

# ALCOHOL DRUG INFORMATION SCHOOL ~ ADIS & VICTIM PANEL REGISTRATION

Welcome to Associated Behavioral Health Please fill out the following information packet as completely and accurately as possible Note that all information that you give is confidential and will be strictly confidential (as disclosed in the confidentiality section) Please feel free to ask any questions you may have as you fill out the following information

**PERSONAL HISTORY**

**How were you referred to us today?** (Please check)  Attorney  Probation / Court  Friend  Internet  Other  
 Yellow Pages Name & Location of referral source: \_\_\_\_\_

\*\*\*\*\*

Today's Date \_\_\_\_\_ Office Location (Please check one):  Bellevue  North Seattle  West Seattle

**Legal Name:** \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
City State Zip

Home / Cell Phone ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**Drivers License or ID #** \_\_\_\_\_ Social Security: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ Sex: Male  Female

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Name Relationship

Have you been a patient here before?  YES  NO If yes, when: \_\_\_\_\_

What is the issue(s) that brought you to us today? \_\_\_\_\_

Are there any special needs our staff should be aware of today? \_\_\_\_\_

What is it that you would like to gain from this class today? \_\_\_\_\_

**LEGAL HISTORY (\*required for Certificate)**

Current Legal Offense(s) pending: \_\_\_\_\_ Date of Offense: \_\_\_\_\_

**Case Number:** \_\_\_\_\_ Next court date: \_\_\_\_\_ Jurisdiction/Location: \_\_\_\_\_

**The Certificate of Completion needs to be submitted to the following Reporting Agent(s):**

**KING COUNTY**

- KCDC EAST DIVISION:  BELLEVUE  ISSAQUAH  REDMOND KCDC SOUTH DIVISION:  BURIEEN  KENT  RJC  
 KCDC WEST DIVISION:  SEATTLE  SHORELINE MUNICIPAL COURTS:  AUBURN  BOTHELL  DES MOINES  
 FEDERAL WAY  ISSAQUAH  KENT  KIRKLAND  LAKE FOREST PARK  MERCER ISLAND  RENTON  
 SEATTLE J C  TUKWILA **SNOHOMISH COUNTY** SCDC  CASCADE DIV  EVERETT DIV  EVERGREEN DIV  
 SOUTH DIV MUNICIPAL COURTS:  EDMONDS  EVERETT  LYNNWOOD  MARYSVILLE

OTHER COURTS NOT LISTED: \_\_\_\_\_

ATTORNEY: \_\_\_\_\_



## CONSENT FOR A/DIS Alcohol Drug Information School And the Victims Panel

I, \_\_\_\_\_ DOB: \_\_\_\_\_ CASE #: \_\_\_\_\_  
(print name clearly)

authorize Associated Behavioral Health to disclose / exchange the following information to / with:

**KING COUNTY**

KCDC EAST DIVISION:  BELLEVUE  ISSAQUAH  REDMOND KCDC SOUTH DIVISION:  BURIEIN  KENT  
 RJC KCDC WEST DIVISION:  SEATTLE  SHORELINE MUNICIPAL COURTS:  AUBURN  BOTHELL  
 DES MOINES  FEDERAL WAY  ISSAQUAH  KENT  KIRKLAND  LAKE FOREST PARK  
 MERCER ISLAND  RENTON  SEATTLE J C  TUKWILA

**SNOHOMISH COUNTY:**

CASCADE DIV  EVERETT DIV  EVERGREEN DIV  SOUTH DIV  
MUNICIPAL COURTS:  EDMONDS  EVERETT  LYNNWOOD  MARYSVILLE

**PIERCE COUNTY:**

PIERCE CTY DISTRICT MUNICIPAL COURTS:  BONNEY LAKE  GIG HARBOR  
 LAKEWOOD  PUYALLUP  SUMNER  TACOMA

OTHER COURTS NOT LISTED: \_\_\_\_\_

ATTORNEY: \_\_\_\_\_

For the purpose of an exchange of information; BY  PHONE;  FAX;  LETTER

(initials required proceeding each box checked)

\_\_\_\_\_ [  ] A/DIS ~ Alcohol Drug Information School attendance Certificate of Completion

\_\_\_\_\_ [  ] Victim Panel attendance Certificate of Completion

I understand that my A/DIS & Victim Panel records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations I also understand that I may revoke this consent at any time This release will expire thirty (30) days after completion of court proceedings or after discharge from treatment which ever is latest

I further acknowledge that the use of this information was explained to me and is given voluntarily by me and of my own free will.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of agency representative

\_\_\_\_\_  
Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Rev. 12/12/07

*Associated Behavioral Health Care, Inc.*

***ALCOHOL DRUG INFORMATION SCHOOL ~ ADIS  
Responsibility Agreement***

I understand that when I complete ADIS ~ Alcohol Drug Information School, I will receive a Certificate of Completion from Associated Behavioral Health Care and a State of Washington Department of Licensing Substance Assessment / Treatment Report form (aka – DOL Blue Form). Both documents will verify my completion of Alcohol Drug Information School on the date indicated on the documents.

*Associated Behavioral Health Care, Inc. will fax the Certificate to my designated reporting agent on the day of class as a courtesy.*

**It will be my sole responsibility** and **not** that of Associated Behavioral Health Care, Inc. ***to make sure*** that proof of completion of this class has been provided to all interested parties.

I have read and understand the responsibility outlined in the above statement.

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**Date Signed:**

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**Name & Signature of Attendee:**

# ***ALCOHOL DRUG INFORMATION SCHOOL ~ ADIS***

## **RULES AND CONSEQUENCES**

1. Participants are expected to attend all sessions of this class.

To successfully complete the class, one must:

- Be on time
- Return from breaks on time
- Stay the entire session
- Cooperate with the Instructors directions

Consequence of a missed session:

- Must repeat session
- Client may be asked to leave class by the instructor if appropriate

2. Participants will not use alcohol or other non-prescription drugs on the day(s) of the class.

Consequence of use as defined above:

- Must leave class session.
- Use will be reported to the Department of Licensing, the Courts, and/or Probation Department and the original A/D Evaluator for review of the initial assessment.

3. Participant will complete the pre & post A/DIS Knowledge Test.

The Post Test must be satisfactorily completed in order to receive a certificate of completion for this class.

**I have read and understand the above rules and consequences**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_