



**Deborah Kay-Ostrander MS IAADC SAP**  
**725 ½ Main Street, Pella, Iowa 50219**  
[Debko@keystosuccesspella.com](mailto:Debko@keystosuccesspella.com)  
**Cell Phone: 641-780-1087**  
**Office: 641-204-0055**

## CLIENT INTAKE INFORMATION

Date:	Full Name:		
Date of Birth:		Age:	
Gender:	Phone Number:		
Social Security Number:			
Email:			
Street Address, Apt# or P.O. Box:			
City, State:		Zip Code:	
County:			
Marital Status (circle one):    Single        Married        Divorced        Widowed			
Spouse Name:		Number of Children:	

[Greyed out header area]

Employer Name:

Employer Address:

[Greyed out header area]

Insurance: Yes or No

Name of Insurance:

Policy Holder:

Address:

Policy Number:

Referred:

## *Keys to Success*

### **CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

The confidentiality of alcohol and drug abuse patient records maintained by the program is protected by Federal law and regulations. Generally, the program may not say to a person outside that program that a patient attends the program, or disclose any information identifying the patient as an alcohol or drug user unless:

1. The Patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law, appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C 290ee-3 for Federal Laws and 42 part 2 for Federal regulations)(Approved by the Office of Management and Budget under control number 0930-0099)(Code of Federal Regulations title 42, volume 1. revised as October 1, 2002)

*Keys to Success*

**CONFIDENTIALITY AGREEMENT**

This is to acknowledge that I am entering Keys to Success as a patient or concerned person. I have been given a copy of the summary of Federal Confidentiality Regulations regarding treatment for alcohol and drug use.

I agree and understand that confidentiality is necessary for me to express myself without fear of disclosure outside the treatment center.

I agree to keep the confidentiality of others that I may come in contact with while participating in treatment at Keys to Success. My discussing their presence or issues would be breach of confidentiality.

I understand that any disclosure by me regarding others in treatment at Keys to Success could result in my discharge from the program.

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

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## *Keys to Success*

### **TREATMENT ACTIVITIES AND CLIENT EXPECTATIONS.**

#### **TREATMENT ACTIVITIES:**

1. Your treatment will consist of educational materials on addiction and recovery, individual counseling sessions, recovery assignments and may include group counseling.
2. Continuing outpatient treatment will be determined by your progress. When the staff determines that your addiction requires a more intense level of care, you will be referred to an appropriate facility that meets your needs.
3. Total abstinence from all alcohol and drug use is mandatory for treatment to benefit you.
4. The fee of \$120.00--\$60.00 sliding fee rate per session for treatment services include your individual counseling sessions, education materials and individual assignment materials. Financial arrangements must be made with the Executive Director of Keys to Success prior to starting treatment. Purchase of books or other materials are not included in treatment fees. Keys to Success is available to assist with your filing insurance claims. Your treatment fees, are however your responsibility and payment is expected when services are rendered.
5. Continuing care is a service for those completing primary treatment at Keys to Success or those who have been referred from other facilities. Continuing care fee is \$60.00 per group for participation.

#### **CLIENT EXPECTATIONS:**

1. You are expected to be on time for appointments, staff may reschedule your appointment when you are late. If an emergency prevents you from being on time, call Keys to Success at 641-780-1087 and our office will reschedule your appointment. Missing appointments could lengthen your estimated discharge from treatment.
2. You are expected to participate fully in your treatment, and to complete assignments on time, give honest feedback in group when assigned to group.
3. You are expected to adhere to confidentiality regulations regarding others at the treatment center, to respect others rights, privacy, opinions and dignity of others.
4. Physical abuse, verbal abuse, sexual misconduct, to be in possession of alcohol or drugs or continued use of alcohol or drugs could result in your immediate discharge from treatment.

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**SERVICE FEE SCHEDULE**

The following fees will be charged for the services provided by The Keys to Success.

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.**

<b>Prime for Life (Drunk Driving Ethic, Course)</b>	<b>\$180.00</b>
<b>OWI SCREENING FEE</b>	<b>\$130.00</b>
<b>EVALUATION FEE</b>	<b>\$135.00</b>
<b>SLIDING FEE RATE</b>	<b>\$85.00</b>
<b>1 HR NEW EVAL/NO INS.</b>	<b>\$85.00</b>
<b>1 HR EVAL/NO INS.</b>	<b>\$65.00</b>
<b>½ HR EVAL/NO INS.</b>	<b>\$32.50</b>
<b>UA</b>	<b>\$25.00</b>
<b>CONTINUING CARE PER SESSION OR GROUP</b>	<b>\$65.00</b>
<b>COPIES OF RECORDS PAGE, (MAX \$50)</b>	<b>\$1.00 PER PAGE</b>

## *Keys to Success*

### **CLIENT RIGHTS**

1. Every client involved with Keys to Success has the right to be treated with respect and dignity.
2. Every client has the right to know by name and credentials, those who are providing services to them.
3. Every client has the right to be informed of current information regarding their diagnosis, progress, in common terms they can understand. If staff judgement feels it is not in the best interest to share this information with the client, the staff may give this information to an appropriate family member of his behalf.
4. Every client has the right to privacy and confidentiality as it relates to his treatment and involvement with Keys to Success.
5. Every client has the right to privacy and individuality regarding his physical, social, psychological, spiritual, and sexual well being.
6. Every client has the right to be free of sexual harassment.
7. Every Client has the right to expect Keys to Success to make reasonable response to his request within a reasonable time frame.
8. Every client has the right to express a grievance or complaint he has relating to his treatment, services, or facilities of Keys to Success- every effort will be made to resolve complaints at the time with the person with whom they occur. It must be understood that not all complaints or grievances can be completely resolved. Opportunity to express complaints or grievances can be done during appointments, by asking to see a staff member, or by completing a grievance form. Clients also have the option of contacting Iowa Board of Addiction Disorder Certification, 3850 Merle Hay Road, Suite 303, Des Moines, Iowa 50310 regarding grievance against a staff member.
9. Every client has the right to privacy or confidentiality of his treatment records and information from his treatment record can be released to other persons or agencies only with his written consent, in accordance with 42 CFR. Part 2.
10. Every client has the right to information about the relationships of Keys to Success to other healthcare institutions and agencies so far as his care or referral is concerned.

Client Signature: \_\_\_\_\_

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

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**INFORMED CONSENT**

**FOR ALCOHOL AND DRUG TREATMENT**

I am in need of counseling and treatment for my addiction to alcohol and/or drugs, or I have been affected by another person's alcohol or drug addiction.

I am agreeing to fully participate in my treatment at Keys to Success, therefore I am making an informed decision to enter into a therapeutic relationship with Keys to Success staff.

I have been given a copy or explanation of the following:

1. Federal Confidentiality Regulations Summary and HIPPA Rights and Regulations.
2. Estimated cost and length of treatment.
3. Clients Rights and Treatment expectations.
4. Confidentiality Agreement.
5. HIV/AIDS information
6. Weapons Policy
7. Chemical Substance Policy.
8. Facility Orientation.
9. Fire and Tornado Procedure.
10. Treatment Plan.

*I understand that I may revoke this agreement at anytime, and that this agreement is valid for the length of my treatment at Keys to Success.*

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

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Keys to Success*

**INFORMED CONSENT**

1. Purpose of treatment: to receive an evaluation addiction disorder and/or recommended treatment.
2. Any possible negative consequences to treatment: The possibility of physical discomfort from stopping misuse of alcohol or drugs and/or possibility of therapist consulting with other professionals in regard to the case.
3. Any alternatives to treatment: any alternatives will be discussed throughout the evaluation and/or upon recommendations for treatment or the clients progress toward recovery goals.

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

Substance Abuse Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

## *Keys to Success*

### **CORE GOALS, OBJECTIVES, AND ACTIVITIES.**

The goal of Keys to Success is to assist clients in identifying and beginning to change behaviors and attitudes that may be caused by their use of alcohol and drugs. All clients of Keys to Success are expected to participate in the core program during their treatment process. The core goals are:

1. Recognize the symptoms and progression of addictive disease.
2. Begin to identify and change negative behaviors related to their addiction.
3. Develop, with the help of staff, a plan of recovery to maintain new behaviors.

The core objectives and activities throughout treatment will include your being open and honest about your personal history of alcohol and drug use and its effects on self and others. You are also agreeing to:

1. Complete an alcohol and addictive disorder history or write your life story, whichever assigned by your counselor.
2. Complete all assignments given.
3. Be on time for your scheduled appointments.

During the treatment process gain knowledge of the 12 Step Recovery Program and how to start practicing the steps and principles can be incorporated into your daily life and ongoing recovery.

1. Complete step work assignments as given.
2. Read and discuss the first 164 pages of the AA Big Book.
3. Attend a 12 step meeting.

During the treatment process demonstrate your willingness to change negative behavior by:

1. Abstain from all alcohol and drug use while in treatment.
2. Follow "Client Expectations"
3. Develop a personal plan for recovery.

Your counselor will monitor the core objectives. The core program may be limited or changed based on the clients abilities or on clinical decision as documented below.

An initial treatment plan will be based upon the presenting problem, and a comprehensive treatment plan based on all assessments will be developed with the clients input within 30 days of admission to level I.

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

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## *Keys to Success*

### **IMPORTANT INFORMATION FOR PATIENTS ABOUT BLOOD TEST FOR THE PRESENCE OF HIV ANTIBODIES**

Iowa law requires that, prior to withdrawing blood for the purpose of performing an HIV-related test, the subject of the test shall be provided with preliminary counseling which shall include a minimum explanation to the test including its positive and negative results, and explanation of the nature of AIDS and ARC, including the relationship between the test results and the diseases; an explanation of the procedures should be followed, requested, either by anonymous administration of the test or by confidential referral to a site which provides anonymous testing; and information concerning behavioral patterns known to expose a person to the possibility of contracting AIDS and methods for minimizing risk of exposure.

**WHAT IS HIV?** Human Immunodeficiency Virus (HIV) is a virus which is the cause of Acquired Immune Deficiency Syndrome (AIDS)

**WHAT IS THE HIV ANTIBODY TEST?** A sample of your blood will be tested to see if it contains antibodies to the virus that is the cause of AIDS.

**REASONS FOR TESTING?** The test is useful in certain clinical situations, and may help you and your physician make certain decisions.

Antibody-positive women should not become pregnant because the virus can be transmitted to the developing child and pregnancy may cause the disease to progress. Certain individuals are more likely to be infected include:

Men who have had sex with another man at anytime since 1978.

Past and present users of intravenous drugs.

Recipients of multiple blood transfusions or blood product in high risk areas from 1978 to May 1, 1985.

Individuals with multiple sex partners or anyone who has sexual conduct with persons from above.

**ANTIBODY TEST RESULTS AND WHAT THEY MEAN- A POSITIVE TEST RESULT:** If your test is positive it means:

1. Your blood sample has been tested more than once and the test indicate that contains antibodies to the AIDS virus (HIV)
2. You have been infected with the AIDS virus, and your body has produced antibodies.
3. You have a definite risk of developing AIDS or AIDS Related Complex. (ARC)

4. Research has shown that most people with HIV antibodies have active virus in their bodies and probably can transmit it to others, even if they show no symptoms. You should consider yourself contagious and capable of passing the virus on to others by sharing needles, blood, organ donation, and intimate sexual contact.
5. If your test is positive and you do not engage in high-risk activity you may have a false positive.

IF YOUR TEST IS POSITIVE, IT DOES NOT MEAN:

1. That you necessarily have AIDS or AIDS Related Complex (ARC)
2. That you necessarily will get AIDS or ARC.
3. That you are immune to AIDS or ARC.

THEREFORE IF YOUR TEST IS POSITIVE, YOU SHOULD DO THE FOLLOWING:

1. Protect yourself from any further infection.
2. It is likely that you will carry the virus in your body throughout your life. Protect others from the virus by following AIDS precautions in sex, drug use, and general hygiene.
3. Consider seeing a physician for a complete evaluation and advice on health maintenance.
4. Do NOT donate blood, plasma, body organs, or other tissue. Do not share needles with anyone.
5. Continue close and supportive relationships with family members and friends. Hugging, casual kissing, and other forms of affectionate behavior that does not involve exchange of body fluids do not spread the AIDS virus.
6. Remember that the AIDS virus is not spread by ordinary nonsexual contact such as shaking hands, sharing an office, coughing or sneezing, preparing or serving food, or sharing toilet facilities.

A NEGATIVE RESULT:

IF YOUR TEST IS NEGATIVE, IT MEANS:

1. No antibodies to the AIDS virus have been found in your blood at the time of the test.

TWO POSSIBLE EXPLANATIONS FOR A NEGATIVE TEST RESULT EXISTS:

1. You have not been infected with the virus.

2. You have been infected with the virus, but have not yet produced antibodies. Research indicates that most people will produce antibodies within 12 weeks after infection. A very small number of people may not produce antibodies.

IF YOUR TEST IS NEGATIVE, IT DOES NOT MEAN:

1. That you have nothing to worry about. The AIDS epidemic has not yet peaked. Repeated exposure to the AIDS virus will increase your chances of being infected.
2. That you have not been infected with the virus. You may have been infected and not yet produced antibodies.
3. You are immune to the virus.

WHO WILL KNOW MY TEST RESULTS?

The result of your test will be placed in your confidential medical record. Medical practitioners and health care professionals responsible for your care and treatment may know your test result. No further disclosure of your test will be made without your written consent, except where required by law.

*Keys to Success*

**Michigan Alcohol Screening Test (MAST)**

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

***Circle your answer: YES OR NO***

1. Do you feel you are a normal drinker? ("normal"-- drink as much or less than most other people.

YES or NO

2. Have you ever awakened the morning after some drinking the night before and found that you can not remember part of the evening?

YES or NO

3. Does any relative or close friend ever worry about your drinking?

YES or NO

4. Can you stop drinking without difficulty after one or two drinks?

YES or NO

5. Do you ever feel guilty about your drinking?

YES or NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

YES or NO

7. Have you ever gotten into physical fights when drinking?

YES or NO

8. Has drinking ever created problems between you and a near relative or close friend?

YES or NO

9. Has any family member or close friend gone for anyone for help about your drinking?

YES or NO

10. Have you ever lost friends because of your drinking?

YES or NO

11. Have you ever gotten into trouble at work because of your drinking?

YES or NO

12. Have you ever lost a job because of your drinking?

YES or NO

13. Have you ever neglected your obligations, your family, or your work for more than 2 days in a row because you were drinking?

YES or NO

14. Do you drink before noon fairly often?

YES or NO

15. Have you ever been told you have liver trouble such as cirrhosis?

YES or NO

16. After heavy drinking have you ever had delirium tremens (D.T.'S), sever shaking, visual, or auditory (hearing) hallucinations?

YES or NO

17. Have you ever gone to anyone for help about your drinking?

YES or NO

18. Have you ever been hospitalized because of your drinking?

YES or NO

19. Has your drinking ever resulted in you being hospitalized in a psychiatric ward?

YES or NO

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problems in which drinking was part of the problem?

YES or NO

21. Have you ever been arrested more than once for driving under the influence of alcohol?

YES or NO

22. Have you ever been arrested, even for a few hours because of behavior while drinking? (if yes, how many times \_\_\_\_\_)?

YES or NO

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

*Keys to Success*

**Drug Abuse Screening Test (DAST)**

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

**Circle your answer: YES or NO**

1. Have you used drugs other than those required for medical reasons?

YES or NO

2. Have you misused prescription drugs?

YES or NO

3. Do you misuse more than one drug at at time?

YES or NO

4. Can you get through the week without using drugs (other those required for medical reasons)?

YES or NO

5. Do you misuse drugs on a continuous basis?

YES or NO

6. Do you try to limit your drug use to certain situations?

YES or NO

7. Have you had "blackouts" or "flashbacks: as a result of drug use?

YES or NO

8. Do you ever feel bad about your drug misuse?

YES or NO

9. Does your spouse (or parents) ever complain about your involvement with drugs?

YES or NO

10. Do your friends or relatives know or suspect you misuse drugs?

YES or NO

11. Has drug misuse ever created problems between you and your spouse?

YES or NO

12. Has any family member ever sought help for problems related to your drug use?

YES or NO

13. Have you ever lost friends because of your drug use?

YES or NO

14. Neglected your family or missed work because of your drug use?

YES or NO

15. Been in trouble at work because of drug misuse?

YES or NO

16. Lost a job because of drug misuse?

YES or NO

17. Gotten into fights when under the influence of drugs?

YES or No

18. Been arrested because of unusual behavior while under the influence of drugs

YES or NO

19. Been arrested for driving under the influence of drugs?

YES or NO

20. Engage in illegal activities to obtain drugs?

YES or NO

21. Been arrested for possession of illegal drugs?

YES or NO

22. Experienced withdrawal symptoms as a result of a heavy drug intake?

YES or NO

23. Had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, or bleeding)?

YES or NO

24. Gone to anyone for help for a drug problem?

YES or NO

25. Been in the hospital for medical problems related to drug use?

YES or NO

26. Been involved in a treatment program specifically related to drug dependence or misuse?

YES or NO

27. Been treated as an outpatient for problems related to drug dependence or misuse?

YES or NO

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

*Keys to Success*

**POSSESSION OF CHEMICAL SUBSTANCES**

Policy: It is the policy of Keys to Success to prohibit the possession of any chemical substances on the grounds of the treatment facility, or inside the treatment center.

Procedure:

1. Any client in possession of chemical substances will be asked to dispose of them by either flushing them in the presence of a staff member, or turning them over to the treatment staff for proper disposal. Refusal to comply could result in law enforcement being called to facility or possible discharge from the program.
2. When substances are turned over to the treatment staff, they will, depending on the substance, be flushed, with a witness, when one is available or turned over to law enforcement for proper disposal.
3. When any chemical substances are destroyed, a record of disposal will be documented and kept in the safety book.
4. If disposal is made by law enforcement, they will be asked to sign that they took possession of the substance for disposal.

*Keys to Success*

***UNDERAGE TOBACCO USE***

Policy: It is the policy of Keys to Success to prohibit underage tobacco use.

Procedure:

1. Staff or patients will not sell, give, or otherwise supply any tobacco, tobacco products, or cigarettes to any person under the age of 18 or any other person at Keys to Success since it is against Federal regulations to allow smoking on premises.
2. Any person or any person under the age of 18, will not smoke, use, purchase, or attempt to purchase tobacco, tobacco products or cigarettes while participating in any treatment modality at Keys to Success.
3. Use of any tobacco product by those under 18 years of age or any other client will result in disciplinary action, which could include discharge from the treatment center.
4. Any adult patient or staff member over the age of 18 who gives any tobacco products to a patient who is under 18 years of age will result in disciplinary action, patient disciplinary action could include discharge from the treatment program.

*Keys to Success*

**TORNADO POLICY AND PLAN**

Policy: It is the policy of Keys to Success to have a tornado plan which will be implemented when a tornado warning or severe weather warning is issued by local authorities, or through public emergency broadcast system.

- Procedure:
1. A tornado plan and evacuation plan will be posted in plain sight near the exit door.
  2. Close all doors and windows.
  3. Remove any items in windows that could become flying projectiles.
  4. All persons will get away from windows and go to the center office of the building or to the basement located at the ground level at the entrance of the office.
  5. Await instructions from staff or via the emergency broadcast.

**\*\*See attached tornado plan notice to be posted and the evacuation map\*\***

## **FIRE POLICY**

Policy: It is the policy of Keys to Success to post a fire and evacuation plan in plain sight near the exit door. In the event of a fire, the following procedure will be implemented.

In the event of a fire or smoke alarm sounding, please follow the steps below.

1. Staff will direct you.
2. Staff will notify the Fire Department and staff will attempt to contain the fire using the fire extinguishers if possible.
3. Staff will close doors and windows, wait in hallway for instructions from the staff.
4. Rescue any patient, visitor or staff.