SAN BERNARDINO COUNTY
Behavioral Health
621 East Carnegie Drive, Suite 210, San Bernardino | Phone: 800-968-2636 • Fax: 909-381-2172
www.SBCounty.gov

Reset

ADMISSION AGREEMENT

I, _____, hereby acknowledge my consent to enrollment in Substance Use Disorder (SUD) Choose Item _____ Treatment services provided by Choose Item _____

I expressly acknowledge that all the information I have furnished upon intake is true to the best of my knowledge and confirm that I am not enrolled in any other Substance Use Disorder (SUD) program at this time.

- **Eligibility for Medi-Cal is payment in full for services rendered.**
- If I am **not** Medi-Cal eligible, I agree to submit payment, based on an increment of service, for Outpatient/Intensive Outpatient services provided by this program until fees are paid in full.

  Unit of Service means: contact on a calendar day for Outpatient Treatment or Intensive Outpatient Treatment. Unit of service is identified in the following table:

Encounter Rates	Unit of Service	Rate
Outpatient Treatment	15 minute increments	$
Intensive Outpatient Treatment	15 minute increments	$

- If I have fees to pay, they will be due: _____ [payment date(s)]
- If I have over-paid fees, then a reimbursement of the over-payment will be refunded to me.

REFUND POLICY:

Client fee refund requests due to over-payment of client fees is initiated by Substance Use Disorder and Recovery Services Administration. These requests will be submitted to Accounts Payable for processing.

PRIVATE PAY POLICY:

The Department of Behavioral Health uses the Uniform Method of Determining Ability to Pay (UMDAP) to calculate your Sliding Scale Fee.

SERVICES INCLUDE:

- Intake
- Individual and/or Group Counseling
- Patient Education
- Family Therapy
- Medication Services
- Collateral Services
- Crisis Intervention Services (when necessary)
- Treatment Planning
- Discharge Services
- Coordination of Care
- Random Drug Testing

- Collaboration with Referral Source

CONFIDENTIALITY:

I have been made aware that only authorized program personnel will have access to my file and that no records, statements, or data contained therein may be used to prosecute, charge, or otherwise infringe upon my Civil Rights. Disclosing my protected health information (PHI) requires I sign an Authorization for Release of Protected Health Information (COM001) unless the disclosure meets one of the exceptions listed below. This assures confidentiality of my records as stipulated by the Code of Federal Regulations, Title 42, Part 2.

Exceptions to Confidentiality - I understand that the program **may be required** to share my information for these purposes:

1. In case of a bon-a-fide medical emergency to a medical professional;
2. Reporting suspected homicide, suicide, elder abuse, or child abuse;
3. Reporting a client's crime on program premises or against program personnel;
4. During a qualified audit or evaluation of the program;
5. Appropriately reviewed and vetted research requests;
6. To a Qualified Service Organization which has a formal agreement in place with the program, or
7. Responding to a court order authorizing the release of my records.

RELAPSE POLICY:

I recognize that relapse can be part of the treatment process. If I begin failing the program because of an inability to discontinue drug or alcohol use, I may be given an opportunity:

1. To return to the program for completion if I can successfully complete withdrawal management or a higher level of care program;
2. To work with program staff to ensure my success at the current program through the use of interim referrals to more intensive treatment, when indicated;
3. To use intervention methods as long as the alcohol and drug counselor's assessment indicates that I am showing adequate motivation to remain alcohol and drug free; **and/or**
4. The alcohol and drug counselor may refer me to a higher level of care at any time, if it is in my best interest and approved by the Program Manager/Clinic Supervisor.

CONSEQUENCES FOR RELAPSE:

I acknowledge that I have been made aware of the consequences for relapse and/or using alcohol/illegal drugs while enrolled in the program _____ (Client initials).

Examples of possible consequences for relapse are, but not limited to:

- Being put on a contract;
- Writing an apology letter to peers;
- Submitting to a drug test before each group;
- Completing community service;
- Being referred to the Probation Department;
- Being referred to a higher level of care, **and/or**
- Possible incarceration.

CONSEQUENCES FOR ATTENDING UNDER THE INFLUENCE:
I acknowledge the following as examples of possible consequences for attending treatment under the influence:

- Being separated from the group and having an intervention with the counselor;
- I may be asked to leave the premises;
- If I am driving, my keys will be confiscated but I will be allowed to call for a ride;
- If I drive away under the influence, police **will be** called;
- I may be referred to detox or higher level of care, **and/or**
- Possible incarceration.

I MAY BE TERMINATED FROM THE PROGRAM FOR:

1. Being consistently late or missing scheduled appointments;
2. Not attending individual and group alcohol and drug counseling as required;
3. Not adhering to counseling treatment as outlined in my treatment plan;
4. Not paying fees for treatment per program guidelines, and
5. Not following program rules.

VIOLATIONS THAT WILL RESULT IN TERMINATION:

I acknowledge that violations of any of these rules shall be cause for **immediate termination** from the program:

1. Any form of violence, physical abuse, or destruction of property
2. Verbal or abusive language while receiving services at the program.
3. Possession of drugs or alcoholic beverages on the premises; I am prohibited from dealing or using drugs/alcohol on or about the premises.
4. Persistent failure to appear at the clinic; this would include three consecutive unexcused absences within one month.
5. Loitering in the parking lot or in the building.
6. Theft, which includes property of the clinic or clinic staff.
7. Threats of violence or disruptive behavior.
8. Bringing any weapon on or near the program will result in arrest per Penal code 171(b).

GRIEVANCE PROCEDURE:
Grievances/Complaints for Substance Use Disorder Services may be directed to:

- Department of Behavioral Health, ACCESS Unit
  303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92418-0026
  (888) 743-1478 or (909) 386-8256, [TDD] 711 Fax (909) 890-0353, or

- Department of Health Care Services, Substance Use Disorder Services
  P.O. Box 997413, MS# 2601, Sacramento, CA 95899-7413
  Fax form to (916) 445-5084

- SUD Compliance Division**,** Public Number: (916) 322-2911, Toll Free Number: (877) 685-8333

I recognize that I am entitled to quality services and that I will not be discriminated against based on race, ethnic origin, sexual orientation, gender, age, religion, disability, or my ability to pay.

☐ I have received a copy of the Admission Agreement _____ (initial)

_____ _____
Client Signature Date

_____ _____
Witness Signature Date