



nsights Educational and Treatment Services, Inc.

1441 St. Andrews Road Columbia, SC 29210 Phone (803) 750-8444 Fax (803) 750-7744

SIMPLE POSSESSION OF MARIJUANA (SPMJ) Intake Form

Please fully complete the following information

Application date: _____

Name (First, M.I., Last): _____

Contact phone #: _____ Social Security #: _____ - _____ - _____

Age: _____ DOB: _____ Gender: Male ___ Female ___

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

In case of emergency, notify: _____ Phone #: _____

Referral Information:

Which agency referred you to our agency? Please list name of referent and agency:

Admission Contract

- You are required to attend 3 consecutive weekly classes.
- The fee for the SPMJ program is \$90.
- \$20 fee must be paid for required drug tests and \$30 fee for required lab test.
- If you do not attend 3 classes on the scheduled dates, you will be dismissed and be required to start the program over. We begin you with class one and attending three consecutive classes, and pay for previous services that were rendered.

Rules of Attendance

- No weapons/violence will be tolerated and will result in termination.
- No drugs or paraphernalia allowed on premises.
- You are not to attend under the influence of drugs or alcohol.
- You must be on time, 6:00 p.m., or you will be considered absent.

To receive a successful discharge, you must:

- Attend all scheduled classes.
- Pay balance in full.

I have read the above admission agreement and fully understand the attendance policy and rules to attend the program with Insights Educational & Treatment Services.

Signature: _____ Date: _____

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ASSESSMENT SCREENING

IMPORTANT: In order to better understand your needs, it is important that you answer all questions completely and honestly. As you answer these questions, keep in mind that we are interested in your entire history, and not just today. All of this information is **confidential** and will be protected in accordance with federal confidentiality and privacy laws.

PERSONAL DATA

Date: _____

First Last M.I.

Street Address

City State Zip Code

Home/Cell Phone (circle one) Emergency Contact/Relationship/Phone Number

If Under the Age of 16, Responsible Party Relationship to Self

Social Security Number Date of Birth Age Gender Race

REFERRAL INFORMATION

Who referred you to Insights? _____

Why were you referred to services? _____

Have you been a client of Insights before Yes No

If yes, approximate dates _____



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Consent for the Release of Confidential Information

Client Name (Last, First, MI)	SSN#
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I, _____, authorize _____
(name of client)

Insights Educational & Treatment Services to disclose to:

(person or organization to whom disclosure is to be made)

the following information:

Recommendations, Participation, Progress Reports, Treatment Plans, Reason for admission, attendance and discharge date, drug screen results and other information as indicated:

Purpose of the disclosure is to:

Coordinate treatment services including referrals and to obtain outcomes and follow up data

I understand that my records are protected under the federal regulations governing Confidentiality, and the Health Insurance 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 the regulations. 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 automatically as follows:

12 months after discharge from services or upon written revocation

(specification of the date, event or condition upon which this consent expires)

I understand that, generally, this company may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign consent form.

Client Signature	Date
Parent, Guardian, or Authorized Representative Signature (if required)*	Date
Witness Signature	Date

*Authorized representatives must demonstrate legal authority to sign