# CONTACT COUNSELING

Bob Chambers, MA, CDP
Director

1118 Finnegan Way
Suite 103
Bellingham, WA 98225

(360) 671-3277
FAX (360) 733-9499

Instructions for Sign Up for an Assessment with Contact Counseling

To sign up for an assessment, we will need you to print and complete the intake (pages 2 through 5 of this document).

Once completed please return by email to contactc4u@gmail.com, by fax to (360) 733-9499,

Or, simply mail the intake to:

Contact Counseling
1118 Finnegan Way, Ste 103
Bellingham, WA 98225

After you send the completed documents, please give us a call at 360-671-3277 to determine an appointment time and take care of payment.

**If you would like to pay in cash, please stop by our office at the address listed above.**
You are welcome to complete the intake paperwork at our office or bring the completed documents along with you.

Please do not hesitate to be in touch with any questions at (360) 671-3277, we are happy to help.

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**Prohibition of Disclosure:** This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for the purpose.

## AUTHORIZATION TO RELEASE COURT RECORDS

I, ______________________________________________________________________________
(Clearly Printed Full Legal Name of Participant)

authorize **Contact Counseling (Requestor)** to obtain copies of Participant's court records and files in the state of Washington, whether in paper or electronic format, including any municipal court, district court, superior court, and juvenile court records and files, and including a compilation of Participant's record and files, such as the Participant's criminal history record.

**Participant information:**

Age: ________ Date of Birth: _____________________ Primary Phone Number: _____________________

Mailing Address: ______________________________________________________________________

_______________________________________________________________________________

Driver's License number or State ID number: ___________________________________________

**Attorney or Public Defender Information:**

Name: ______________________________

Phone: ______________________________

Fax: ________________________________

**Probation Officer or DOC Officer Information:**

Name: _____________________________________

Phone: _____________________________________

Fax: _______________________________________

**Validity:** This authorization shall be valid for ninety (90) days from the date of Participant's signature herein. A photocopy of this authorization shall be as valid as the original.

**Disclaimer:** Contact Counseling acknowledges that the court providing records pursuant to this authorization makes no representations as to the accuracy and completeness of the data except for court purposes.

**Costs:** Contact Counseling acknowledges that the court may request payment of costs prior to transmitting the requested records and files.

________________________________ ________________________
**Participant Signature** **Date**

## PROFESSIONAL FEES

| Standard Assessments: | Family Law & Custody Assessments: | Re-evaluations: |
|---|---|---|
| Cash (in person only): $300.00 | Cash (in person only): $500.00 | Cash (in person only): $150.00 |
| Credit/Debit/Money Order: $325.00 | Credit/Debit/Money Order: $525.00 | Credit/Debit/Money Order: $175.00 |
| Attorney check: $300.00 | Attorney check: $500.00 | Attorney check: $150.00 |

- We are unable to accept personal checks; however, we are able to accept checks from attorneys.
- You will only be eligible for a re-evaluation if you completed an assessment at Contact Counseling within the last 12 months.
- Please note that additional case management after your initial assessment may incur further fees; a re-evaluation or new assessment may be in order in certain situations.

- Please be aware that we require a minimum of 24 hours' notice to reschedule appointments (or by 5:00pm on the last business day prior to an appointment).
- A single same day cancelation or missed appointment will incur a $50.00 fee. Any additional same day cancelations and/or missed appointments will each incur an $75.00 fee.
- If you are more than 15 minutes late for your appointment, it will be considered a missed appointment and rescheduling fees will be incurred.
- If you give adequate notice, but reschedule your appointment more than four times, a $50.00 rescheduling fee will be incurred for each additional scheduling change.

Please check the reason(s) for your visit:

- ☐ DUI
- ☐ Assault IV
- ☐ Probation Violation
- ☐ Work requirement (Note: our counselors are not DOT certified SAPs)
- ☐ Physical Control
- ☐ Child Custody Case
- ☐ License Reinstatement
- ☐ Other:________________________________________
- ☐ MIP
- ☐ Family Law Case
- ☐ Personal Development

**I understand that all the above FEES ARE NOT REFUNDABLE.**

I hereby certify that I understand all of the above information: ________________________ _______________

**Participant Signature** **Date**

## COUNSELING STAFF

This program is approved by the Department of Social and Health Services (DSHS), Department of Behavioral Health (DBHR) to provide substance abuse assessments, per WAC 246-811. The credentials of each counselor are monitored and regularly inspected by DSHS to verify that counselors continue to meet requirements. All certified CDP counselors are qualified in the State of Washington. In the course of your assessment at this agency you may receive services from the following counselors whose registration numbers and qualifications are listed below:

| Counselor Name: | Qualifications: | License Number: |
|---|---|---|
| Bob Chambers | MA, CDP | CP00003660 |
| Steve Burger | BA, CDP | CP00003148 |

I hereby certify that I understand all of the above information: ________________________ _______________

**Participant Signature** **Date**

## ASSESSMENT PHILOSOPHY

A Substance Use Disorder is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. A Substance Use Disorder is characterized by impaired control over the use of alcohol or other drugs, preoccupation and use despite adverse consequences. The American Medical and American Psychiatric Association have concluded that Substance Use Disorders have recognizable signs and symptoms. These symptoms may be continuous or periodic. Substance Use assessments are best accomplished by a trained and experienced person who can state the basis of his/her methods and expertise.

CONTACT COUNSELING makes no assumptions about whether or not an individual is chemically dependent. We provide services to individuals who need or want to explore their relationship with alcohol or other drugs.

## CLIENTS RIGHTS

CONTACT COUNSELING shall assure the following rights to each client or potential client:

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
- Be free of any sexual harassment;
- Be free of exploitation, including physical and financial exploitation;
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
- Receive a copy of agency grievance system procedures upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and
- Lodge a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.

## DISCLOSURE STATEMENT

Counselors practicing for a fee must be registered or certified with the Department of Health for the protection of public health and safety. Recognition with the department does not include any proactive standards nor necessarily imply effectiveness of any treatment.

## CONSENT FOR SERVICES

I hereby voluntarily consent to receive assessment services from CONTACT COUNSELING. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Laws and regulations. Outside persons or organizations which provide services to the agency are required by written agreement to protect confidentiality. The program may not disclose any information identifying a patient as an alcohol or drug abuser unless:

1) the patient consents in writing;
2) the disclosure is allowed by a court order;
3) the disclosure is made to medical personnel for research, audit or program evaluation; and/or;
4) the patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the U.S. Attorney in the district where the violation occurs. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State Law or local authorities.

I hereby certify that I understand all of the above information: ___________________________ ________________

**Participant Signature** **Date**

### In Regards to the Use of Marijuana

Pre-trial requirements for DUI charges may include refraining from the use of alcohol, marijuana and non- prescribed substances. If you are unsure of your pre-trial requirements, please speak with your attorney who will be familiar with your case.

Please be aware that positive drug screens for any non-prescribed substances will be noted in the assessment. If you have a prescription for medical marijuana, please be ready to provide us with your medical marijuana card as well as a doctor's note indicating medical necessity.

______ ___/___/___
**Initials Date**

### In Regards to Reinstating your Driver's License

We are happy to submit a DOL form regarding assessment results upon request. To avoid losing your driver's license pre-trial, please wait until your trial is complete before requesting the DOL form to be sent. Your attorney or probation officer will be able to confirm if it is the proper time to reinstate your license.

When you are ready to have your license reinstated, please provide us with the following information so we are able to send documentation to the Washington State DOL:

- A signed release of information authorizing an exchange of information with the DOL;
- A clear copy or photo of your terminated driver's license.

In addition:

- If you have ADIS requirements, please be sure that the facility that hosted the ADIS class sends in proof of your attendance to the DOL;
- If you have treatment requirements, please be sure that the treatment center where you attended classes sends in proof of your attendance to the DOL.

Please note that other than assuring that the information we send is accurate, there is little we can do to expedite processing times at the DOL.

______ ___/___/___
**Initials Date**

### In Regards to Confidentiality

Please remember that due to confidentiality regulations, we are unable to disclose information to anybody unless we have your written consent allowing us to do so. This regulation includes significant others, family members, co-workers, and friends.

If you share a phone or if another person might place or receive calls for you, please let the receptionist know so you may have the opportunity to sign a release of information. We will only disclose information you are comfortable with us sharing, mainly appointment reminders or if we need you to return a call to discuss anything pertaining to the evaluation.

______ ___/___/___
**Initials Date**