**Substance Use/Abuse Rights**

1. If you are coming to me for a substance use/abuse problem, you will need to be clear about what your goal in treatment is. If it is to reduce or eliminate your use, please let me know. However, if you are unable to achieve that goal given sufficient time, I will refer you to a higher level of care. A private practice like mine is the lowest level of outpatient care available. A substance abuse facility will have more resources than I do. Your honesty related to your use is important. If you omit, lie, or “stretch the truth” in session, you will still have to deal with the negative effects your use is having on your life. A higher level of care may be needed to change your use and its consequences.
2. You can choose to get toxicology screens. I use Quest laboratories. There are several located nearby my Mineola office. The two closest facilities are 520 Franklin Ave Ste 104, Garden City, NY 11530 and 212 Station Plaza, Mineola NY 11501. You may be able to utilize your insurance to pay for the lab or you can self-pay. The results will be mailed to my office and a copy put in your file. The results usually take about 1 week to get, but I have no control over that. When I give you paperwork to bring to Quest, please provide a specimen within 24 hours.
3. If you are mandated to treatment by the legal system or your job, the results of treatment and toxicologies will be shared with your referral source. I will need a release of information signed upon your admission date for your referral source. You may choose not to provide it or revoke it, and I cannot share any information with them. However keep in mind that when a referral source hears “I can’t confirm or deny who you’re talking about,” (the typical response provided without a release) they usually know that means a release was revoked or was never provided and may take disciplinary measures against you.
4. I may breathalyze you during session for any reason. You may refuse. If you are positive or refuse and you drove to my office, I will ask for your keys. If positive, I will and continue to breathalyze you until the reading is zeroed out. Whether positive or you refuse, you are free to call someone to pick you up, call a ride share service, use public transportation, etc., when leaving my office. We can talk about how you will get your keys back if you chose to do this. However, I cannot forcibly take them, nor do you have to give them to me. If you chose to leave with your keys, I will do what I can to report to the police that I suspect that you are drinking and driving and why. I have a duty to warn and to protect the public, this is not negotiable.
5. You are welcome to invite family members into session. I may make referrals to Alanon (for alcohol) or Naranon (for narcotics) as your family may need additional support. If you choose to do so, I will need a release of information signed before that session starts. I will not keep secrets from anyone you bring into session, nor lie on your behalf.
6. I am a NYS Credentialed Alcohol and Substance Abuse Counselor (CASAC). Any complaints you have against my credential can be filed at <https://www.oasas.ny.gov> or call 518-473-3460.
7. I may (probably will) make a lot of suggestions throughout of our counseling relationship. You do not have to take any suggestions, you do not have to do anything I say. However, if no/minimal suggestions are taken and nothing appears to be changing, at some point I will probably ask you if our working relationship is beneficial to you and I may provide referrals. I don’t want to waste your time, 3rd party’s money, and risk your health and safety.

**Substance Abuse Responsibilities**

1. Please show up to sessions, on time, resolve any copays or fees, and participate.
2. Please be honest with me in session.
3. Please let me know if you relapse.
4. Please be clear about your goals. If you have doubts, we’ll figure it out together.
5. When being assessed, please tell me all substances you are currently using/abusing, any you have used/abused in the last year, and any that you think you may have had a problem with in the past.
6. Feel free to bring your treatment history with you to the assessment, it will help to speed the assessment along. Where you went to treatment, when you went to treatment, what level of care (Inpatient, outpatient, Therapeutic community…) how long you were there, reason for discharge, and if you completed treatment.
7. You will work towards your goals of harm reduction or abstinence. I work from an abstinence-based model. If you have a substance abuse addiction, and you wish to return to use in moderation, I will agree to meet you where you are at. If you are unable to maintain your goals, it is up to you to let me know so we can reevaluate your expectations if need be.
8. If you are prescribed any medical or mental health medication from an outside source, I will ask for releases of information for those sources to confirm the prescriptions and inquire if there has been a history of abusing that medication. This includes but is not limited to Opioid agonist/antagonist medication, Benzodiazepines, amphetamines, and Vivatrol shots. I suggest you sign a release with your providers for my office.
9. If/when paperwork is given to you for toxicology screens, please provide a sample within 24 hours. The results will tell me when a sample was provided. I will share the results with you if you ask, or if there is a positive for any substance.
10. Social media and reviews: Should you choose to post, like, review, comment, etc., on any online or print forum/platform, anything related to myself or my practice, please understand you may be publicly giving up your confidentiality as a client of mine. You do so at your own risk.
11. By signing below, you acknowledge that I have provided you a copy of your rights, and you acknowledge your responsibilities as a substance use/abuse client. This form will be kept in your file in my office and your chart.

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Print name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information for an Emergency contact

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information requested or authorized for release or exchange pertains to:

* Emergency contact

Confirm appointments

Toxicology results

Progress of Treatment/counseling

Answer drug/alcohol abuse questions

Admit date

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Status

Discharge Date

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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 unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Name Date of Birth

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information to third party insurance company

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Insurance provider

The information requested or authorized for release or exchange pertains to:

Confirm Appointments

Toxicology Results

Progress of Counseling

Admit Date

Discharge Date

Discharge Status

Provide/Discuss Diagnosis

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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 unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
 *[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Name Date of Birth

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Signature Today’s Date