Indiana University Health

IU West
Addictions Treatment Recovery Center (ATRC)
317-217-2711

The ATRC is a highly qualified team of medical and clinical professionals committed to assisting patients in their personal recovery through compassion and excellence.

IU West ATRC Office Hours: Monday through Friday from 8a-5:00pm

This is an intensive treatment program that runs daily for approximately 4-6 weeks, depending on the client's progress toward their individualized treatment goals and objectives. Patients will have access to nursing staff that will assess, address and support their medical needs through intake and history, physical, labs, and medication management. Patients will then participate in a variety of in-house recovery support services including: spirituality, self-care, 12-step support, and other community engagements. Clinical services will be offered through individual group, and family therapy focusing on variety of topics to educate the patient and provide realistic coping strategies. Topics include brain disease, triggers, craving management, recognizing stress, maintaining healthy boundaries and relationships. The ATRC's purpose is focused on providing excellent care combining evidence-based practice and realistic expectations of achievable recovery.

Monday	Tuesday	Wednesday	Thursday	Friday
9:00-10:00a **Meditation Session**	9:00-10:00a **Health Education**	9:00-10:00a **Life Skills**	Individual and family therapy session times available. Please check with your therapist about your weekly appointments.	9:00-10:00a **DBT Skills**
10:00-12:00p **Process Group Therapy**	10:00-12:00p **Process Group Therapy**	10:00-12:00p **Process Group Therapy**		10:00-12:00p **Process Group Therapy**
12:00-1:00p Lunch	12:00-1:00p Lunch	12:00-1:00p Lunch		12:00-1:00p Lunch
1:00-2:00p **Psychoeducational Group**		1:00-2:00p **Yoga & Meditation**		1:00-2:00p **Psychoeducational Group**

**Patients will also be seen for weekly individual therapy sessions scheduled outside group therapy sessions. Please check with your therapist about your weekly appointment time.

***Virtual services are available. For more information, ask your therapist.*

Client Guidelines to Recovery:

- Attend all groups and individual sessions and arrive on time. If you can't, notify us as soon as possible.
- Respect yourself and others.
- Length of treatment varies and involves weekly discussions with your therapist about your treatment goals. Treatment lasts a minimum of 4-6 weeks.
- Be honest about your use; a lapse does not end treatment and honesty allows us to help you.
- Maintain confidentiality of treatment – what happens here, stays here.
- Participate actively in treatment
- Be willing to allow coordination of services with other providers to best assist you
- Involvement with family and friend's is encouraged as it improves a person's recovery
- Stay current with any financial obligations and talk to us if you're having trouble.
- Maintain safety of treatment environment
- It is not advisable to enter outside relationships with group peers

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Recovery Plan

Goal(s) for Recovery:

Why is this Important to me?

Personal Commitments I am willing to make in Recovery to make my goals a reality:

Strengths I already have:

-
-
-
-
-

Supports that will help me (Include their phone numbers):

-
-
-

Triggers for relapse (Be very specific about people, places, things)

-
-
-
-
-

Specific plan to address my triggers:

Plan to Address my Overall Health:

My Plan if I relapse:

Additional Commitments I may need to make:

_____ _____

Name Date

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Indiana University Health West Hospital
Addictions, Treatment and Recovery Center
Statement of Patient's Rights

1. To be informed of patient's rights in advance of services being provided or discontinued.
2. To be informed about substance use disorder programs nature, structure and programs expectations.
3. To considerate, respectful and compassionate care which encompasses understanding of cultural diversity.
4. To be informed about your condition and treatment in understandable terms.
5. To receive information necessary to give informed consent prior to the start of any procedure or treatment.
6. To participate in the development and implementation of your plan of care, and to refuse or request treatment.
7. To be completely informed if transfer to a higher level of care or to another hospital becomes necessary.
8. To expect every consideration for your privacy in the environment that preserves dignity and contributes to positive self-image.
9. To receive care in a safe setting.
10. To know the identity of your treatment providers.
11. To expect all communications and records pertaining to your care will be treated as confidential, and to access medical information contained in your records within reasonable timeframe.
12. To be free from inappropriate restraints, seclusion, or medications that are not medically necessary.
13. To expect timely and appropriate assessment and treatment of physical pain and emotional and spiritual discomfort.
14. To have a right to practice one's own religion.
15. To obtain information as to the relationship of this hospital to other healthcare and educational institutions.
16. To receive adequate information to consent or to decline participation in clinical research.
17. To expect continuity of care and to be informed healthcare discharge instruction.
18. To receive an explanation of your bill.
19. To know your responsibilities as a patient and to know the program expectations.
20. To expect equal medical treatment regardless of race, creed, religion, national origin, age, disability, veteran status, sexual orientation, or gender identity or expression.
21. To have your family member or representative of your choice and your own physician notified promptly of your admission to a higher level of care means the inpatient hospital.
22. To have advanced directives that expresses your choice about future care.
23. To be free from all forma of abuse and harassment.

If you have a complaint or question about your care, please discuss it with your treatment provider or the Director of Chronic Pain and Chemical Dependency.

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Location: IU West ATRC

Intake Form

*Please answer all questions to your comfort level and to the best of your knowledge. Please know that all patients receive services regardless of background race, gender, creed, or orientation.

Patient Name: _____ DOB: _____

Patient Address: _____

Home Phone: (____) ____-_____ Cell: (____) ____-_____ Email Address: _____

Okay to leave voicemail? Y/N Preferred method of contact? Written / Email / Phone / Face to face

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Insurance:_____ Policy #_____ Primary Policy holder? _____

Race: _____ Gender Identity: _____ Sexual Orientation: _____ Marital Status_____

Veteran? Y / N Combat Veteran? Y / N Discharge Status: _____

Tell us why you are seeking services_____

_____

Do you have any concerns about treatment?

_____

Previous Treatment

Have you ever been treated for a substance use problem by another facility? If so, when and where?

_____

_____

Mental Health

Have you ever been diagnosed with any mental health conditions? If yes, which diagnoses: _____

_____

Are you currently receiving care from a psychiatrist, counselor, social worker, etc ? _____

_____

Referral Source

Name and Contact information:_____

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Substance Use Disorder Patient Records
Authorization for Disclosure – Treatment, Payment, Health Care Operations & HIE

A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

As IU Health maintains one electronic medical record (EMR) system for its affiliated facilities and clinics, patient records are available to other treating providers through the EMR system, including all records concerning your substance use disorder. This consent form authorizes the disclosure of your substance use disorder information to an individual or entity with which you have a treating provider relationship, certain health information exchanges (HIE) and to health insurance companies/payors for patient account billing.

I, _____,
(Patient's Name)

authorize Indiana University Health and its affiliated covered entities (IU Health) **to disclose information related to the diagnosis and treatment of my substance use disorder to**: (i) all of my treating providers for medical treatment purposes; (ii) all HIEs in which IUH participates, including access by HIE members having a treating provider relationship with me, for medical treatment purposes; (iii) all of my health insurance companies or payor sources for billing purposes; and (iv) for IU Health's health care operations, including for the purposes of quality improvement, medical training and population health management. I understand that this consent grants access to all of my substance use-related information created before and after the date of this consent. I understand that upon request I am entitled to receive a list of all entities that have received my information pursuant to this consent.

I understand that my substance use disorder records are protected under the federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R Part 2, and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that the HIE will act according to the substance abuse confidentiality 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 when IU Health no longer has a record retention obligation with regard to my records.
I understand that I will be denied substance use disorder services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations, as IU Health is unable to conceal my substance use disorder records within the EMR system. I have been provided a copy of this form.

Signature: _____ Date: _____

Patient / Patient's Authorized Representative

Signature of Minor: _____ Date: _____

If Patient is a Minor, the signature of the Minor is also required.

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Total _____

Over the last 2 weeks, how often have you Been bothered by the following problems?
(Use "✔" to indicate your answer)

	Not At all	Several Days	More than Half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T____* = ____ + ____ + ____)

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Please complete the chart of substances below to the best of your knowledge:

Authorization for Discussion of Medical Information
With Family Member/ Significant Other

Patient Name: _____ MRN#_____

DOB: _____/_____/_____ SSN: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____

Reason for Disclosure: *Collateral information to be utilized during Intensive Outpatient Treatment at IU Health Addiction Treatment and Recovery Treatment Center. Assessment and treatment information may be shared during treatment planning meetings, groups and other pertinent communication.*

The primary purpose of the discussion is to enable your family member/significant other and our team to share information that may be helpful with your treatment.

Dates of Treatment: _____

I hereby authorize discussion of my medical information with: (family member/significant other name, telephone number).

_____

_____

_____

I understand and acknowledge that this may include information regarding physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does *not* include permission to release outpatient psychotherapy notes* as defined below. The release of psychotherapy notes requires a separate authorization. *(*) Psychotherapy notes are defined as notes that document private, joint, group, or family counseling session that are separate from the rest of a patient's medical record.*

_____ / _____ _____/_____/_____

Signature of Patient/Legal Guardian *Print Name* *Date signed*

_____ / _____ _____/_____/_____

Signature of Patient/Legal Guardian *Print Name* *Date signed*

If other than a patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) MUST accompany the authorization when presented. Exception; parent signing for patient under age 18.