

BK Professional Counseling Center, LLC.

125 East Plaza Drive, Mooresville, NC 28115 Ph: 704-662-3923, Fax: 704-662-3913

Please complete these forms prior to coming in to do your Orientation. We will complete the last two pages together. You are responsible to read this information and you will be given a copy of these forms after we complete the orientation. There is a one-time \$25.00 charge for Orientation.
BK PROFESSIONAL COUNSELING CENTER PROGRAM AGREEMENT

Client Name: _____ Date: _____

As a program participant, the following conditions have been explained.

1. There are three levels of treatment at BKPCC. ADETS/Prime for Life-16-hour Education Classes, Level I Short-Term treatment is 20-39 hours and Level I Long-Term treatment is 40-89 hours. You are required to come no less than one time per week regardless of your level of treatment. It is a requirement of the State DWI Services that we monitor your progress no less than once weekly. Failure to attend groups once weekly will result in additional classes. If this is a non-dwi offense, it is required by BKPCC to attend weekly.

2. Participation is expected. We all attend as a group the first Thursday of the month a self-help meeting at Celebrate Recovery at Southside Baptist Church. This is a three-hour class in which you get credit for 3 hours of group and 2 hours of your self-help meetings. That is the only time you will be required to pay 60.00 for a weekday class. This is the only time during the week, the first Thursday of the month that you will have a three hour class during the week and the cost remains the same at 20.00 per hour so this group would be 60.00 since you are getting credit and attending a three hour group that week.

3. Abstinence from alcohol and mood-altering drugs is expected 7 days a week, 24 hours a day, during treatment. Difficulties with abstinence should be reported to the counselor. Random breathalyzer and/or urinalysis are part of treatment. You may or may not be given a random drug screen. If you are the results are not shared with anyone except you and staff. If you want them shared, then you can sign a release of information for that person and it will be shared with whomever you choose to share this with. Some folks come into treatment and drug testing is required depending on why they are here. Not everyone is tested.

4. Should additional information surface regarding diagnostic status, or should abstinence difficulties be unresolved, additional assessment and alternative recommendations may be required.

5. Both staff and clients expect confidentiality of all clients and staff matters. The program will not release information without written consent. Clients are not to discuss other clients outside the treatment group setting. Clients are not to discuss anything that is said between staff and clients as well. While we welcome your call, we are attempting to serve our clients and provide you with the best services available.

6. Should opportunity for activities outside the facility be presented during the program, participation is on a voluntary basis. We may go to events that are related to Drugs/Alcohol outside the premises. BK Professional Counseling Center is not liable for any injuries that may occur. treatment and/or any outside activities we may participate in during my course of treatment

7. Possession of any weapon (concealed or visible) alcohol/drugs, or drug paraphernalia is prohibited on the premises. Having any of the is immediate grounds for dismissal from group.

8. You may pay for the services in full at beginning of treatment or pay \$20.00 per hour until paid in full. Under no circumstances may BK Professional Counseling Center send paperwork to DMV or completion letters without payment in full and all AA, NA or Celebrate Recovery Sheets are turned in. You are also required to complete a Discharge Summary after your last class. **No one graduates unless all fees are paid in full, all assessments completed and paid for, such as \$100.00 for each charge we are clearing or any out of state charges that are due prior to graduating. All Self-Help sheets are submitted and the Discharge Summary is completed on the same day of completion of treatment.**

Failure to adhere to any one of these conditions may result in the need for additional assessment and alternative recommendations.

I have read and agree to these conditions.

Client Sign: _____ Date: _____ Staff Signature: _____ Date: _____

FINANCIAL AGREEMENT

PLEASE INITIAL EACH ONE

By initialing the following items, I acknowledge that I understand and agree to the terms and conditions outlined below:

_____ I agree to make payments per agreement below, and I understand that weekly payments must be paid. I understand that I can discuss with BK Professional Counseling Center staff if special circumstances arise.

_____ I understand that outstanding balances will be reported to Probation Officers, EAP, School Designee or anyone else you are accountable to concerning this treatment.

_____ I understand that BK Professional Counseling Center will NOT give verbal or written verification of completion of treatment to ANY outside agency, including NCDMV, EAP, employers, and legal representatives until all financial responsibilities have been met.

_____ I understand random drug screens may occur and if I am given a random drug screen, then I agree to pay 25.00 for the drug screen given. These are random, not everyone is given a drug test and that is what random means. You may or may not be given a drug test. The drug test given are sent to a laboratory and the results are between you and the staff at BKPCC, no one else gets a copy of the drug testing unless you request this to be given to someone else.

_____ **I understand that no refunds are given for paid in full status or for any other reason. No exceptions. If you stop coming to group for at least one month, your case will be closed and you will be required to start over and pay again. If your assessment expired while you were not attending group regularly, you will have to complete and pay for another assessment. I also understand that all assessments must be paid for prior to me requesting my case to be transferred to another provider if I choose another provider.**

_____ **I understand that if I miss two groups in a row without appropriate documentation of an excusable absence then I will be given extra groups and payment is required for any extra groups given due to attendance issues as weekly attendance is required by the state of NC and BKPCC. If attendance is a problem, do not lose all of your money, talk to staff. We set this program up where folks cannot fail unless they try hard to do so. We work hard to assist you.**

I agree to pay BK Professional Counseling Center _____ \$20.00 _____ per hour.	
_____ <i>Client Signature & Date</i>	_____ <i>BK Professional Counseling Center Staff and Date</i>

I agree to pay BK Professional Counseling Center _____ \$25.00 _____ for each drug screen. Drug testing is random and you may or may not be given one. No one sees the results but you and I unless you request that the results be given to someone else.

**Client Signature: _____ Date: _____ Staff Signature: _____ Date: _____
Rhonda Lazenby-CSAC/ICADC**

GROUP GUIDELINES

1. Turn Cell Phones “**OFF**”—**NO** Texting during group. Use of cell phones during group is an **automatic dismissal from group. IF YOU ARE CAUGHT WITH YOUR CELL PHONE ON DURING GROUP, YOU WILL BE AUTOMATICALLY DISMISSED FROM GROUP. NO EXCEPTIONS. PLEASE ADHERE TO THIS. IT WILL BE ENFORCED.**
2. Be on time for group. Do not call as I do not answer the phone during orientation and group times out of respect for my clients. After **10 minutes- GROUP IS CLOSED.** You will not be able to enter.
3. Participate in group. Be respectful of others. No Sleeping—No side conversations.
4. Try to take restroom breaks before group, during break or after group.
5. Must sign roster and complete group note appropriately. (i.e. down to topic and complete effectiveness section). If either is not completed, you will not get credit for attending.
6. Share your personal experiences, accepting your part by owning the problem.
7. Random drug test may be requested. By signing, you acknowledge this policy.
8. Failure to sign in on the group roster and to complete your group sheet will result in no credit for group on that date.

SUPPORT GROUP MEETING ATTENDANCE

For

(Name)

Due to the BK, Professional Counseling Center Out Patient Program's belief in the importance of Support group meetings as a path to recovery, it is a requirement of your treatment program to attend meetings.

We appreciate the cooperation of so many support group members in assisting us in the effort through their willingness to sign this form to verify attendance at meeting.

While you may not necessarily have a problem with drugs or alcohol as the result of being in class, some of your peers may need these meetings desperately and we want to make sure everyone knows there is a solution to the disease of Alcoholism and Drug Addiction, therefore, we all participate in a few classes to support those in treatment that need these meetings.

Thank you for supporting your peers in treatment by your willingness to participate in self-help groups whether you need them or not.

We also understand the principal of anonymity and want to assure you that every effort is made to protect confidentiality, both our clients and the member of the support group fellowships.

PLEASE SEE MEETING SCHEDULE-ATTACHED!!!

LOCATION	DATE	INITIALS	PHONE # (Optional)

BK Professional Counseling Center, LLC.

125 East Plaza Drive, Mooresville, NC 28115 Ph: 704-662-3923, Fax: 704-662-3913

TRACKING SHEET

Name: _____

Program Level: I-Short-Term-20-39 hours

Address _____

 I-Long-Term-40-89 hours

City _____ Zip _____

Phone Number: _____

Number of Treatment Hours given _____

Referred By: _____

Send Reports to: _____

Attorney _____

Probation Officer _____

Contact #: _____

Fax#: _____

Email Address _____

Financial Agreement: \$50.00 discount if paid in full for all groups at the beginning of treatment only. \$50.00 discount if you are a veteran. We cannot combine discounts.

I agree to pay \$20.00 per hour for group therapy. I agree to pay 60.00 for individual counseling should I not be able to attend group therapy. Total cost: _____ Individual sessions are on an as needed basis as we conduct group therapy for all clients unless special circumstances arise.

Signed: _____ Date: _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____ Date _____ Pd _____ Hrs. _____

DRUG TEST DATE GIVEN _____ DATE PAID _____

DRUG TEST DATE GVEN _____ DATE PAID _____

BK Professional Counseling Center, LLC.

125 East Plaza Drive, Mooresville, NC 28115 Ph: 704-662-3923, Fax: 704-662-3913

TREATMENT PLAN

Client name: _____ Date: _____

DIAGNOSIS(ES):		Principal (P)= Admitting/Provisional Dx, Primary (R) = Focus of Treatment, Current Dx Both Principal & Primary (B), Additional (A) = May Impact Tx, Not Focus of Tx	End Date
Code	Class	Description	
Social:			

Supports / Strengths		Preferences	
Date		Date	

Problem/Needs			
Date		Date	

Date: _____ **SERVICE PLAN**

Goal #1	Objective(s) (including frequency)	Intervention(s) (including frequency)	Responsible Parties
<p>Client. will take appropriate steps toward reinstating NC driver's license.</p> <p>Client will take appropriate steps toward clearing drug/paraphernalia charges that brought them into SA Tx. as evidenced by following objectives 1, 2, 4 and 5 of the objectives noted in following column.</p> <p>Corresponding ASAM Dimension(s): 4, 6</p>	<ol style="list-style-type: none"> 1. Client will complete a minimum of _____ hrs of SA Tx. in no less than _____ days. 2. Client will maintain abstinence from all non-Rxed mood altering substances as evidenced by <u>self-report</u> /BAC/ UDS results (1x/wk.). 3. Client will gain knowledge of NC DWI Laws by participating in group discussions and exercises (1x). 4. Client will pay all fees of \$_____ and inform SAC of conviction date. 5. Client will actively participate in all groups and activities with minimal prompting and engage in developing coping skills to deal with issues other than use/drink alcohol/drugs. 	<ol style="list-style-type: none"> 1. SAC will facilitate SA Tx and maintain all records of attendance /participation. 2. In group, SAC will encourage client to share triggers and barriers to maintaining abstinence as they arise. SAC will maintain records of Client by self-report of abstinence/ substance use (1x/wk.). 3. SAC will facilitate group discussion and exercises on NC DWI Laws utilizing handouts. SAC will maintain all records of Client attendance and participation (1x). 4. SAC will enter Certificate of Completion (E508) once Client has completed tx, paid all fees, and provided conviction date(s). 5. Client will participate at least once weekly to any of the three groups offered each week. 	<p>SAC & Client</p> <p>SAC & Client</p> <p>SAC & Client</p> <p>SAC & Client</p> <p>SAC & Client</p>

Target Date	Reviewed Date	Status Code	Status Codes: N= New R = Revised O = Ongoing A = Achieved D = Discontinued Justification for Continuation / Discontinuation of Goal:
		N	

BK Professional Counseling Center, LLC.

125 East Plaza Drive, Mooresville, NC 28115 Ph: 704-662-3923, Fax: 704-662-3913

Treatment Plan (cont.)			
Date:			
Goal #2	Objective(s) (including frequency)	Intervention(s) (including frequency)	Responsible Parties
Corresponding ASAM Dimension:	1. Client will report progress on this goal and indicate to counselor how the goal is being met. 2. Client will verbalize steps taken to fulfill this goal and verbalization of goals in group therapy and how this goal is affecting his/her life and/or how they want this goal to affect their life. 3. Client will learn new coping skills and identify ways to meet goal.	1. SAC will facilitate group discussion and/or 1:1 counseling on this goal to assist client in identifying coping skills to deal with the goal as well as gaining insight from other peers to gain knowledge of how to help client meet this goal as requested. 2. SAC and peers will assist client in identifying barriers to this goal and how to overcome barriers to meeting this goal. 3. Client will participate at least once weekly in group therapy to any of the three groups offered.	SAC & Client SAC & Client SAC & Client
Target Date	Reviewed Date	Status Code	Status Codes: N= New R = Revised O = Ongoing A = Achieved D = Discontinued Justification for Continuation / Discontinuation of Goal:
		N	

Date:			
Goal #3	Objective(s) (including frequency)	Intervention(s) (including frequency)	Responsible Parties
Corresponding ASAM Dimension:			SAC & Client
Target Date	Reviewed Date	Status Code	Status Codes: N= New R = Revised O = Ongoing A = Achieved D = Discontinued Justification for Continuation / Discontinuation of Goal:
		N	

SERVICE PLAN

Staff and Client / Legally Responsible Person sign below whenever the plan is implemented / reviewed / revised.			
Date	Staff Signature	Date	I have had input into this plan and I agree with this plan. (Client / Legally Responsible Person Signature)

(Each treatment goal should correspond with one or more ASAM Dimensions)

- ASAM Dimension 1: Acute Intoxication/Withdrawal Potential**
- ASAM Dimension 2: Biomedical Conditions and Complications**
- ASAM Dimension 3: Emotional/Behavioral or Cognitive Conditions and Complications**
- ASAM Dimension 4: Readiness to Change**
- ASAM Dimension 5: Relapse/Continued Use Potential**
- ASAM Dimension 6: Recovery Environment**