Comanche Nation Prevention & Recovery Outpatient

STAFF USE ONLY

Name: _____ **Date:** _____

Tribe Affiliation/Nationality: _____ **SASSI ID#:**_____

Service Requested: (Mark all that apply)

- ☐ Inpatient Referral
- ☐ CNP&R Residential
- ☐ SASSI
- ☐ DUI Referral
- ☐ License Reinstatement
- ☐ Urine Analysis
- ☐ MAT
- ☐ BIP
- ☐ Detox
- ☐ Transportation
- ☐ Interlock Device
- ☐ SAE Class
- ☐ Parenting Class
- ☐ Gambling Class
- ☐ Grief Support
- ☐ Counseling Services/Referrals
- ☐ Hygiene
- ☐ Clothing
- ☐ Shelter
- ☐ Family Activities
- ☐ Financial Assistance

Referral Source:

- ☐ Self
- ☐ Probation & Parole
- ☐ DHS/ICW/CPS
- ☐ CNPRC
- ☐ Tribal
- ☐ Courts
- ☐ Other _____

Case Notes/Observations:

Staff make sure to date, time, and initial all communications with client

Release of Information:
_____
_____

Date/Initial:	Case Note:
	_____
	_____

Date/Initial:	Case Note:
	_____
	_____

Date/Initial:	Case Note:
	_____
	_____

ADD ADDITIONAL CASE NOTE IF NEEDED

Comanche Nation Prevention & Recovery Outpatient

Outpatient Services

Answer each category completely. If it does not apply, answer non-applicable (N/A).
If you do not answer each category in this application, it will be considered incomplete.

Name: _____ Date of Birth: _____

Age: ___ Gender: _____ Email: _____

Telephone number: _____ Message number: _____

Address: _____

City, State, & Zip: _____

Tribal Affiliation: _____ Race/Ethnicity: _____

Emergency Contact: _____ Telephone: _____

Legal Guardian Information: (if client is under the age of 18)

First Name: _____ MI: _____ Last Name: _____

Tribal Affiliation: _____ DOB: _____/_____/_____

Primary Telephone Number: _____ Secondary Number: _____

Insurance Information:

Primary Insurance Provider: _____

Policyholder Name: _____

Subscriber ID# (including letters): _____

Group Number: _____

Employment: *(circle one)* **Full-Time** **Part-Time** **Not-Employed** **Student**
Homemaker **Disabled** **Retired**

If yes, what's the name of your employer: _____

Marital Status: *(circle one)* **Married** **Unmarried Couple** **Single** **Divorced**
Separated **Widowed**

Highest Grade Completed: *(circle one)*
1st-4th **5th-8th** **9th** **10th** **11th** **12th**

Some College **2-Year College** **4-Year College** **Graduate Degree**

Number of Total Arrests: _____Number of DUI/DWI Arrests: _____Number in Household____

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Prior Alcohol/Drug Treatments: *(circle one)* Multiple Inpatient Outpatient Education None

Are you pregnant? Yes or No If yes, due date: _____

Do you have any children? Yes or No If yes, how many? List below:

Name	Age	DOB	Tribe Affiliation	Legal Guardian

Substance history for the last 12 months:

Mark Y/N for all and date last used.

SUBSTANCE NAME	Y/N	DATE	SUBSTANCE NAME	Y/N	DATE
Alcohol			Cocaine		
Inhalants			Marijuana/Hash		
PCP			Methamphetamines/AMP		
Hallucinogens			Codeine		
Heroin			Fentanyl		
Librium			Percocet		
MDMA(Ecstasy)			Xanax		
Oxycodone			Valium		
Morphine			Other?		

LEGAL:

Are you currently involved with the Legal System? Y or N

Do you have a Probation Officer: Y or N What County? _____

If yes, what is the name of your Probation Officer: _____

Date of charge: *(estimated)*	Charge:	County:
1.		
2.		
3.		

By signing, I understand that all parts of this application have been answered honestly and to the best of my ability in order to be considered for services.

_____ _____

Signature Date

_____ _____

Staff Signature Date

Comanche Nation Prevention & Recovery Outpatient

Mental Health Counseling Services

Are you currently receiving mental health services or counseling? (Please circle): Yes or No

Have you ever received mental health services or counseling in the past? (Please circle): Yes or No
If so, when was the last time you attended counseling? _____

Do you have a preference for in-person or telehealth/teletherapy? If yes, please specify. _____

Do you have a preference for the gender of your counselor? If yes, please specify. _____

Would you like to receive information about psychiatric medication? _____

Please provide a brief statement/reason/need for counseling or treatment.
_____
_____
_____

Identify one **specific** goal you would like to achieve in counseling or treatment.
_____
_____

Statement of Understanding:

affirm that the information in this application is correct to the best of my knowledge. I understand that if I am above the age of 16, I have the right to refuse treatment. I understand that all services and/or funding are subject to the availability of funds and approval/denial of the Prevention & Recovery Executive Director. The Comanche Nation Prevention & Recovery department operates off of an invoice payment system; therefore, the facility must be willing to accept payment in the form of a check from the Comanche Nation. I understand that payment will be made only once a bill is received by the Comanche Nation Prevention & Recovery from the referral location on file. By signing this statement, I agree that I am responsible for scheduling all appointments and will attend sessions as scheduled. I agree that I will not cancel any appointment without proper notice as required by the therapist and/or clinical office. Payment will not be provided for any session that I do not attend the full amount of time allotted. I am responsible for any fee that may incur if I am late, cancel, or no call/no show.

_____ _____
Signature Date

_____ _____
Staff Signature Date

Comanche Nation Prevention & Recovery Outpatient

Release of Confidential Information

If you do not provide a complete address, to include street, city and zip code, **notification of your inquiry will not be mailed.**

I, _____ authorize:
(Print name)

Comanche Nation Prevention & Recovery
Outpatient Center
807 S.W. F Ave Lawton, OK 73501
Phone: 580-357-3449

To release my confidential information to:

Name of person to receive information: _____

Organization: _____

Address: _____

City, State, & Zip Code: _____

Telephone number: _____

Email: _____

- **Information may include but not limited to assessment results, the progress report, or certificate of completion.**
- **I understand that my mental health records are protected under HIPAA (Health Insurance Portability and Accountability Act) and cannot be released without my written consent.**
- **I understand that my records are protected under Federal and State Confidentiality Regulation (42: CFR) and cannot be released without my written consent.**
- **I understand that I may revoke this authorization, in writing at any time, except for actions that may have already taken place prior to the date on my written revocation.**
- **In any event, this consent expires automatically ninety (90) days after the termination of current services.**
- **I acknowledge the release of confidential information was fully explained to me and I consent.**

_____ _____
Print Name Date

_____
Signature

Comanche Nation Prevention & Recovery Outpatient

Informed Consent

Group counseling can be a powerful and valuable avenue for healing and growth. It is the desire of your group facilitator(s) that you reap all the benefits group has to offer. To help this occur, groups are structured to include the following elements:

- A safe environment in which you are able to feel respected and valued as you work. An understanding of group goals and norms, and an investment by your facilitator and members to produce a consistent group experience.
- A safe environment is created and maintained by both the facilitator and the group members. Primary ingredients are mutual respect and a chance to create trust.
- Your group facilitator is BOUND by law to uphold and maintain confidentiality. Group members are bound by HONOR to keep **what is said in group, to stay in group** and to maintain confidentiality.

What to expect:

Group time consist of both teaching and processing time. Processing may revolve around an issue one member of the group is working on, with time for structured feedback and reactions by other group members. The group may focus on topic(s) with all members verbally participating. The group dynamic offers a place where you can experience support, and to understand more clearly how dynamics of addiction effect your own life, the life of others, and examine your own belief about yourself, God or your own higher power.
These dynamics provide a very powerful environment of recovery.

YOUR PRESENCE IS HIGHLY IMPORTANT! Taking a step into recovery and making it a priority is a commitment. It is understood that emergencies do occur and may prevent you from attending group. It is your responsibility to contact the CNP&R facilitator and making them aware of your absence.

In general, the law protects all communications between a client and CNP&R staff. CNP&R can release information to others about progress ONLY with WRITTEN PERMISSION. However, there are EXCEPTIONS:

- A client is in danger to self or others.
- A client is below 18 years of age.
- An elderly person is being abused or neglected.
- A client is requesting a release of information.
- A child is being abused or neglected.

I, _____ am requesting services from CNP&R. I acknowledge and agree to the terms of the informed consent.

Signature: _____ Date: _____

Comanche Nation Prevention & Recovery Outpatient

Service Agreement

I, _____ am requesting services from the Comanche Nation Prevention & Recovery (CNP&R). By initialing the following, I acknowledge and agree to the terms and conditions of the service agreement:

1. If I do not agree with the method, length, and outpatient strategies being utilized by CNP&R, I may seek services elsewhere. I will be given resources if I chose to seek other services. _____ (Initial)

2. CNP&R utilizes evidence-based curriculum with the Substance Abuse Education (SAE) class, NICWA Parenting, and Gambling (Whichever applies). However, no specific outcome can be guaranteed. _ (Initial)

3. I understand, if three (3) of the (12) twelve classes for SAE/Gambling, or one (2) of the eight (8) classes for Parenting are missed, I will be obligated to start from the beginning. The class schedule I choose is set and cannot be changed. NO EXCEPTIONS! _____ (Initial)

4. I agree to attend all scheduled classes and be on time. I agree to call in advance if I am going to be late or if I am unable to attend. _____ (Initial)

5. I understand, that I am responsible for any curriculum given to me, CNP&R will not replace any forgotten, lost, or stolen curriculum. I will write out notes from class if such events require. _____ (Initial)

6. I understand that ALL twelve (12) or eight (8) classes must be done with CNP&R. No outside AA or NA group signature will be accepted. If I withdraw from the program, I agree to discuss the decisions with my class facilitator prior to taking any actions. _____ (Initial)

7. I understand class participation is required with open group discussions and in class writing. Refusal to participate in class and no class room cooperation are grounds for CNP&R to **terminate services and execute dismissal.** Upon dismissal, resources will be provided to gain service elsewhere. NO EXCEPTIONS! _____ (Initial)

8. I understand that I must Sign-In and attend the entire class in order to receive credit for that class. Our services are intended for individuals who want to abstain from alcohol and drugs and gain knowledge from our offered classes. _____ (Initial)

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9. I understand that I will not use my cell phone during class. _____ (Initial)

10. I understand that ALL information discussed and/or disclosed is STRICTLY CONFIDENTIAL and is protected by US 42 CFR. CNP&R staff will not release any information without written authorization by client. _____ (Initial)

11. CNP&R utilizes an internal and an external video surveillance recording system for security purposes only, not for client clinical record. The recordings are visual only, not auditory. _____ (Initial)

12. No vaping in the classroom. _____ (Initial)

13. Talking about prescribed medication is prohibited, any discussion in class you will be warned and/or asked to leave. _____ (Initial)

14. I understand that immediate termination of services and appropriate authorities will be notified if I, verbally, physically, or threaten to harm any CNP&R staff, clients, and/or potential client_____ (Initial)

15. ZERO TOLERANCE-Staff working for the Comanche Nation have the right to carry out their work in a safe environment. Violence, foul language, and/or abusive behaviors re not accepted on the premises. Verbal threats or acts of violence towards staff, associates, or visitors will not be tolerated and may result in denial of services and/or removal from this facility and/or may result in prosecution. _____ (Initial)

16. I agree that it is essential for me to come to class drug and alcohol free. **I understand that I will be asked to leave if I am under the influence. I will have to arrange safe transportation home. _____** (Initial)

List one goal from receiving services: _____

Print Name: _____Date: _____

Signature: _____Date: _____

Comanche Nation Prevention & Recovery Outpatient

Photo Release Form

For good and valuable consideration, the receipt of which is hereby acknowledged,

I, _____, hereby grant Comanche Nation Prevention & Recovery Outpatient permission to use my likeness in a photograph in any of its publications, including but not limited to, printed and digital publication. I understand and agree that any photograph using my likeness will become property of the Comanche Nation Prevention & Recovery Outpatient I acknowledge that since my participation of Comanche Nation Prevention & Recovery Outpatient is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize Comanche Nation Prevention & Recovery Outpatient to edit, alter, copy, exhibit, publish or distribute this photo for purpose of publicizing Comanche Nation Prevention & Recovery Outpatient programs or any other related, lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph(s).

I agree that my participation with the Comanche Nation Prevention & Recovery Outpatient will be released and announced in accordance with photographs or program information. I hereby hold harmless or release and forever discharge Comanche Nation Prevention & Recovery Outpatient from all claims, demands, and causes of action which, I, my heirs, representatives, executors, administrators, or any other acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Print Name: _____Date: _____

Signature: _____Date: _____