraint

## **4. Communication**

- a. Telephone
- b. Mail
- c. Visits

## **6. Rights to Protection and Advocacy**

- a. Notice of Rights
- b. Compliant
- c. Grievance

## **8. Treatment**

- a. Right to Treatment
- b. Right to Refuse Treatment
- c. Individual Plan of Service
- d. Physical
- e. Behavior Modification
- f. Least Restrictive
- g. Environment

## **10. Personal Property and Money**

## **11. Work and Compensation**

## **12. Discrimination**

## **13. Environment**

## **Client Advocacy Contact Information**

### **Legal Issues:**

Aids Legal Project: (404) 614-3969  
The Cancer and ALS Legal Project (404) 614-3969  
Home Defense (404) 524-5811 Ask for County  
Family Law (404) 524-5811 Ask for County  
Seniors Legal Hotline (404) 657-9915  
Grandparents/Relative Caregiver Project (404) 524-5811  
Ombudsman-Mental Health (800) 436-7442  
DeKalb Legal Aid (404) 377-5381  
Health Law Partnership (404) 785-2005  
Southern Juvenile Defender Center (Emory)  
(404) 727-6235

### **County Legal Aid Offices:**

Fulton County (404) 524-5811  
Cobb County (770) 528-2565  
DeKalb County (404) 377-0701 Gwinnett County (678) 376-4545

### **State Child Advocate:**

Tonya C. Boga (404) 656-4200  
Spanish Speaking Child Advocate (800) 869-1150 or (404) 651-9367

## SCHEDULE OF FEES

<b>Admission Fee</b>	\$400.00	<b>Additional Services:</b> Additional service fees must be paid in advance. <i>Optional Gym Membership Fees</i> \$15.00 mo.
First Months Fees	\$700.00	
Total for admission	\$1,100.00;	
	The Admission Fee includes Intake Session, Bio/Psycho/Social Assessment, Nursing Assessment, Admission Drug Screen and the first months Residential Fees.	
<b>Residential Fee</b>	\$700.00/month \$175.00/week	<b>Relapse Chain Analysis Assessment</b> \$150.00/ea
	Monthly payments paid in (1) single payment at the onset of the month or weekly rates will apply.	
<b>House Fees</b>		<b>Court Services</b>
Incident Fee for rule violations	\$10.00	Jail Screenings: \$100.00
In House Urine Drug Screen	\$10.00	Court Evaluations: \$125.00
Late Fees	\$30.00	Court Transport Fee – local: \$ 75.00
	plus \$10.00 per day through discharge.	Transport Fee to and from other jurisdictions based on mileage.
Missed Meeting Fee	\$20.00	Court Appearance: \$100.00/half-day \$50.00 each half hour-after
Missed House Work Day Fee	\$50.00	
Aftercare Fee	\$50.00/wk	
		<b>House Arrest Program</b>
		Court Monitoring: \$300.00/month
		<b>Court Ordered Clients who fail to pay their court ordered fees and / or fines, including His House program fees and charges, are in contempt of the court's order and may be reported and / or remanded to the court having jurisdiction in the matter.</b>

\*\*There is a 3% processing fee for paying online. We use PayPal and are charged a 3% fee for using the PayPal service. The 3% processing fee is only charged to cover this cost. Online Payments need to be made by the appropriate payment deadlines. If processing fees or late charges are not included in the online payments, they are still due and will be collected from the clients. COURT SERVICES Jail screening and court appearance fees may vary from one jurisdiction to another, depending on distance of travel. The Metro Atlanta area includes City of Atlanta, Fulton County, DeKalb County, Cobb County, Clayton County and Gwinnett County. If your jurisdiction is not listed, please contact our office for a fee amount. Metro Atlanta Area Fees or jail screenings are \$100.00. The defendant's attorney should make arrangements with the appropriate authorities for a contact visit with our staff member to conduct a Mental Health Screening for Substance Abuse. This correspondence should be forwarded to our office as well. Metro Atlanta Area fees for Court Appearances are \$100.00 for a half day, then \$50.00 per hour thereafter. Our Staff needs as much advance notice as possible to schedule a Court Appearance. Fees for Jail Screenings and Court Appearances are to be paid in advance. Be mindful that the Court is not obligated to take our recommendation. Court Appearance Fees are non-refundable regardless of outcome in Court. Note: Fees for Services not listed will be determined by the Executive Director. Fees are subject to change. Please consult with the Executive Director to ensure current Schedule of Fees.

I, \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ have read and agree to the above Schedule of Fees. I understand that my participation at His House Recovery Residence, Inc. and its Program of Recovery is for a period of 52 weeks and agree to make my weekly / monthly Program Fee payments in the amount of \$\_\_\_\_\_ for a period of \_\_\_\_\_ weeks / months or until my entire balance is paid in full. I agree to be responsible for payment and the total sum of this agreement of \$\_\_\_\_\_ plus any accrued fees assessed in accordance with the above Schedule of Fees. I understand and agree that I will be responsible for any costs associated with the collection of these fees including, but not limited to, applicable court costs and attorney fees. I understand and agree that my participation at His House Recovery Residence, Inc. does not imply or confer the existence of a Tenant / Landlord Relationship, and as such, is not subject to Georgia State Law regarding the existence of a Tenant / Landlord Relationship. I understand that from time to time it is necessary for His House Recovery Residence, Inc. to immediately discharge a client from the residence without notice in order to safeguard the clients, staff, premises and integrity of His House Recovery Residence, Inc. and therefore is not subject to Tenant / Landlord State Law.

Client Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Services Contract for Program Admission

This Contract for Services is made effective \_\_\_\_\_, 20\_\_\_\_ by and between His House Recovery Residence, Inc. of 19 Latimer Lane NE Kennesaw, Georgia and \_\_\_\_\_ of \_\_\_\_\_.

1. **Description of Services.** Beginning on \_\_\_\_\_, 20\_\_\_\_ His House Recovery Residence, Inc. will provide \_\_\_\_\_ the following services:

**Grant admission to His House Recovery Residence, Inc.'s Discipleship Program of Recovery.**

**Payment.** Payment shall be made to His House Recovery Residence, Inc. at 19 Latimer Lane NE Kennesaw, Georgia. \_\_\_\_\_ of \_\_\_\_\_ agrees to pay the sum of \$\_\_\_\_\_ for admission fees to His House Recovery Residence, Inc.'s Program of Discipleship Recovery as follows:

<b>Event</b>	<b>Payment Amount</b>	
<i>Contract Signing</i>	\$450.00	
<i>Installments</i>		
____ 52 Weekly Installments of:	\$150.00	Place a checkmark next to the installments selected.
____ 12 Monthly Installments of:	\$600.00	

First Payment of \$\_\_\_\_\_, beginning on \_\_\_\_\_, 20\_\_\_\_ with the final installment, including any additional accrued charges, due on \_\_\_\_\_, 20\_\_\_\_.

In addition to any other right or remedy provided by law, if \_\_\_\_\_ fails to pay as a material breach of this Contract, His House Recovery Residence, Inc. may cancel this Contract and / or seek legal remedies.

2. **Terms.** This contract will automatically terminate upon completion of the services required by this Contract.
3. **Work Product Ownership.** Any copyrightable works, ideas, discoveries, inventions, patents, products, or other information (collectively the Work Product) developed in whole or in part by His House Recovery Residence, Inc. in connection with the services will be the exclusive property of His House Recovery Residence, Inc. Upon request, His House Recovery Residence, Inc. will execute all documents necessary to confirm or perfect the exclusive ownership of His House Recovery Residence, Inc. to the Work Product.
4. **Confidentiality.** His House Recovery Residence, Inc., and its employees, agents, or representatives will not at any time or in any manner, either directly or indirectly, use for personal benefit of His House Recovery Residence, Inc., or divulge, disclose, or communicate in any other manner, any information that is proprietary to \_\_\_\_\_. His

House Recovery Residence, Inc., its employees, agents, and representatives will protect such information and treat it as strictly confidential. This provision will continue to be effective after the termination of this Contract.

Upon termination of this Contract, His House Recovery Residence, Inc. will make available upon request to \_\_\_\_\_ all records, notes, documentation, and other items that were used, created, or controlled by His House Recovery Residence, Inc. and its employees, agents, or representatives.

5. **Indemnification.** \_\_\_\_\_ agrees to hold His House Recovery Residence, Inc. harmless from all claims, losses, expense, fees including attorney fees, costs, and judgments that may be asserted against His House Recovery Residence, Inc. that result from the acts or omissions of His House Recovery Residence, Inc. and / or its employees, agents, or representatives.
6. **Warranty.** His House Recovery Residence, Inc. shall provide its services and meet its obligations under this Contract in a timely and workmanlike manner, using knowledge and recommendations for performing the services which meet generally acceptable standards in His House Recovery Residence, Inc.'s community and region, and will provide a standard of care equal to, or superior to, care used by service providers similar to His House Recovery Residence, Inc. in similar environments.
7. **Default.** The occurrence of any of the following shall constitute a material default under this Contract.
  - a. The failure to make a required payment when due.
  - b. Any violation of His House Recovery Residence, Inc.'s program policies and procedures which specify grounds for termination from His House Recovery Residence, Inc.'s program of recovery and / or facilities.
  - c. The failure to make available or deliver the Services in the time and manner provided for in this Contract.
  - d. The subjection of either party's property to any levy, seizure, general assignment for benefit of creditors, application or sale for or by any creditor or government agency.
8. **Remedies.** In addition to any and all other rights a party may have available according to law, if a party defaults by failure to substantially perform any provision, term, or condition of this Contract ( including without limitation the failure to make a monetary payment when due), the other party may terminate the Contract by providing written notice to the defaulting party. This notice shall describe with sufficient detail the nature of the default. The party receiving such notice shall have 7 days from the effective date of such notice to cure the default(s). Unless waived by a party providing notice, the failure to cure the default(s) within such time period, shall result in the automatic termination of this contract.

9. **Force Majeure.** If performance of this Contract or any other obligation under this Contract is prevented, restricted, or interfered with by causes beyond the other party's reasonable control (Force Majeure), and if the party unable to carry out its obligations gives the other party prompt written notice of such event, then the party invoking this provision shall be suspended to the extent necessary by such event. The term Force Majeure shall include, without limitations, acts of God, fire, explosion, vandalism, storm or other similar occurrence, order or acts of military or civil authority, or by national emergencies, insurrections, riots, or wars, or strikes, lock-out, work stoppages, or other labor disputes, or supplier failures. The excused party shall use reasonable efforts under the circumstances to remove such causes of non-performance and shall proceed to perform with reasonable dispatch whenever such causes are removed or cease. An act or omission shall be deemed within the reasonable control of a party if omitted or committed, or caused by such party or its employees, agents, representatives, officers or officials.
10. **Arbitration.** Any controversies or disputes arising out of or relating to this Contract shall be resolved by binding arbitration in accordance with the then-current Commercial Arbitration Rules of The American Arbitration Association. The parties shall select a mutually acceptable arbitrator knowledgeable about such issues relating to the subject matter of this Contract. In the event the parties are unable to agree to such a selection, each party shall select a third arbitrator, all three of whom shall preside jointly over the matter. The arbitration shall take place reasonably centrally located between the parties, or otherwise mutually agreed upon by the parties. All documents, materials and information in the possession of each party that are in any way relevant to the dispute shall be made available to the other party for review and copying no later than 30 days after the notice of arbitration is served. The arbitrator(s) shall have power to issue mandatory orders and restraint orders in connection with the arbitration. The decision rendered by the arbitrator(s) shall be fixed and binding on the parties, and judgment may be entered in conformity with the decision in any court having jurisdiction. The agreement to arbitration shall be specifically enforceable under the prevailing arbitration law. During the continuance of any arbitration proceeding, the parties shall continue to perform their obligations under this Contract.
11. **Entire Agreement.** This Contract contains the entire agreement of the parties, and there are no promises or conditions in any other agreement whether written or oral concerning the subject matter of this Contract. This Contract supersedes any prior written or oral agreement between parties.
12. **Severability.** If any provision of this Contract will be held invalid or unenforceable for any reason, the remaining provisions will continue to be valid and enforceable. If a court finds that any provision of this Contract is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision will be deemed to be written, construed, and enforceable as so limited.

13. **Amendment.** This Contract may be modified or amended in writing if the writing is signed by the party obligated under the amendment/
14. **Governing Law.** This Contract shall be construed in accordance with the laws of the State of Georgia.
15. **Notice.** Any notice or communication required or permitted under this Contract shall be sufficiently given if delivered in person or by certified mail, return receipt requested, to the address set forth in the opening paragraph or to such other address as one party may have furnished to the other in writing.
16. **Waiver of Contractual Right.** The failure of either party to enforce any provision of this Contract shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Contract.
17. **Assignment.** Neither party may assign or transfer this Contract without the prior written consent of the non-assigning party, which approval shall not be reasonably withheld.

In Witness Whereof, the party's hereto have caused this agreement to be executed by their duly authorized representative as of the date first above written.

**Services Recipient:**

BY: \_\_\_\_\_  
Recipient's Signature and Date mm/dd/yyyy

\_\_\_\_\_  
Recipient's Name Printed

**Services Provider:**

BY: \_\_\_\_\_  
Provider's Signature and Credential, Date mm/dd/yyyy

\_\_\_\_\_  
Provider's Name Printed

**Guarantor:**

Guarantor's Signature and Date mm/dd/yyyy

\_\_\_\_\_  
Guarantor's Name Printed

**Guarantor Notary Signature and Seal / Stamp:**

BY: \_\_\_\_\_  
Notary Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Notary's Name Printed

**Guarantor:**

BY: \_\_\_\_\_  
Guarantor's Signature and Date mm/dd/yyyy

\_\_\_\_\_  
Guarantor's Name Printed

## Consent for Recovery Residential Services

This form is to document that I (Print) \_\_\_\_\_, give my permission and consent for Recovery Coaching from staff at His House Recovery Residence Inc. I understand that Recovery Coaching is not Treatment, and treatment services will be referred to a qualified professional within the community, upon client request. I understand that I will be required to participate in 3 NA/AA meetings a week, and may be asked to voluntarily attend recovery oriented psycho-educational programming offered at the residence while in recovery. I understand that it is a condition of the program that I maintain employment while in residence. I understand that if I miss a scheduled work day that I may incur additional programming fees.

I understand that personal fitness is available to myself upon acceptance into the recovery residence and that any participation in an exercise program is completely voluntary and does not constitute a program requirement for my residence at His House Recovery Residence Inc., on my behalf. I understand that a letter of consent from my physician to participate in an exercise program may be requested by house staff, and I will not be allowed attend exercise programming if medical screening determines that I am unable to reasonably participate in an exercise program at the independent level, without medical monitoring.

I understand that His House Recovery Residences Inc, staff/employees/contractors that I may come into contact with may or may not be individuals in recovery, and are to be treated with respect. I understand that any act of violence toward a recovery peer, staff, or community member while in residence at His House Recovery Residence Inc, will be reviewed for my continued participation in residence.

I understand that I am free to discontinue participation in residence, with knowledge that any paid fees/security deposit will be forfeit for the current month of residence, if notice of termination of residence is not provided thirty days in advance. I further will notify the Recovery Staff so that effective planning for continued care could be implemented through my transition back into the community.

I understand that His House Staff conversations within the house community are considered private, and not to be repeated to members outside of the community. As such, all communication with His House recovery coaches is confidential.

I understand that I might be required to visit a licensed practitioner of the healing arts as part of the initial assessment if screening material suggests a co-occurring/or medical concern prior to acceptance into His House Recovery Residence.

I have read and understand all rules and program violations that would lead toward expulsion from the program. I understand that if I violate these rules, it is the policy for mandatory and temporary expulsion from His House Recovery Residence Inc, for a minimum of five days. I further understand that I am responsible for all program fees that accrue within the time that I am absent from the program. I understand that a negative drug screen from the public health department will be required from me upon my return to His House Recovery Residence Inc, prior to my acceptance back into the program. I understand that non-payment of fees for the program can result in discontinuation of recovery residential services. It is the policy of His House Recovery Residence Inc, that each case be reviewed for proper continuum of care, discharge planning upon His House determination in the event of a discontinuation of residential services is reviewed on a case-by-case basis.

Court Mandated Consumers: I understand that if a condition of my probation is that I comply with all drug screens and program requirements, that His House Recovery Residence Inc, will request authorization to disclose Drug Screening results and program attendance to my Probation Officer/Court.

I have been provided a schedule of His House Recovery Residence Inc, Fee structure, and agree to abide by all program cost, and remit monthly fees on the first of each month.

- |   |   |
|---|---|
| 1. Introduction of our company and services<br>2. Client's Bill of Right<br>3. Limits of Confidentiality<br>4. HIPPA Form<br>5. Client Rights Complaint Form<br>6. Choice of Provider | 7. Consent to Treatment<br>8. Orientation to Advocacy<br>9. Orientation to Mental Health Advance Directives<br>10. Treatment Course<br>11. Services that will be provided<br>12. Right to Ethical Treatment |
|---|---|

I have read and understood the following forms and that I agree to abide by its terms during our professional relationship  
**BY SIGNING THIS FORM I AM ATTESTING TO THE FACT I AM LAWFULLY IN THE UNITED STATES**

Name of the Client (printed)

Signature

Date

Recovery Staff/Date

**USE THIS SPACE ONLY IF CLIENT/ LEGAL GUARDIAN REFUSES THE TREATMENT** I voluntarily refuse the treatment of myself and/or my child/grandchild and I am aware of legal and other implications related to my decision. I understand that the client needs to go through the new referral process if he or she is to re-enter the program.

## **Contract for Safety**

Date: \_\_\_\_\_

I, \_\_\_\_\_, (client), hereby contract with \_\_\_\_\_ (therapist), that I will take the following actions if I feel suicidal.

---

1. I will not attempt suicide.
2. I will phone at: \_\_\_\_\_,
3. If I do not reach: \_\_\_\_\_, I will phone any of the following services:

Name/Agency Phone

4. I will further seek social supports from any of the following people:
- 
- 
- 
- 

Name Phone

5. If none of these actions are helpful or not available, I will contact the National Suicide Hotline at 1-800-SUICIDE (1-800-784-2433), (1-877-727-4747), (1-800-273-8255)

6. I will seek further help from Georgia Crisis & Access Line by calling 1-800-715-4225
7. If none of these actions are helpful or not available, I will check-in the ER at one of the following:

Closest Hospital Address/Phone:

Wellstar Kennestone Hospital  
677 Church St, NE  
Marietta, GA  
770-793-5000 (General)  
770-426-3228 (MH Unit)  
5.4 miles from His House Inc.

8. If I am not able I will phone 911, or 0 for help.

Client's signature: \_\_\_\_\_ Date: / /

Counselor/Therapist's signature: \_\_\_\_\_

## **General Liability Release of Claims**

I, \_\_\_\_\_, do hereby release and forever discharge His House Recovery Residence, Inc, their agents, employees, successors and assigns, and their respective heirs, personal representatives, affiliates, successors and assigns, and any and all persons, firms or corporations liable or who might be claimed to be liable, whether or not herein named, none of whom admit any liability to the undersigned, but all expressly denying liability, from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, which I now have or may hereafter have, arising out of or in any way relating to any and all injuries and damages of any and every kind, to both person and property, and also any and all injuries and damages that may develop in the future, as a result of or in any way relating to the following:

Residential Accomodations While Engaging Treatment for Substance Abuse Disorders.

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It is understood and agreed that this Release is made and received in full and complete settlement and satisfaction of the aforesaid actions, causes of action, claims and demands; that this Release contains the entire agreement between the parties; and that the terms of this Agreement are contractual and not merely a recital. Furthermore, this Release shall be binding upon the undersigned, and his respective heirs, executors, administrators, personal representatives, successors and assigns. This Release shall be subject to and governed by the laws of the State of Georgia.

This Release has been read and fully understood by the undersigned and has been explained to me.

EXECUTED this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name (print) \_\_\_\_\_ Client's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize **His House Recovery Residence Inc.**, of P.O. Box 701 Kennesaw GA 30144 770.312.2598 (Fax: 770.312.2598) and their designed staff to receive information, and obtain copies of written reports/evaluations from the agencies mentioned below:

Agency Name: \_\_\_\_\_

Address of Agency: \_\_\_\_\_

Agency Phone: \_\_\_\_\_

Agency Fax: \_\_\_\_\_

Please remit information to: His House Recovery Residence Inc., 3166 Cherokee St., Suite 201, Kennesaw GA 30144  
Phone: 770.312.2598      Fax: 770.516.8638

I authorize for Release My

- Drug and Alcohol Assessments
- Medical Records
- Probation Records
- Medication Administration Record
- Psychological/Psychiatric evaluation
- Safety plans

- Progress notes
- Treatment Plans
- Therapy Notes
- Case Management Notes
- Recommendations from prior treatment providers
- Discharge/Aftercare referrals

For the purpose of:

- Continuity of Care
- Probation

- Court Records
- Personal Records

With the following Restrictions: \_\_\_\_\_

**I authorize** these agencies to share information by phone, in person, fax and/or email contact. All information I hereby authorize to be obtained from this Agency, Department or Office will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect:

24 month from date of Client Signature below

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Name of the Client (printed) Signature Date \_\_\_\_\_

Clinician (printed) Signature w/ credentials Date \_\_\_\_\_

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### **USE THIS SPACE ONLY IF CLIENT/ PARENT/ LEGAL GUARDIAN WITHDRAWS CONSENT**

Date Signature of Client/Parent/Legal Guardian \_\_\_\_\_



## AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name (print) \_\_\_\_\_ Client's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_

I hereby authorize **His House Recovery Residence Inc.**, of P.O. Box 701 Kennesaw GA 30144 770.312.2598 (Fax: 770.516.8638) and their designed staff to receive information, and obtain copies of written reports/evaluations from the agencies mentioned below:

Agency Name:

Address of Agency:

Agency Phone: \_\_\_\_\_

Agency Fax: \_\_\_\_\_

Please remit information to: His House Recovery Residence Inc., 3166 Cherokee St., Suite 201, Kennesaw GA 30144  
Phone: Phone: 770.312.2598 Fax: 770.516.8638

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With the following Restrictions: \_\_\_\_\_

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24 month from date of Client Signature below

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Name of the Client (printed) Signature Date \_\_\_\_\_

Clinician (printed) Signature w/ credentials Date \_\_\_\_\_

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### **USE THIS SPACE ONLY IF CLIENT/ PARENT/ LEGAL GUARDIAN WITHDRAWS CONSENT**

Date Signature of Client/Parent/Legal Guardian \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name (print) \_\_\_\_\_ Client's DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize **His House Recovery Residence Inc.**, of P.O. Box 701 Kennesaw GA 30144 770.312.2598 (Fax: 770.516.8638) and their designed staff to receive information, and obtain copies of written reports/evaluations from the agencies mentioned below:

Agency Name: \_\_\_\_\_

Address of Agency: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Agency Phone :\_\_\_\_\_

Agency Fax:\_\_\_\_\_

Please remit information to: His House Recovery Residence Inc., PO Box 701, Kennesaw GA 30144  
Phone: Phone: 770.312.2598 Fax: 770.516.8638

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For the purpose of:

- Continuity of Care
- Probation
- Court Records
- Personal Records

With the following Restrictions: \_\_\_\_\_  
\_\_\_\_\_

**I authorize** these agencies to share information by phone, in person, fax and/or email contact. All information I hereby authorize to be obtained from this Agency, Department or Office will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect:

24 month from date of Client Signature below

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Name of the Client (printed) Signature Date \_\_\_\_\_

Clinician (printed) Signature w/ credentials Date \_\_\_\_\_

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**USE THIS SPACE ONLY IF CLIENT/ PARENT/ LEGAL GUARDIAN WITHDRAWS CONSENT**

Date Signature of Client/Parent/Legal Guardian \_\_\_\_\_

## **Confidentiality Agreement**

His House Recovery Residence, Inc. has legal and ethical responsibilities to safeguard the privacy of its employees, students, and patients and their families and to protect the confidentiality of protected health information and all other types of confidential information. Members of the His House Recovery Residence, Inc. community include but are not limited to:

- **Workforce Member:** an individual performing work on behalf of HHRR, Inc. and under the direct control of HHRR, Inc., whether or not the member is employed by HHRR, Inc.. Examples include: staff; faculty; temporary agency workers; students; contractors; and volunteers.
- **Extended Community Member:** an individual who is present on HHRR, Inc. premises or accessing information resources at HHRR, Inc. for a specific treatment, payment, or health care operation business purpose allowed under the Health Insurance Portability and Accountability Act (HIPAA) such as a third party payer representative, a visitor for a guided tour or observation experience, media or vendor representatives, or other health care providers involved in a patient's continuum of care.
- **Business Associate:** is a person or company that performs certain functions or activities on behalf of, or for, HHRR, Inc. that involve the creation, use or disclosure of HHRR, Inc. protected health information.

As a member of the His House Recovery Residence, Inc. community I agree to conduct myself in strict conformance with all applicable laws and with His House Recovery Residence, Inc. and HHRR, Inc. policies governing confidential information. I understand and agree that measures must be taken so that all confidential information captured, maintained, or utilized by HHRR, Inc. and any of its off-site campuses or affiliated entities is accessed only by authorized users. These obligations apply to confidential information that is collected or maintained verbally, in paper, or electronic format.

HHRR, Inc. Confidential Information includes any and all of the following categories:

- Patient information including demographic, health, and financial information (in paper, verbal, or electronic form regardless of how it is obtained, stored, utilized, or disclosed);
- Information pertaining to members of the HHRR, Inc. Workforce or Extended Community (such as social security numbers, banking information, salaries, employment records, student records, disciplinary actions, etc.);
- His House Recovery Residence, Inc. or HHRR, Inc. information (such as financial and statistical records, academic or research funding, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary information including computer programs, source code, proprietary technology, etc.);
- Third-party information (such as insurance, business contracts, vendor proprietary information or source code, proprietary technology, etc.); and
- Patient, research, academic program, or other confidential or proprietary information heard or observed by being present on HHRR, Inc. premises.

As a condition of and in consideration of my use, access, and/or disclosure of confidential information, I agree that:

1. I will access, use, and disclose confidential information only as authorized and needed to perform my assigned job duties. This means, among other things, that I:
  - a) will only access, use, and disclose confidential information that I have authorization to access, use, and disclose in order to perform my job duties;
  - b) will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly and clearly authorized within the scope of my job duties and as in accordance with all applicable His House Recovery Residence, Inc. policies and procedures and with all applicable laws;
  - c) will report to my supervisor or to the appropriate office any individual's or entity's activities that I suspect may compromise the privacy or security of HHRR, Inc. Confidential Information.

2. If I am granted access to His House Recovery Residence, Inc. electronic systems, including email, I am the only person authorized to use the individual user identification names and passwords or access codes assigned to me. I agree to the following:
  - a) To safeguard and not disclose my individual user identification passwords, access codes or any other authorizations that allow me to access HHRR, Inc. Confidential Information to anyone including my manager, supervisor, or LAN manager.
  - b) To not request access to or use any other person's passwords or access codes.
  - c) I accept responsibility for all activities undertaken using my passwords, access code and other authorizations.
  - d) It is my responsibility to log out of any system to which I have logged on. I will not under any circumstances leave unattended a computer to which I have logged on without first either locking it or logging off the workstation.
  - e) If I have reason to believe that the confidentiality of my password has been compromised, I will immediately change my password.
  - f) I understand that my user identification will be deactivated upon notification to Information Management that I am no longer a HHRR, Inc. Workforce Member, Extended Community Member, or Business Associate; or when my job duties no longer require access to the computerized systems.
  - g) I understand that HHRR, Inc. has the right to conduct and maintain an audit trail of all accesses to confidential information, including the machine name, user, date, and data accessed and that HHRR, Inc. may conduct a review of my system activity at any time and without notice in order to monitor appropriate use.
  - h) I understand and accept that I have no individual rights to or ownership interests in any confidential information referred to in this agreement and that therefore His House Recovery Residence, Inc. may at any time revoke my passwords or access codes.
  - i) I understand that individuals who access HHRR, Inc. Confidential Information from home must follow His House Recovery Residence, Inc.'s Security Guidelines for Remote Access.
  - j) I understand that it is my responsibility to be aware of HHRR, Inc. Human Resource policies, HHRR, Inc. Operations policies, and other policies that specifically address the handling of confidential information and misconduct that warrants immediate discharge.
  - k) I understand that in addition to protecting confidential information I am also required to be aware of the HHRR, Inc. Computer Privileges and Responsibilities policy and to abide by all of its requirements regarding the appropriate use of HHRR, Inc. and HHRR, Inc. computer systems.

**My signature below indicates that I have read, accept, and agree to abide by all of the requirements described above. I acknowledge that any violation of these requirements may result in disciplinary measures up to and including termination of employment and/or affiliation with His House Recovery Residence, Inc. .**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Department / School: \_\_\_\_\_

## **His House Ministries Complimentary Guest Accommodations Agreement**

I, \_\_\_\_\_, of, \_\_\_\_\_,

\_\_\_\_\_ understand and acknowledge that, as a participant in the His House Program of Discipleship Recovery, I may be afforded the courtesy and convenience of temporary Complimentary Guest Accommodations which may include overnight rooming and household privileges during the course of my program participation.

*No fees, monies or payments made to His House, its management, or Staff are associated with any costs regarding His House Ministries Complimentary Guest Accommodations.*

I acknowledge that all fee payments made to His House are for professional services rendered by His House personnel in the mutual pursuit of my recovery from substance abuse and co-occurring disorders. These services include recovery counseling, recovery coaching, group therapy facilitation, educational services and materials, recreational activities and case management services.

*I acknowledge that any complimentary overnight guest accommodations are provided free of charge and not considered tenancy or residency and that no rental or lease agreement exists that would constitute or imply a landlord/tenant relationship between myself and His House Ministries*

I acknowledge that my permanent address of record is located at \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ and is not presently, nor shall ever be construed as, located at, or in any property or dwelling under the control of His House Ministries, its owners, officers or assigns.

I acknowledge that, as a participant and/or guest of His House Ministries, I am subject to complying with program rules, regulations, policies and procedures, and violations of such may be grounds for immediate discharge, and without prior notice of either party, from the program of recovery and its premises(s).

I acknowledge that in the event I am discharged from the program of recovery, I agree to immediately leave the premises in a quiet and respectable manner, or else I may be subject to criminal prosecution for trespassing. I further agree not to return to the premises(s) without the expressed permission of His House Management or Staff. I acknowledge that refusal to leave the premises upon request may result in me being escorted off of the premises by law enforcement officials and without remedy or recourse.

My signature below, and initials alongside of each above paragraph, signify that this Agreement document has been thoroughly and clearly explained to me by His House personnel, that all questions I had were answered to my satisfaction, and that I willingly and without duress of any kind agree to abide by its content and intent. I acknowledge that failure to abide by this Agreement will constitute a breach of contract and that I will bear all responsibility and legal costs associated with its enforcement in a court of law.

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Program Participant's Printed Name

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Program Participant's Signature

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Date

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Witnessed By: Printed Name

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Witness's Signature

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Date