REV 5/22/23

INFORMED CONSENT & AGREEMENT TO RECEIVE SERVICES

SERVICE: RECOVERY COACH

Your Recovery Coach will:

- Work with you to create a health & wellness plan with recovery goals
- Help you connect with other people to help you succeed in recovery
- Sign you up for other social services and assistance to get back on track, if desired
- Keep your information confidential, only stating you are receiving services if we have your permission
- Not provide an evaluation of your recovery or report on your use of substances
- Acknowledge how long you participated in coaching, counseling, and your attendance
- Report if you disclose personal involvement with child/elder abuse/neglect, threaten self-harm, or harm to others.
- Not provide clinical assessments/treatment other than counseling, or maintain clinical records

You are responsible for:

- Your Recovery. The decisions you make are yours and not the responsibility of your Coach.
- Honestly exploring your goals to improve your quality of life.
- Attending coaching meetings on showing up on time. If you need to cancel or reschedule, please call your Coach.
- Not holding your Coach or Reality Check legally responsible for consequences of your decisions or actions.
- Contacting the Director of Recovery Services to request a different Coach.

CONSENT

I consent to participate in Reality Check, Inc's Recovery Services. I understand the purpose of it is to measure the performance of Reality Check, Inc's Recovery Services.

I understand the Reality Check staff responsible for this project is Dr. Shelley Janiczek Woodson who can be reached at Reality Check, Inc offices: 603.532.9888.

I understand I will be asked to participate in three separate sessions to complete a 30-60 minute questionnaire to help meet the purpose of this project.

I understand any compensation for my participation will be awarded as explained by my Recovery Coach.

I understand there are no known psychological risks associated with this project.

I am aware my responses will be kept confidential and my name will not be included or associated with my responses in public discussions or presentations of the data.

I understand my participation in this project is voluntary and may discontinue participation at any time without consequences. Dr. Woodson will answer inquiries concerning procedures.

I have read the above and give my consent and agreement to complete the questionnaires.

Signature:_____Date:_____

Printed Name: _____

Staff Signaure:_____Date:_____

SERVICE: DRUG & ALCOHOL COUNSELING

Your Licensed Alcohol & Drug Counselor will:

- Meet with you to identify and evaluate your substance use problem
- Explore any mental health issues that may be driving your substance use
- Identify other issues causing you to believe you need to abuse substances
- Create goals and treatment plans and show you new coping mechanisms
- Encourage you to attend group sessions and other support groups
- Provide updates and progress reports to courts as required
- Set up aftercare plans with you
- Meet with family members and provide guidance and support as needed
- I grant permission for a Coach or LADC to contact me on my phone or email address.

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I understand my treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent. Federal law permits Reality Check to disclose information without my permission about services I receive to report a crime committed on Reality Check property or against their staff/Coaches; to medical personnel in a medical emergency; to appropriate authorities to report suspected child or elder abuse and/or neglect; to appropriate authorities if participant poses an imminent danger to self or others; as allowed by court order; Pursuant to an agreement with a qualified service organization/business associate. Before Reality Check can use or disclose information about my health in a manner which is not described above, we will obtain your written consent allowing it, which may also be revoked by me in writing. If I feel my privacy rights have been violated I may file a complaint with Reality Check staff, the HIPAA Privacy Officer at NHDHHS, 129 Pleasant Street, Concord, NH 0330, or the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 2020. Reality Check will take no retaliatory action if I file a complaint.

Signature:_____Date:_____

Printed Name: _____

Staff Signaure:_____Date:_____