

Full Name: _____ **Sex:** M _____ F _____
 Last **First** **Middle**

Address _____
 Street/ PO Box **City** **State** **Zip**

Date of Birth: _____ **Phone Number** _____

Date

Starting Point, Inc.
ALCOHOL AND DRUG INFORMATION SCHOOL
RULES AND CONSEQUENCES

1. Participants are expected to attend all sessions, in their entirety.

To successfully complete each session, one must;

- Be on time.
- Return from breaks on time.
- Stay for the entire class.
- Cooperate with instructor's directions.

Consequence of not complying with above expectations: Must repeat entire class.

2. Participants will not use alcohol or other drugs on the day of the class.

Consequence of not complying with this expectation: Participant will be asked to leave by the instructor. Drug/alcohol use will be reported to your probation officer, court monitor, department of licensing or any other referral agency. Participant will be referred back to original assessor for review of the initial assessment.

3. Everyone must complete an ADIS Knowledge Test.
4. Everyone who attends class has the right to CONFIDENTIALITY. This relates to the participant's identity as well as information regarding the participant's attendance at ADIS. The participant is asked not to discuss, out of class, who is seen in the session or what other participants say about themselves of a personal nature.

Consequences for not complying with this expectation: possible legal action.

I have read and understand the above rules and consequences.

Patients Signature

Date

Starting Point, Inc.

Live Telehealth Consent Form

Client Name: _____

Phone (Texting available): _____

Email: _____

Purpose / Nature of Telehealth

I understand that **telehealth / telemedicine** involves the use of electronic communications (video, audio, etc.) to enable my health care provider to deliver health care services without an in-person visit. I understand that this may include evaluation, consultation, treatment, follow-up, and education relating to my condition.

By signing below, I consent to the use of telehealth in my care and understand that the quality of care, advantages, and risks differ from in-person services.

Risks, Limitations & Alternatives - I understand and acknowledge the following:

- That telehealth may involve technical problems, such as interruptions, poor image or audio quality, hardware or software failures, or delays.
- That confidentiality could be compromised (e.g. unauthorized access, hacking) despite security measures.
- That not all aspects of care can be done remotely; in some cases, an in-person visit may be necessary.
- That I can refuse telehealth and instead seek in-person care or alternatives.

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Confidentiality & Privacy - I understand:

- The telehealth session will be conducted using a secure, HIPAA-compliant (or equivalent) platform whenever possible.
- The provider and staff will take reasonable steps to protect my health information and use encryption or secure technologies as feasible.
- Other participants (e.g. trainees) may be present, with my advance notice and consent.
- The rules regarding confidentiality (e.g., exceptions for mandatory reporting, harm disclosure, etc.) apply equally in telehealth as in in-person visits.

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Recording and Observers - I understand:

- No sessions will be recorded without my explicit permission.
- If recording or observation by others (e.g. students, colleagues) is to occur, I will be informed.

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Patient Responsibilities - I agree to:

- Be in a private, quiet location during the telehealth visit.
- Use appropriate devices (camera, microphone, internet connection) to facilitate the session.
- Protect privacy on my end (e.g. headphones, ensure no one else overhears).
- Communicate if I experience technical difficulties, interruptions, or unclear transmission.
- Notify the provider if I wish to end or terminate any session.

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Voluntary Participation & Right to Withdraw - I understand:

- Participation is voluntary.
- I may withdraw my consent for telehealth at any time without affecting future access to care.
- If telehealth is not clinically appropriate, the provider may recommend in-person care or referral.
- I acknowledge that I have been informed of my rights to privacy and confidentiality under Washington State Law (WAC) and that I have been given the opportunity to ask questions.

I agree and consent to the above terms and conditions.

Client Signature: _____ **Date:** _____

STARTING POINT, INC.

CONSENT TO E-MAIL FINANCIAL STATEMENT/INVOICES

I, _____, hereby authorize
(Name of client/patient)

Starting Point, Inc to Email Financial Statements/Invoices weekly and/or monthly to the below e-mail address:

E-mail Address: _____

The purpose for disclosure/exchange of this information is to summarize treatment payment plans and payments/charges posted to account.

I understand that my alcohol and/or drug 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 (AHIPAA@), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for the regulations. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create assessment or report for disclosure to the recipient identified in this authorization. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires as follows:

Signature of Client/Patient

Date

Signature of Person Authorized to Sign in Lieu of the Client (where required)

Date

SPI Updated: 11.11.25

Starting Point, Inc.

WAC 246-341

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize
(Name of client/patient)

Starting Point, Inc.

(Name of Program Exchanging/Releasing Information)

To release and/or exchange information with:

(Name of Person/Entity to which disclosure is to be made to and/or information is to be received from)

The following information: **MUST INITIAL EACH ITEM**

_____ Identifying Information	_____ Financial Compliance
_____ Psychological Testing Information	_____ Treatment Compliance
_____ Significant Other Questionnaire	_____ Social History
_____ Family Program	_____ Discharge Summary
_____ Diagnosis/Test Results/Recommendations	_____ Medical History and Physical
_____ Aftercare Plan/Participation	_____ Consultations
_____ Treatment Plan _____ Progress Notes	
_____ Urine Analysis Testing	_____ Insurance Information
_____ Deferred Prosecution Treatment Acceptance Letter	
_____ Other (specify) _____	

Method of Disclosure: { } Mail { } Phone { } Fax { } Hand Deliver
{ } Email { } Other (specify) _____

The purpose for disclosure/exchange of this information is to facilitate treatment, summarize treatment, coordinate Aftercare programs, and allow for processing of insurance (if appropriate).

I understand that my alcohol and/or drug 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 (AHIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for the regulations. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create assessment or report for disclosure to the recipient identified in this authorization. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires as follows:

90 days following the last date of service, or: _____
Specific date, event, or condition which this consent expires.

Signature of Client/Patient

Date

Signature of Person Authorized to Sign in Lieu of the Client (where required)

Date

Signature of Program Representative

Date

Starting Point, Inc.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION: CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, hereby consent to communication between
(Name of Client)

Starting Point, Inc

(Name of program making disclosure)

and _____
(Court, probation, parole, and/or other referring agency to which disclosure is to be made)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above, of the results of my assessment and/or my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at substance use dependency treatment sessions, my cooperation with the treatment program, prognosis, any failures in maintaining compliance with referent or agency expectations or agency rules, and,

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

(Other time when consent can be revoked and/or expires)

I also understand that any disclosure made, is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and the recipients of the information may redisclose it only in connection with their official duties.

Date

Signature of Client

Date

Signature of Substance Use Professional



STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Olympia, Washington 98504-8001

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
TO THE DEPARTMENT OF LICENSING**

I, _____, authorize Starting Point, Inc.
NAME OF PATIENT NAME OF PROGRAM MAKING DISCLOSURE

WA Driver License #: _____

to disclose to the Washington State Department of Licensing information regarding my alcohol and/or drug assessment, information school involvement, participation in treatment, progress in treatment, and program compliance and non-compliance. The purpose of this disclosure is to monitor my program involvement as a result of an alcohol and/drug related license restriction, and may be used in arriving at a decision regarding my driving privilege in the State of Washington. I further consent for this information to be re-disclosed to the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, for purposes of chemical dependency program monitoring.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and, except as indicated above and otherwise provided for in the regulations, cannot be re-disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days following the date of termination of services from the program.

_____ SIGNATURE OF PATIENT/CLIENT	_____ DATE
_____ SIGNATURE OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE, WHEN REQUIRED	_____ DATE
_____ WITNESS	_____ DATE