Adult & Teen Challenge

Arkansas

INDUCTION CHECKLIST
CONFIDENTIAL

To be initialed by STAFF conducting the Induction, and by the NEW STUDENT

DATE: _____ **STUDENT NAME:** _____

INDUCTION PROCEDURE	*Staff Initials*	*Student Initials*
Photo Taken		
Copy ID, SS card, Insurance Card		
Strip Search		
Belongings Search		
Luggage Marked **(Personal Property to be placed in Luggage)**		
Personal Property Release		
Christian Conciliation Agreement		
Medication Agreement		
Personal Story & Media Release Form		
Background Information Consent Form e		
Fountain Lake Pharmacy & Medication Form		
SNAP Agreement		
Release Form for Contacts **(Include Phone #s of Contacts)**		
Vocational Therapy Acknowledgement Form		
Receipt and Agreement to Student Handbook		
[illegible]		
Allow Student to make 3-minute phone call **(To inform EMERGENCY CONTACT of arrival)** **Person Contacted:** _____ **Phone Number:**_____		
Review Discipline Policy with student		
Complete Front of File Folder		
Initial Personal Contact **Minister/Student:** _____		
Answer Any Questions		
Other:		

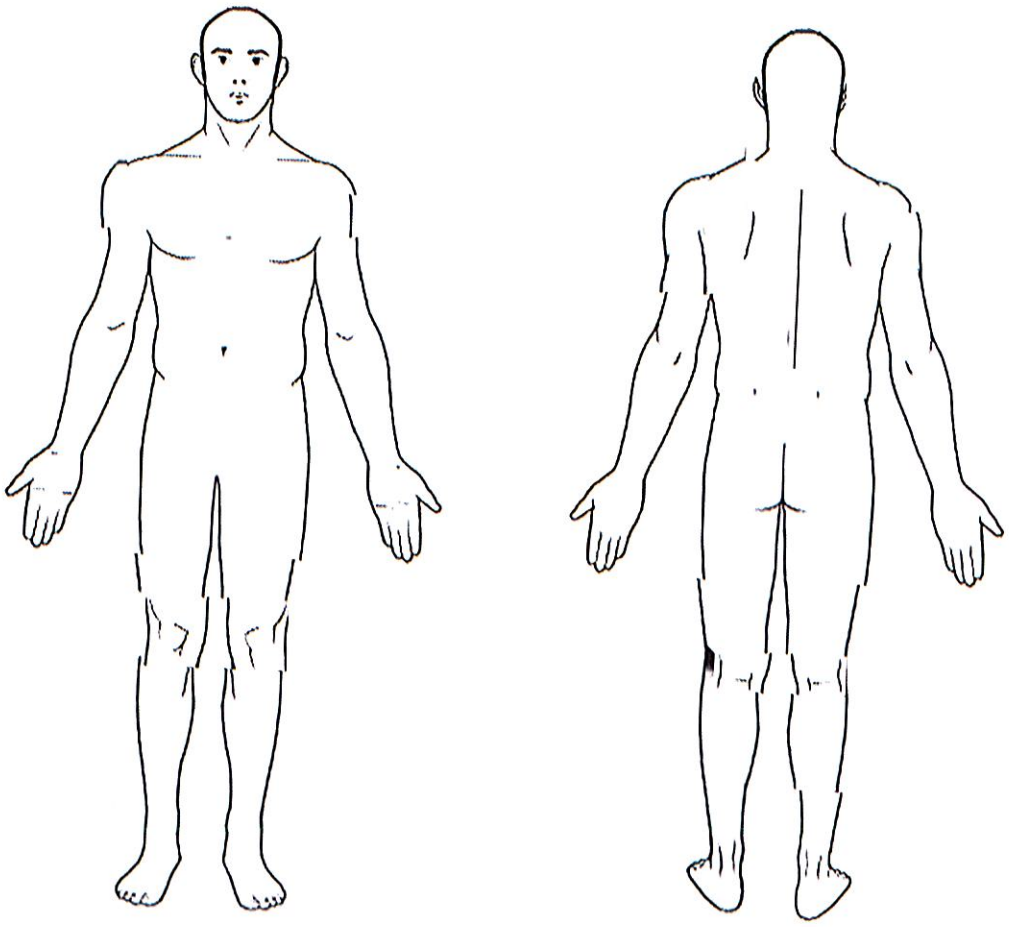
Adult & Teen Challenge

Arkansas

Adult & Teen Challenge Body Search Form

Mark any bites, sores, cuts, rashes, bruising, etc. on the pictures below.

Student Name: _____ Date: _____



Staff Name: _____ Initial: _____

Staff Name: _____ Initial: _____

Adult & Teen Challenge
Arkansas

Personal Property Release
Confidential

I, _____, acknowledge and accept that any and all personal property left behind at the time of my departure from the program will become the property of Adult & Teen Challenge of Arkansas, and that I will not hold Adult & Teen Challenge of Arkansas responsible for storage or disposal of any property left behind. I further understand that when traveling by bus I may only take two items of luggage with me. One piece weighing no more than 25 lbs. to be carried on the bus and one piece weighing no more than 50 lbs. to be stowed underneath the bus. (Greyhound guidelines)

_____ _____
Student Signature Date

_____ _____
Staff Signature Date

_____ _____
Witness (if necessary) Date

Adult & Teen Challenge

Arkansas

Adult & Teen Challenge
Christian Conciliation and Arbitration Agreement

In consideration of the following terms and provisions, and the valuable consideration the receipt of which I acknowledge, the undersigned parties hereby agree as follows:

They accept the Bible as the inspired word of God. They believe that God desires that they resolved their dispute with one another within the Church and that they be reconciled in their relationships in accordance with the principles stated in I Corinthians 6:1-8, Matthew 5:23-24, and Matthew 18:15-20.

Accordingly, the undersigned parties hereby agree that any dispute or controversy arises between them and is not resolved in private meetings between the parties pursuant to Matthew 5:23-24 and 18:15, then the dispute or controversy will be settled by biblically based mediation and, if necessary, legally binding arbitration, in accordance with the Rules of Procedure for Christian Conciliation (Rules) of the Institute for Christian Conciliation, a division of Peacemaker Ministries (rules available at www.HisPeace.org). The undersigned parties agree that these methods shall be the sole remedy for any dispute or controversy between them and to the full extent permitted by applicable law, expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce arbitration decision, or to enforce this dispute resolution agreement. Any mediated settlement agreement, or arbitrated decision hereunder shall be final and binding, and fully enforceable according to its terms in any court of competent jurisdiction.

_____

Signature Date

_____

Witness Date

Adult & Teen Challenge
Arkansas

Adult & Teen Challenge of Arkansas

Medication Agreement

Adult & Teen Challenge of Arkansas (ATCAR) is a non-medical and non-clinical facility. ATCAR does not prescribe or dispense medication. ATCAR supervises the taking of medications as part of its addiction recovery program. It is the student's responsibility to know and understand the medication he is taking.

Medication will be stored in a locked area accessible only to authorized personnel. The student is to come to the Med Room, or to a predetermined location, at the prescribed time to receive medication. Prescription medication will be taken according to instructions printed on the package. If samples are given from a doctor, the doctor should send instructions on prescription paper or letterhead.

The date, time, and dosage of the medicine taken will be logged in the med log book. The student taking the medication and the staff member supervising will sign acknowledging the taking of the medication.

Over-the-Counter (OTC) medications will be treated in the same manner. OTC medication will be taken according to the instructions printed on the package.

In no case may any staff or student administer any medication outside the framework of the procedures outlined here and/or in ATCAR regulations.

_____

Student Printed Name

_____

Student Signature Date

_____

Witness Date

Adult & Teen Challenge

Arkansas

PERSONAL STORY & MEDIA RELEASE FORM

In consideration of and as a condition to my admission to *Adult & Teen Challenge of Arkansas,* Christian recovery and discipleship ministry ("the Ministry"), I hereby give *Adult & Teen Challenge of Arkansas* (the "Licensee") and its sub licensees, assigns and legal representatives including, but not limited to Adult & Teen Challenge USA and Global Adult & Teen Challenge the perpetual, unlimited, but revocable worldwide right to use, publish and/or broadcast my name and personal story which I have related to *Adult & Teen Challenge of Arkansas* in whole, or in part, along with my voice, name, statements, testimonials, pictures, photographs and/or composite representations thereof for archival, educational, inspirational, advertising, publicity, promotion, news, documentary, print, broadcast, and in all electronic and other media. This grant includes the right to modify and edit any film, videotape, audiotape and photograph taken or made of me during my participation in the Ministry, and to use words, symbols, designs, illustrations, recordings or other communications elements in conjunction with it or them.

The Licensee will not use any information about me other than what I voluntarily and personally provide.

I agree that all recordings, video, film, photography, drawings or other images taken or made of me by the Licensee are owned by it and that it may copyright any such creative works. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else. I hereby waive my right to review or approve any of the above or the use to which they may be applied. The Licensee shall not be obligated to make use of any of the rights granted therein.

I hereby release, discharge and agree to hold the Licensee, its sub licensees and all persons acting with its permission or authority harmless from any claim, demand or liability attributable to any use or activity authorized herein, including without limitation any claims for defamation, libel or invasion of privacy or publicity rights.

I have read the above and I fully understand and agree to the contents thereof. This agreement shall be binding upon me and my survivors, heirs, legal representatives and assigns.

I understand that upon ninety days written notice from me to *Adult & Teen Challenge of Arkansas*, the Ministry will discontinue all uses and activities authorized above, and, if it has authorized third parties to make such uses or engage in such activities, it will make reasonable efforts to see that such third party or parties discontinues them as well.

Student Signature: _____ Date: _____

Print Name: _____ Age: _____

Staff Signature: _____ Date: _____

Adult & Teen Challenge
Arkansas

Authorization for Release of Information
Adult & Teen Challenge of Arkansas, Inc

IF YOU RECEIVE INFORMATION RELEASED WITH THIS FORM THE FOLLOWING REGULATIONS APPLY TO YOU:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Name: _____ Client D.O.B. _____

I _____ hereby authorize Adult & Teen Challenge of Arkansas to

Release (specific information requested) Program Status Progress discharge

_____

The purpose or need of this authorization is: **_Program Status & Emergency Contact**

_____

The information is to be released to: _____

I know that this release may be revoked by me at any time, except to the extent that reliance has been taken thereon, and except if I have been referred by the Criminal Justice System, in which case the authorization is irrevocable. If not expressly revoked by me, this release will expire 1 year from the date below, unless a different date, event or condition is listed here:

Date and/or condition for the date to expire:

_____

Student Signature: _____ **Date of Signing:** _____

Witness Signature: _____ **Date of Signing:** _____

Adult & Teen Challenge
Arkansas

Authorization for Release of Information
Adult & Teen Challenge of Arkansas, Inc

IF YOU RECEIVE INFORMATION RELEASED WITH THIS FORM THE FOLLOWING REGULATIONS APPLY TO YOU:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Name: _____ Client D.O.B. _____

I _____ hereby authorize Adult & Teen Challenge of Arkansas and Restored fior Life Recovery Centers to Release (specific information requested) Program Status Progress discharge

The purpose or need of this authorization is: Program Status & Emergency Contact

The information is to be released to: _____

I know that this release may be revoked by me at any time, except to the extent that reliance has been taken thereon, and except if I have been referred by the Criminal Justice System, in which case the authorization is irrevocable. If not expressly revoked by me, **this release will expire 1 year from the date below,** unless a different date, event or condition is listed here:

Date and/or condition for the date to expire:

_____

Student Signature: _____ **Date of Signing:** _____

Witness Signature: _____ **Date of Signing:** _____

Adult & Teen Challenge
Arkansas

Authorization for Release of Information
Adult & Teen Challenge of Arkansas, Inc

IF YOU RECEIVE INFORMATION RELEASED WITH THIS FORM THE FOLLOWING REGULATIONS APPLY TO YOU:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Name: _____ Client D.O.B. _____

I _____ hereby authorize Adult & Teen Challenge of Arkansas to

Release (specific information requested) Program Status Progress discharge

_____

The purpose or need of this authorization is: Program Status & Emergency Contact

_____

The information is to be released to: _____

I know that this release may be revoked by me at any time, except to the extent that reliance has been taken thereon, and except if I have been referred by the Criminal Justice System, in which case the authorization is irrevocable. If not expressly revoked by me, **this release will expire 1 year from the date below,** unless a different date, event or condition is listed here:

Date and/or condition for the date to expire:

_____

Student Signature: _____ **Date of Signing:** _____

Witness Signature: _____ **Date of Signing:** _____

BACKGROUND INVESTIGATION CONSENT

I, _____ hereby authorize Adult & Teen Challenge of Arkansas, Inc. and/or its agency to make and independent investigation of my background, references, character, past employment, education, credit history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualifications , employment now and, if applicable, during the tenure of my employment with Adult & Teen Challenge Arkansas, Inc.

I release Adult & Teen Challenge of Arkansas and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge:

_____ _____

Full Name **Other Names Used**

_____ _____

Present Address **How Long?**

_____

City **State** **Zip**

_____ _____

Previous Address **How Long?**

_____

City **State** **Zip**

_____ _____ _____

***Date of Birth** **Social Security Number** **Driver's License Number & State**

_____

Signature **Date**

*NOTE: The above information is required for identification purposes only, and is in no manner as qualification for employment. Teen Challenge of Arkansas, Inc. is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Age (40 and over), Handicap or National Origin.

Healthy Connections
Community Health Network

Healthy Connections, Inc. / P.O. Box 1848 / Mena, AR 71953 / Phone: 888-710-8220 Fax: 866-573-0761

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMTION

First Name	Middle Name	Last Name	Date of Birth	Today's Date

Address	1679 N Hwy 7		
City	Hot Springs Village	State AR	Zip Code 71909
Home Phone	501-624-2446	Social Security Number	Please print any previous names under your records may be found:

Are you transferring out of our facility? ☐ YES ☐ NO

I authorize Healthy Connections, Inc to: ☐ **Obtain** my records from *or* ☐ **Release** my records to:	**The purpose of this disclosure:** ☐Medical ☐Legal ☐Disability ☐Insurance ☐At the patient request ☐Other
Facility Name	Doctor's Name
Address	
City / State / Zip Code	
Phone ( )	Fax ( )

The dates of service and type(s) of information to be used or disclosed are as follows:
☐Entire Record ☐History & Physical ☐Discharge Summary ☐ED Record ☐Psychiatric Intake & Eval. ☐Consultations
☐Billing Records ☐Laboratory Records ☐Radiology Reports ☐Psychosocial Assess. ☐Progress Reports
☐Other: _____

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Medical Records in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and this, may no longer be protected by federal privacy regulations.
- I understand that my treatment and continued treatment by Healthy Connections, Inc. is in no way conditioned on whether or not I sign this authorization and I may refuse to sign it.
- I understand this authorization is inclusive of ALL the information contained in my files. This may include alcohol, drug, and psychological information. And any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS related symptoms. It may also include information concerns cancer, cancer testing, and cancer results.
- I agree that a copy or fax of this release shall be valid as the original release and release Healthy Connections, Inc. from any liability for potential breach of confidentiality due to misdirection of transmission failure to receive transmission of my records.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 16) or has a legal guardian.
- Healthy Connections, Inc., its employees, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
- I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by Healthy Connections, Inc. to provide the copies requested. I understand that I may inspect or copy the information to be used or disclosed.

I, the undersigned patient, or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and HIV related information.

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Time**

_____ _____ _____
Witness **Date** **HCI Provider**

Relationship to patient: ☐Self ☐Parent ☐Guardian ☐Conservator ☐Executor of Estate ☐Power of Attorney ☐Other: _____

If signed by Legal Representative attach appropriate documentation to verify authority

Arkansas

Fountain Lake Family Pharmacy

Patient Name: _____ Date of Birth: _____ SSN # _____
Drug Allergies: _____
Insurance Information:
Name of Plan: _____ ID # _____
Bin # _____ PCN # _____ RX Group # _____

I, _____ authorize Fountain Lake Pharmacy to fill the below medications. In signing this form, I give express written consent to the pharmacy to contact my prescriber, or another pharmacy with prescriptions on file to fulfill this request.

Name of medication	Strength of medication (if known)	Consent of patient (*please check box for each medication*)
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Patient SIGNATURE: _____ **DATE:** _____

***NOTE:** Pharmacy team, please attach form to patient profile.

*This request is in accordance with SECTION 1. Arkansas Code Title 17, Chapter 92, Subchapter 1,17-92-118

Adult & Teen Challenge Arkansas

Student's SNAP Agreement/Release Form

I, _____, hereby give Adult and Teen Challenge of Arkansas, Inc. (ATCAR), the right to use my SNAP card for the duration of my stay. The card will be returned to me upon completion of the program or early termination, whichever case occurs. By giving ATCAR the right to use my SNAP benefits, I am helping provide food for myself and others enrolled in the program and, I agree to give full access to ATCAR staff to use the card for the above stated purpose.

DATE: _____

SIGNATURE: _____

ATCAR STAFF SIGNATURE: _____

Adult and Teen Challenge Arkansas COVID-19 Liability Waiver and General Release Form

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to person contact, by contact with contaminated surfaces and objects, and in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and death. Even with social distancing, mask-wearing and development of vaccines, new and emerging variants of COVID-19 may increase risk of transmission and/or mortality.

Adult and Teen Challenge Arkansas (ATCAR) the staff, board, and premises upon which the program occurs, including each of their affiliates, subsidiaries, members, employees, officers, coaches, instructors, aides, and/or agents (the "Released Parties") cannot prevent you from becoming exposed to, contracting, or spreading COVID-19 while participating in ATCAR residential addiction recovery program, other ATCAR activities. It is not possible to prevent against the presence of the disease. Therefore, if you choose to participate in ATCAR, you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19. ASSUMPTION OF RISK: I have read and understand the above warning concerning COVID-19.

I hereby choose to accept the risk of contracting COVID-19 for myself, and for my family members or others who I may expose, in order to participate in ATCAR. These services are of such value to me that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to participate in ATCAR.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against the Released Parties in connection with exposure, infection, and/or spread of COVID-19 related to my participation in ATCAR. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence, and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

OTHER TERMS: I fully understand and agree that (a) this Release is intended to be as broad and inclusive as permitted by the laws of the State in which ATCAR is conducted; (b) if any portion of this Agreement is for any reason held invalid or legally unenforceable, then the balance shall, notwithstanding, continue in full force and legal effect; and (c) I have had the opportunity to ask any questions about this Agreement and I fully understand its terms and meaning.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS WAIVER AND GENERAL RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: _____ Date: _____

Name (printed): _____

Adult & Teen Challenge
Arkansas

STUDENT ACKNOWLEDGEMENTS REGARDING VOCATIONAL THERAPY

Statement of Student Applicant

- I understand that if I am admitted as a student, that I will be required to participate in ATCAR Vocational Therapy Program.
- I acknowledge that I have read and fully agree with ATCAR Program's description of its Vocational Therapy Program, which addresses the importance of my work assignments in helping to build in me the Biblical values of a good work ethic and the character of a responsible, upright individual.
- I understand that if I am admitted, I will be performing my assignments not as an employee of Adult & Teen Challenge of Arkansas, but solely for my benefit, to further my spiritual growth and maturity, character development, recovery from controlled substances, and readiness to go back into the work place.
- I further understand that under no circumstance can Adult & Teen Challenge be under any obligation to me; and that I am a beneficiary and not an employee.
- Accordingly, by submitting this Application, I am not applying for a position of employment, and if admitted, I understand I will not be receiving any compensation or in-kind benefits in exchange for the performance of any work assignments.
- I further understand that if I fail to perform my work assignments, Adult & Teen Challenge may revoke my status and privileges as a student, not because performance of work assignments are the consideration for the receipt of such status and benefits, but because each student's participation in the Vocational Therapy Program is a necessary and vital part of the recovery process.

_____ _____

Student Signature Date:

_____

Printed Student Name

_____ _____

Staff Signature Date:

Adult & Teen Challenge
Arkansas

ACKNOWLEDGMENT OF RECEIPT OF STUDENT HANDBOOK

The Adult & Teen Challenge of Arkansas (ATCAR) Student Handbook contains important information, policies, and benefits about your participation at ATCAR. I understand that I should consult a staff member regarding any questions not answered in the handbook.

I have had an opportunity to read the handbook, and I understand that I may ask my minister any questions I might have concerning the handbook. I accept the terms of the handbook. I also understand that it is my responsibility to comply with the policies contained in this handbook, and any revisions made to it. I further agree that if I remain with ATCAR following any modifications to the handbook, I thereby accept and agree to such changes.

I have received a copy of ATCAR's Student Handbook on the date listed below. I understand that I am expected to read the entire handbook. I understand that this form will be retained in my student file.

_____ _____

Signature of Student Date

_____

Student's Name - Printed

Consent for Release of Information to the Arkansas Department of Human Services

TO: **Adult & Teen Challenge of Arkansas**
Person or Agency

155 Walnut Valley Rd
Address

Hot Springs Village **AR** **71909**
City State Zip

This is your authority to release the requested **SNAP**
Specify Type of Information

information regarding _____ , _____
First Middle Last SSN

to the Arkansas Department of Human Services or authorized representative listed below.**

_____ _____
Date Signature of Applicant/Recipient or Authorized Representative and Title

_____ _____
Witness Signature of Spouse/Relative if Applicable and Relationship

Garland
County

Obtain original signatures on all copies. Worker may sign as witness.

** **Note:** If the request involves medical records or information from a medical file, then form DHS-4000 should be used to make the request. This form doesn't authorize the release of medical or health records.

If you need this material in a different format, such as large print, contact your DHS office.

Restored For Life
Recovery Centers

www.rflrecovery.com P: 1-866-921-01491 F: 479-777-4400

Patient Name: _____ DOB: _____

Phone: _____ SSN: _____

Address: _____

_____

Primary Insurance: _____ Member ID: _____

Primary Care Physician: _____ Clinic: _____

Pharmacy: _____ Location: _____

Emergency Contact: _____ **Relationship:** _____

Phone: _____

How did you hear about us: _____

How can we help you? _____

_____

_____

Current Medications:

_____

_____

_____

_____

Statement: All other past and current medical and mental health history will be asked during pre-screen at intake appointment. Please be prepared with the information.

Here at RFLRC we do not allow any Prescription Opiates, Benzodiazepines, Amphetamines, Barbiturates, or Cannabinoids (including the use of prescribed medical marijuana).

Patient signature: _____ **Date:** _____

STATEMENT OF ACCURACY

By completing the pre assessment you acknowledge that you are responsible for the accuracy of the information you provided throughout the interview and to your knowledge all answers are truthful and accurate. If any of the information is determined by any competent authority to be invalid, untruthful, unlawful or unenforceable, such information may be grounds for discharge from the program.

Patient agrees: _____ Date: _____

NOTICE OF PRIVACY PRACTICES, FINANCIAL AGREEMENT & TREATMENT CONSENT

Effective Date: October 1, 2019. PLEASE SEE ATTACHED AND REVIEW IT CAREFULLY.

By signing below, you acknowledge your receipt, review, and treatment consent of the above.

Patient agrees: _____ Date: _____

FINANCIAL RESPONSIBILITY: By signing I am asking and giving permission for Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers: to bill my insurance plan as a service to me. I Understand that I may need to call my insurance company to see if they will approve and pay whatever amount is not covered and give Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers permission to call my insurance to obtain this information as well. I am aware that this does not mean that the insurance company will agree to pay for my services. I agree to pay whatever amount is not covered.

I am also asking and giving permission for Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers to assist me in applying for any health insurance coverage that may be available to me. I assign all my rights and claims for payment under any health insurance plan to Adult & Teen Challenge and Restored for Life Recovery Centers. I appoint Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers and/or its agents as my authorized representative to act for me in getting payment for services provided If I apply more than what I owe for this medical visit, I agree that it can be used to pay any unpaid bills I have with Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers, addresses, or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing systems, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe Adult & Teen Challenge of Arkansas and Restored for Life Recovery Centers

I UNDERSTAND AND AGREE WITH THE ABOVE INFORMATION. THIS CONSENT IS VALID FOR 3 YEARS.

Patient agrees: _____ Date: _____

The undersigned understands:

1. I am acknowledging that I have read and understand the contents of this form completely.
2. That this consent is given voluntarily.
3. That I am legally competent and have the authority to provide consent for treatment.
4. That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Patient agrees: _____ Date: _____

I have received, reviewed, and understand ATCAR's Telehealth Services Agreement.

Patient agrees: _____ Date: _____

I have received, reviewed, and understand the Sexually Transmitted Diseases & HIV information presented to me during this appointment.

Patient agrees: _____ Date: _____

PARTICIPANT AGREEMENT

Read each of the following statements carefully. Your **initial** indicates you have read and agree to each item on this form.

_____I agree to abide by the policies of Adult & Teen Challenge of Arkansas and Restored For Life Recovery Centers. I do hereby state, that I wish to enter into their program.

_____ I understand that if I am dismissed from or leave the program, there will be a 30-day period before I will be considered for re-entering in the program.

_____ I understand that if I decide to leave, I will have 72 hours to retrieve my personal belongings before they are removed from the premises and donated.

_____ I have read and understand the Adult & Teen Challenge of Arkansas and Restored For Life Recovery Centers' "Client Rules/ Handbook". I voluntarily choose to abide by said rules and policies and cooperate with Adult & Teen Challenge of Arkansas and Restored For Life Recovery Center staff for my betterment. I understand that if I do not cooperate with the rules and policies of Adult & Teen Challenge of Arkansas and Restored For Life Recovery Center, I can be dismissed from the program. It is further understood that if I do not cooperate with the rules and regulations of Adult & Teen Challenge of Arkansas and Restored For Life Recovery Centers, Inc., I can be asked to leave.

_____ I understand that I have the right to voluntarily leave at any time if I wish to do so against medical advice.

_____ I understand and agree that I will not hold Adult & Teen Challenge of Arkansas and Restored For Life Recovery Center responsible for any loss of personal items at any time.

_____ I understand that Adult & Teen Challenge of Arkansas and Restored For Life Recovery Centercannot be held responsible for personal injury while I am in the program.

_____ I understand that I will be held responsible for all medical expenses incurred while in the program.

Patient agrees: _____ **Date:** _____

Financial Evaluation Form

Per the ARKANSAS DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES, each client shall receive a financial evaluation that includes all sources of income. The sources shall be verified and documented. Sources must include all household income (i.e. public assistance, retirement, social security and VA). If specific amounts are unavailable, averages or reasonable estimates may be used. A client's insurance coverage shall be documented. IF you have any concerns, please speak with one of our staff.

Name _____ D.O.B. _____

Insurance Provider _____ Member# _____

Employer _____ Average Weekly Income _____

Are you receiving any form of public assistance? ☐Yes ☐No

If yes, what type? _____ How much are you receiving monthly? _____

If no, would you like more information about public assistance? ☐ Yes ☐ No

Are you receiving any form of retirement/VA benefits? ☐Yes ☐ No

If yes, what type? _____ How much are you receiving monthly? _____

Are you receiving any form of social security? ☐ Yes ☐ No

If yes, what type? _____ How much are you receiving monthly? _____

Are you receiving any other form of income not listed above? ☐Yes ☐ No

If yes, what type? _____ How much are you receiving monthly? _____

I understand that the above is true and accurate and that I may be prosecuted if I knowingly or intentionally do not report my resources.

Signature _____ Date _____

Revised 7/10/2023

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission.* If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history, not* just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ..... Yes No
2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? ..... Yes No
3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? ..... Yes No
4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? ..... Yes No
5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? ..... Yes No
6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? ..... Yes No
   (b) Did you ever attempt to kill yourself? ..... Yes No
7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? ..... Yes No
8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? ..... Yes No
9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? ..... Yes No
10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? ..... Yes No
11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ..... Yes No
12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? ..... Yes No

continued on other side

13. Have you *ever* had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? .... Yes No

14. Have you *ever* had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? ..... Yes No

15. Have you *ever* had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. ..... Yes No

16. Have you *ever* lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? ..... Yes No

17. Have you *ever* been told by teachers, guidance counselors, or others that you have a special learning problem? ..... Yes No

Print client's name: _____

Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

Restored For Life
Recovery Centers

www.rflrecovery.com P: 1-866-921-01491 F: 479-777-4400

Medical Record & Medical Information Release Form

Patient Name: _____ Patient DOB: _____

Release From:

Name: _____

Address: _____

Phone: _____ Fax: _____

Release To:

Name: Restored For Life Recovery Centers

Address: 1679 Hwy 7 N, Hot Springs Village, AR 71909

Phone: 1-866-921-01491 Fax: 479-777-4400

Describe the information that you authorize to be released or discussed:
( ) Therapy/Treatment Notes ( ) Lab Reports/Results ( ) Insurance/Demographic Information
( ) Entire Medical Record ( ) Needs for Treatment
( ) Other: _____

Indicate the date(s) of service to be released:
( ) All dates of service
( ) Specific date range of service: _____

I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information may no longer be protected and may be re-disclosed. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that this authorization is active until it is revoked or until the end of 3 years. I may revoke this authorization at any time, but revocation will not apply to information that has already been released. *Note: The revocation must be in writing and delivered to the above address of the person/entity of whom was to release the information.* I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the facility director. I understand that I have the right to obtain a copy of this authorization.

Patient Signature_____ Date: _____
Or Legal representative of patient:

Witness Signature: _____ Date: _____

Hot Springs,AR 728011 P: 866-921-01491 F: 479-777-4400

Medical Record & Medical Information Release Form

Patient Name: _____ **Patient DOB:** _____

I, _____ , give Restored For Life Recovery Centers the authority to contact my insurance company, the local DHS office, Arkansas Works Program, and/or Medicaid to act on my behalf to obtain my insurance application status and submit information for me if it is requested by any entity listed above. I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information may no longer be protected and may be re-disclosed. I understand that I may refuse to sign this authorization. I understand that this authorization is active until it is revoked. I may revoke this authorization at any time, but revocation will not apply to information that has already been released.

Note: The revocation must be in writing and delivered to the above address of the person/entity of whom was to release the information. I understand that I have the right to obtain a copy of this authorization.

Patient signature _____ **Date:** _____
or Legal representative of patient:

Witness signature: _____ **Date:** _____

ATCAR Non-Med Facility

Name:_____

My last use date:_____

From:_____.

I understand the risks of detoxing in a non-medical facility include:

- Insomnia
- Anxiety
- Digestive discomfort
- Headaches
- Heart palpitations
- Hallucinations
- Panic attacks
- Tremors
- Muscle pain
- Psychosis
- Seizures
- Delirium tremens

Signature :_____

Date_____

Family Counseling Policy and Procedure

Adult and Teen Challenge of Arkansas (ATCAR) is dedicated to supporting the holistic restoration of our students. To achieve this, we provide counseling services for our students and their families. We highly recommend that all students and families take advantage of this valuable resource, as we believe it can greatly aid in the healing process of their relationships and the recovery of the student. It is important to note that participation in family counseling is voluntary and requires consent from both the student and their family.

Family counseling preparation will commence in the admissions process. Signed Informed Consent forms will be obtained from the student and family member(s) chosen by the student. The Admissions department will also collect the required signatures on the Release of Information forms, which will be recorded in ATCAR's electronic medical records system. NOTE: If a student decides not to pursue counseling upon admission to our program, they may choose to participate at a later time. Counseling services for families are offered to all students throughout their time at ATCAR.

The Case Manager will ensure that the designated family member is suitable for counseling. Family counseling is designed for individuals within the student's family who have been adversely affected by the student's behaviors and will play an active role in the student's future. Family counseling will not be permitted for friends, past romantic partners, or individuals with current addiction issues. After confirming the eligibility of the family member, the Case Manager will arrange the initial counseling session. This session will be scheduled after the family has completed the *Families in Addiction* introductory courses and the student has transitioned to Phase Two.

A qualified Mental Health Professional will oversee the counseling process for family sessions, addressing a variety of topics customized to the individual needs of the student and family member. The Mental Health Professional will employ appropriate methodologies to assist the student and family in reaching their desired goals and objectives. The Mental Health Professional will be responsible for developing treatment plans, leading each session, maintaining detailed documentation, and managing appointment scheduling. It is important to adhere to a schedule of monthly family sessions, with no more than two sessions occurring within a month.

FAMILY COUNSELING OPTION

At Adult and Teen Challenge of Arkansas (ATCAR), we really believe in the importance of family counseling to help our students and their families heal and grow together. We believe it can make a big difference in the student's recovery process. Remember, participating in family counseling is totally up to you and the student. And no worries if you're not ready to dive into counseling right away - you can always join in later. We offer family counseling for all our students during their time here.

When you decide to be a part of family counseling, these are the steps:

1. Alert ATCAR staff that you have decided to participate in the family counseling option.
2. Staff will provide you with more information about how counseling will be conducted.
3. Staff will get written permission from you.
4. Then, staff will get with you and schedule the appointment that fits your schedule.

That's it! You're ready to go!

Hey, just a heads up on some important stuff:

- Counseling will be free of charge for family members.
- The student will need to agree to family counseling.
- Counseling starts after you finish the *Families in Addiction* class.
- The student needs to be in Phase 2 or higher of the ATCAR *Restored for Life* program.
- Sessions are usually once a month for an hour.
- Counseling is just for family members who have been affected by the student's actions.
- Friends, ex-partners, or people currently dealing with addiction can't participate in counseling.

If you have any questions, please call the case manager at 1-866-921-0149

Adult & Teen Challenge Arkansas
Client Belongings Intake Form

Client Name: _____
Date of Intake: _____
Case Manager: _____

Personal Belongings Inventory

Item Description	Quantity	Condition (New, Good, Fair, Poor)	Notes/Damage Details
Clothing			
Shoes			
Toiletries			
Electronics			
Jewelry			
Bedding			
Books/Bible			
Medications			
Wallet/ID			
Other			

Condition of Items Upon Intake

- Are any items damaged or missing parts? ☐ Yes ☐ No
  - If yes, describe: _____
- Are all medications properly labeled and documented? ☐ Yes ☐ No
  - If no, explain: _____

OUTPATIENT BEHAVIORAL HEALTH SERVICES DISCLOSURE FORM

Client Acknowledgment of Service Information and Rights

Client Name: _____ **Date of Birth:** _____

Parent/Guardian (if applicable): _____ **Date of Disclosure:** _____

In accordance with regulatory requirements, this form provides important information about the Outpatient Behavioral Health S offered by our agency. Please read carefully and sign below to confirm your understanding.

Nature of Services

I understand that the services I (or my ward) will receive are **Outpatient Behavioral Health Services** provided by a certified Behavioral Health Agency. These services may include, but are not limited to, **non-residential, medically necessary mental hea** services designed to support individuals with emotional, behavioral, or mental health disorders. These services are typically deli in clinics, community settings, or via telehealth and are intended to help individuals function more effectively in their homes, sch jobs, and communities without requiring inpatient hospitalization.

Core services typically provided:

Diagnostic and Evaluation Services

- Comprehensive Mental Health Assessments
- Psychiatric Evaluations
- Risk Assessments (e.g., suicide/self-harm, danger to others)

Therapeutic Services

- Individual Therapy
- Group Therapy
- Family Therapy
- Couples Counseling

Medication Services

- Psychiatric Medication Management
- Medication Monitoring and Education
- Prescriptions by licensed medical providers (e.g., psychiatrists, nurse practitioners)

Case Management / Care Coordination

- Assessment and development of individualized service plans
- Referral to community resources (housing, employment, transportation)
- Coordination with schools, primary care providers, and social services

Crisis Intervention

- Immediate support for clients in psychological distress
- Safety planning
- Mobile crisis outreach or in-office interventions

Rehabilitative Services

- Skills training (e.g., emotional regulation, social skills, daily living)
- Psychoeducation (for clients and families)
- Behavioral intervention strategies

Peer Support Services

- Delivered by Certified Peer Support Specialists (CPSS)
- Focused on recovery and empowerment
- Support from those with lived experience

Specialty Services

- Substance Use Counseling (co-occurring disorders)
- Other services as prescribed

Eligibility Criteria

I understand that to qualify for services, I (or my ward) must meet clinical criteria for Serious Mental Illness (SMI) (for adults), as determined through a clinical assessment.

Description of Services
I have been given a brief overview of the services offered, which may include but are not limited to:

- Diagnostic assessments
- Individual, group, or family therapy
- Medication management
- Case management
- Peer or support services

Medical Necessity
I understand that all services must be medically necessary, as determined by a licensed clinician based on clinical guidelines a treatment planning.

Insurance and Payment Information
I understand that third-party payment (e.g., Medicaid, private insurance) for these services may be denied based on the payer's policies or eligibility requirements. Should they be denied, I understand that I am responsible for payment of said services.

Additional Services
The following additional services may be offered:

- Copies of medical records
- Completing forms for medical/legal providers
- These services are Optional
- Cost is $1 per page for copies of medical records and completing forms for medical/legal providers is $50 per page.
- Payment is to be made in advance for said services.

Right to Discontinue Services
I understand that I (or my ward) may discontinue services at any time by notifying the provider.

Access to Rules and Policies
I have been offered a copy of the Behavioral Health Agency's rules and the policies that govern Outpatient Behavioral Health Services.

Complaints to the Provider
I understand that if I have concerns or complaints about services, care delivery, or discrimination, I may contact:
Provider Contact for Complaints:
Name: Leslie DeLorenzo
Phone: 501-624-2446
Email: leslie@atcar.org
Address: 1679 N Highway 7, Hot Springs Village, AR 71909

External Complaints and Grievance Contacts
I have also been provided information on how to file complaints with appropriate external agencies, including Medicaid, licensir boards, and civil rights authorities (contact list provided separately).

Acknowledgment and Signature
I certify that I have read and understand the information provided above. I have had the opportunity to ask questions, and I volu consent to receive services.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Representative Signature: _____ Date: _____

Name/Title: _____

Adult and Teen Challenge of Arkansas
90-Day Program Acknowledgment Form

Client Name:_____

Entry Date:_____

150-Day Program Completion Date:_____

I, _____, acknowledge and understand that the program length is 90 days from the date of entry (listed above) to the calendar day on which the 90th day falls. This has been discussed with me at this time.

I understand that I will receive my 90-day certificate on the 90th day and no sooner. I am also aware that I am free to leave the program on that day. Additionally, I may choose to return on the next scheduled Graduation/Completion Ceremony to be recognized for my success in completing the 90-day program.

Client Signature:_____ Date:_____

Client Printed Name:_____ Date:_____

Staff Signature:_____ Date:_____

Adult & Teen Challenge Liability Waiver & Release

Event/Activity: _____
Date(s): _____
Location: _____

Participant Information

Name: _____
Address: _____
Phone: _____
Emergency Contact: _____
Emergency Contact Phone: _____

Assumption of Risk

I understand that participation in off-campus events and activities sponsored by Adult & Teen Challenge (hereinafter "ATC") may involve physical activities, transportation, and other circumstances that carry potential risks, including but not limited to personal injury, illness, property damage, or accident. I voluntarily assume all such risks.

Liability Release

In consideration of being allowed to participate, I release and hold harmless Adult & Teen Challenge, its directors, officers, staff, volunteers, representatives, and affiliates from any and all liability, claims, or demands for injuries, damages, or losses sustained as a result of my participation in this event, whether arising from negligence or otherwise, to the fullest extent permitted by law.

Medical Authorization

In the event of an emergency, I authorize ATC staff or volunteers to secure medical treatment for me, including hospitalization, anesthesia, surgery, or other care deemed necessary. I accept financial responsibility for any such medical services.

Transportation

I understand that ATC may provide or arrange transportation for this event. I release ATC from liability for any accident, injury, or damages that may occur during transportation.

Code of Conduct

I agree to abide by all ATC rules, policies, and staff directions during this event. Failure to comply may result in dismissal from the activity at my expense.

Acknowledgment

I have carefully read and understood this agreement. I voluntarily sign it with the knowledge that I am giving up certain legal rights.

Participant Signature (if 18 or older): _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

Printed Name of Parent/Guardian (if applicable): _____

ADULT & TEEN CHALLENGE OF ARKANSAS
Release of Information (ROI) – Insurance & SNAP Liaison Authorization - Eaton Insurance Agency

---

Client Name: _____
Date of Birth: _____ / _____ / _____
Phone Number: _____

I hereby authorize **Adult & Teen Challenge of Arkansas** to communicate with and act as my liaison with the insurance representative(s) of the health plan I select below for purposes including but not limited to: verifying benefits, obtaining authorizations, coordinating billing, and advocating for my healthcare needs.

Please select your insurance plan choice (check one):

☐ **Ambetter**
☐ **Blue Cross Blue Shield (BCBS)**

Information to be Disclosed/Obtained:

- Insurance eligibility and benefits
- Authorization and referral status
- Claims and billing information
- Any other information necessary to coordinate my care and insurance coverage

Duration of Authorization:

This authorization is valid for one (1) year from the date signed below, unless revoked earlier in writing.

Acknowledgements:

- I understand that I may revoke this authorization at any time by providing written notice to Adult & Teen Challenge of Arkansas.
- I understand that revoking this authorization will not affect information already shared based on this consent.
- A copy or facsimile of this authorization shall be as valid as the original.
- I understand that Adult & Teen Challenge of Arkansas and my insurance provider may exchange information to coordinate my benefits and care.

Client Signature: _____
Date: _____

Parent/Guardian Signature (if applicable): _____
Relationship to Client: _____
Date: _____

Staff Witness Signature: _____
Date: _____

To be completed by Insurance Representative Only:

Insurance Company: _____
Policy/Member ID #: _____
Group #: _____
Phone Number (on insurance card): _____

ADULT & TEEN CHALLENGE OF ARKANSAS

CLIENT ARRIVAL LOG

Client's Name: _____

Purpose: Record the client's arrivals, including transportation details, driver information, time of arrival, and any notes, questions, or concerns raised by the driver.

_____

Date: _____ **Time of Arrival:** _____

Mode of Arrival (Car/Bus/Other): _____

Driver's Name: _____

Address Client Came From: _____

_____

Condition of Client Upon Arrival: _____

_____

Was the Arrival On Time? Yes / No – Reason if late:

_____

Notes / Questions / Concerns Raised by Driver: _____

_____

Client Signature: _____ Date:_____

Staff Signature: _____ Date:_____

ADULT & TEEN CHALLENGE OF ARKANSAS

Client's Name: _____

Date: _____ Time: _____

Height: _____ Weight: _____

Blood Pressure: _____

Respiratory Rate: _____

Temperature: _____

Pulse OX: _____

Heart Rate: _____

UA: _____

Strip Search: _____

Belongings Search: _____

Intake Packet: _____

Picture: _____

3 Minute Phone Call: _____