LeQuion Ulrich MR SIR2024-139 DOB: 06/03/1975 Male Blue Cross Blue Shield of Oklahoma

Package: full chart

Table of Contents

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Date 1st contact	Rep on intake call	1st contact name	1st contact phone	1st contact relationship
07/19/2024	Sandy Rosa	n/a	n/a	n/a

Location: Step Into Recovery Centers INC

Admission Date	Referrer	Contact?	Anticipated Discharge Date
07/12/2024 12:00 AM		No	

Discharge/Transition Date	Discharge/Transition to
10/03/2024 12:12 PM	

PARTICIPANT INFORMATION HAS NOT BEEN VALIDATED - PLEASE VALIDATE

participant Information

LeQuion Ulrich

Current Address:
4238 NE 1st St
Pryor, OK 74361 United States

Date of Birth: 06/03/1975 SSN:

Birth Sex: Male

Pronouns:

Preferred Language:

Marital Status:

Race:
Ethnicity:

Payment Method

Insurance

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Blue Cross Blue Shield of Oklahoma	YUQ947218735			Active	Primary
Internal ID / External ID	**Group Plan Name**	**Group ID**	**Plan Type**	**Payor Type**	**Insurance Phone**
13123 /			PPO		
Rx Name	**Rx Group**	**Rx BIN**	**Rx PCN**	**Rx Phone**	**Plan Period**

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
LeQuion Ulrich	Self		06/03/1975	Male

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
4238 NE 1st St		Pryor

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
74361	OK	United States

Concurrent Reviews

Start Date	End Date	# of Days	Auth Date	Authorization Number		Status	Managed	Level of Care
07/12/2024	10/09/2024	90	07/12/2024	Nonauth		New	Yes	OP
Next Review	**Days of Week**		**Hours per Day**	**Days per Week**	**Frequency**	**LCD**	**Next LOC**	**Next LOC Date**
10/10/2024					Daily	No		

Insurance Name	Insurance Policy No.
Blue Cross Blue Shield of Oklahoma	YUQ947218735

Contacts

Allergies and Food Restrictions

Allergies

No Known Allergies/NKA

Diets

Regular Diet

Lab Testing

Lab Bill To	Lab Guarantor Type	Lab Guarantor	Lab Guardian	Lab Patient Class
Unassigned	Unassigned	Unassigned	Unassigned	Not Applicable

Lab Primary Insurance	Lab Secondary Insurance
Unassigned	Unassigned

participant Record Source: N/A

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Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Belongings Placed in the Safe 07/14/2024 11:39 PM

Date: 07/14/2024 11:39 PM

Additional luggage in storage: ☐ Yes ☑ No

Driver's license: No

Other IDs: None

Insurance Card(s): No

Cash: No

Checks (blank): No

Checks (written): No

Wallet: No

Credit or debit cards: None

Phones and electronic devices

Sharps: None

Other items: None

Attachments:

Clients are to be encouraged not to keep valuables on the unit and to send them home whenever possible. The facility maintains a safe for safekeeping your money and valuables. The facility shall not be liable for the loss or damage to any pocketbooks, money, jewelry, eyeglass/contact lens, dentures, documents, personal electronic devices or other articles of

value that are personally kept/not deposited in the safe for your security. It is strongly recommended that all items not required and/or needed during your stay in the facility be sent home.

I have reviewed the above statement and am taking responsibility for any items that I keep in my possession and will hold the facility harmless for any loss or damage to such items.

LeQuion Ulrich (participant), 07/14/2024 11:49 PM

Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:49 PM

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(GMT-08:00) Pacific Time (US & Canada)

Safe Call 07/14/2024 11:39 PM

Date/Time: 07/14/2024 11:39 PM

Emergency Contact:

Consent Release Signed? ☐ Yes ☐ No

Relationship to Patient:

Phone Number:

Emergency Contact Reached?

When?

What is the follow up plan?

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

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D&T Wellness

Activities Release and Waiver of Liability

Notice: This form contains a release and waiver of liability and when signed is a contract between the undersigned participant and D&T Wellness with legal consequences. Please read this Agreement, consisting of one (1) pages in its entirety, carefully before signing your name at the bottom of the page. This form must be signed in the presence of one (1) witness who should sign as a witness.

Date of Execution of Release and Waiver of Liability:

The undersigned agrees that this “Activities Release and Waiver of Liability” form agreement is valid from the date of execution through the date of discharge.

Acknowledgments and Representations by Client:

The undersigned is currently a client of D&T Wellness . The undersigned has voluntarily consented to participate in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and other such types of voluntary sports or physical activities, which may not be specifically identified herein while being a client at such facility. The undersigned acknowledges and represents that their participation in such sports activities and physical activities is not a mandatory requirement of D&T Wellness , and that any participation by the undersigned in any and all sports-related activities and physical activities, is purely voluntary and of the undersigned’s own free will. The undersigned acknowledges and represents that there has been no coercion or force on the part of D&T Wellness for the undersigned to execute this release and waiver of liability agreement. The undersigned has knowingly, freely, and voluntarily consented to execute this release and waiver of liability agreement. The undersigned acknowledges and understands that it is the undersigned’s sole decision to participate in such voluntary activities. The undersigned acknowledges and represents that he has been informed that he has an absolute right to refuse to participate in any and all sports-related activities or physical activities.

To D&T Wellness , Inc.: In consideration of the opportunity afforded to me, by D&T Wellness , to participate in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and any other similar types of voluntary sports or physical activities which may not be specifically identified herein, the undersigned client freely agrees to make the following contractual representations and agreements with D&T Wellness .

The undersigned client, does hereby knowingly, freely, and voluntarily assume all liability for any damage or injury that may

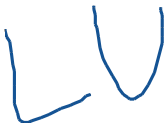
occur as a result of my (or my dependent/ward) participation in the activities described herein and agree to release, waive, discharge, and covenant not to sue D&T Wellness , its officers, agents, employees, and volunteers from any and all liability or claims that may be sustained by me or a third party directly or indirectly in connection with, or arising out of participation in the activities described herein, whether caused in whole or in part by the negligence of D&T Wellness , or otherwise.

The undersigned client, has read this form, fully understand its terms, and understand that, I have given up substantial rights by signing it and have signed it freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of any and all liability to the greatest extent allowed by law, and I agree that if any portion of this contract is held to be invalid the balance notwithstanding, shall continue in full legal force and effect.

I also agree, that the rules provided to me by the D&T Wellness , will be followed during the course of my voluntary participation in the activities described herein. Otherwise, my privilege of participating in such activities will be revoked immediately. Each client must sign a release and waiver of liability form in order to participate in the voluntary activities described herein. I acknowledge that due to the nature of the activities described herein, D&T Wellness staff will not be able to prevent injuries from occurring during the course of such activities; therefore, I am choosing to participate in such activities at my own risk and agree to assume all risks associated therewith.

Indemnification of D&T Wellness : The undersigned client shall at all times hereafter indemnify, hold harmless and, at D&T Wellness Attorney's option, defend or pay for an attorney selected by D&T Wellness to defend D&T Wellness , its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused by negligent act or omission of the client, other clients, D&T Wellness , its employees, agents, servants, or officers, or accruing, resulting from, or related to the undersigned client engaging in any voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and any other similar types of voluntary sports or physical activities which may not be specifically identified herein, including, without limitation, any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. The provisions of this section shall survive the expiration or earlier termination of this Agreement or the discharge of the client from the residential/outpatient facility operated by D&T Wellness .

Venue: This Agreement shall be interpreted and constructed in accordance with and governed by the laws of the State of California Venue for litigation concerning this Agreement shall be in County.



LeQuion Ulrich (participant), 07/14/2024 11:40 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:40 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Admission Orientation Checklist

Name: LeQuion Ulrich MR#: DTW2024-19 DOB: 06/03/1975

Upon admission, I have been oriented and understand the following as indicated by a checkmark next to each requirement and my signature below.

- ☑ A description of services to be provided
- ☑ Consent for treatment
- ☑ A copy of the fee schedule, financial responsibility policy, and applicable fees
- ☑ Advanced Directives used at the facility
- ☑ A copy of individual rights
- ☑ A copy of the grievance process and procedure
- ☑ Program rules
- ☑ Group Confidentiality, Confidentiality and limitations of confidentiality
- ☑ Infection control procedures
- ☑ Therapist Assignment
- ☑ Treatment Schedule
- ☑ Fire exits and emergency evacuations procedures
- ☑ Emergency Services
- ☑ Responsibilities for participation in treatment
- ☑ A summary of the facility's admission and discharge criteria

My signature confirms that I have engaged in an orientation process with D&T Wellness staff member. It further confirms that I was given the opportunity to ask questions for clarification purposes and that I understand the aspects of the program listed above.

LeQuion Ulrich (participant), 07/14/2024 11:41 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:41 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

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D&T Wellness

Client Rights

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status, or national origin, are assured that their lawful rights as Clients shall be guaranteed and protected. While being served, you the Client are assured and guaranteed the following rights:

1. To be treated with respect and dignity.

2. To receive timely treatment by qualified professionals.

   a. Every effort will be made to use the least restrictive, most appropriate treatment available, based on Client needs.
   b. Each Client shall be afforded the opportunity to participate in activities designed to enhance self-image.
   c. An individualized treatment plan shall be developed for each Client in accordance with the provisions established for each program component.

3. To receive quality treatment that is best suited to his/her needs and shall include appropriate services, whether they be medical, vocational, social, educational, and/or rehabilitative services.

4. To express by signature an informed consent of the right to release information for communication purposes with other agencies.

5. To receive communication and correspondence from individuals.

6. To privacy for interview/counseling sessions.

7. To practice your religious practices.

8. To be provided humane care and protection from harm.

9. To contract and consult with legal counsel and private practitioners of your choice at your expense.

10. To exercise your constitutional, statutory, and civil rights.

11. To be free of physical restraint or seclusion.

12. To be informed of the nature of treatment or rehabilitation, the known effects of receiving the treatment or rehabilitation, and alternative treatment or rehabilitation programs.

13. To be provided with information on an ongoing basis regarding your treatment or rehabilitation.

14. To be provided services in accordance with standards of practice, appropriate to your needs, and designed to afford you a reasonable opportunity to improve your condition.

15. To confidentiality of the Client being in treatment and of the Client's records. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse Client. Federal regulations state any person who violates any provision of the law shall be fined not more than $500.00 in the case of the first offense and not more than $5,000.00 in the case of each subsequent offense, except where noted in the Federal Law of Confidentiality, 42 CFR, Part 2, Section 2.22, which includes the following:

a. The limited circumstances of release of Client information include, crimes on program premises or against program personnel, medical emergencies, mandated reports of child abuse or neglect, elderly abuse, threats to harm self or others, research, audit, and evaluations, or court orders.

16. To receive full information regarding the treatment process.

17. To refuse treatment.

18. To all other constitutional and legal rights, including the right to personal clothing and effects.

19. To be informed of the Client grievance procedure upon request.

Confidentiality of Alcohol and Drug Abuse Patient Records/Limits to Confidentiality

The confidentiality of alcohol and drug abuse Client records maintained by this program are protected by Federal law and regulations. Generally, the program may not say to a person outside the program that the Client attends the program or disclose any information identifying a client as an alcohol or drug abuser unless:

1. The Client consents in writing
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel
4. The disclosure to a qualified person for research, audit, or program evaluation; or
5. The disclosure is made to protect self or others or a crime has been committed; or
6. The disclosure in the event of threats of harm to self or others (Duty To Warn).

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by the Client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about elderly abuse, suspected child abuse or neglect, threats to harm to self or others from being protected. These may be released under State law to appropriate State or local authorities beyond Federal CFR42-Regulations.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations,)

Grievance Procedure:

1. Any person(s) who believes that their rights have been violated or has a complaint or grievance may file a complaint pursuant to the procedures set forth below, on their behalf or on the behalf of another person. All persons are encouraged to file a grievance. By filing a complaint the individual will not subject themselves to any form of adverse action, reprimand, retaliation, or otherwise negative treatment by D&T Wellness . The client shall have immediate access to the grievance form; a posting of the grievance procedure will be within the facility with the levels of appeals, and in the Patient Handbook.

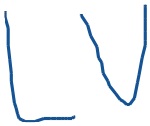
2. The processing procedures for grievances and complaints are as follows:

a. The Client is encouraged to discuss any problems with their therapist. The Client and therapist will try to find a resolution. The therapist will correspond with the Clinical Director on the grievance and/or complaint and any resolution.
b. All grievances shall first be filed with the Clinical Director by completing a "Client Grievance" form. The Human Resources Director and/or Designee shall give the Client a receipt of the filed grievance and log the grievance. The Director will conduct an internal investigation and render an initial determination and resolution within 2 days of receipt of the complaint in writing.
c. If the complaint is not satisfied or if the complaint is not resolved with the results achieved in Step 2, the complaint may file an appeal and/or the grievance shall be forwarded to the Executive Director and this meeting shall be held within five working days of the date it is requested.
d. The Client shall be presented with a resolution and response to their grievance in writing.
e. In the event that the Client does not feel a resolution has been reached they may contact the state regulatory department and the applicable client advocacy institution.

3. The Clinical Director and the Executive Director shall take steps to ensure an appropriate investigation of each complaint to determine its validity. These rules contemplate informally, but thorough, investigations affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.

4. Any allegations of physical or sexual abuse by a therapist shall immediately be brought to the attention of the Clinical Director and the police shall be notified. The Client will be afforded the opportunity to contact the Police, state Abuse Hotline, the state department of family services, and the state disability rights department where applicable. The telephone numbers of the hotlines are posted within the facility.

I, LeQuion Ulrich, hereby acknowledge receipt of and understand the "Client Rights" statement.



LeQuion Ulrich (participant), 07/14/2024 11:41 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:41 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Confidentiality Policy

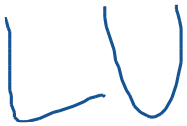
The following information is provided to assist you in your counseling experience at D&T Wellness .

Counseling and treatment is a personal and confidential relationship between a clinician and individual, group, or family.

We work from a team approach at D&T Wellness . Therefore, there may be times when it is necessary for us to consult with other professional staff either individually or at our clinical team meetings in an effort to provide you with the highest consideration and quality. Our clinicians are all Mastered prepared and professionally licensed, graduate student interns, or clinicians working toward certification in substance abuse counseling.

No information will be released from D&T Wellness regarding counseling or consultation sessions without your expressed written consent. If you wish for information to be released to anyone, it will be necessary for you to complete a Release of Information form, stipulating the professional to whom the information is being sent. The law stipulates that in the event of imminent danger to yourself or others, we **must** breach confidentiality. We must also act in accordance with any applicable state laws regarding mandatory disclosure of child, elder, or other abuse.

I have read the above policies and procedures and understand them.



LeQuion Ulrich (participant), 07/14/2024 11:41 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:42 PM

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D&T Wellness

Consent for Reporting Communicable Diseases

I hereby give my permission to release to the California Public Health Department, Disease Control Division any information regarding the below:

California Statutes provide that any attending practitioner licensed in Florida to practice medicine who diagnoses or suspects the existence of a communicable disease among humans or from animals to humans shall immediately report that fact to the Department of Public Health.

The Public Health Unit serves as the department's representative in this reporting requirement.

Modifiable diseases or conditions which are to be reported**immediately** to the County Health unit are listed below:

- Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed that is of urgent public health significance

- Anthrax
- Amebic encephalitis
- Arboviral diseases not otherwise listed
- Botulism, foodborne, wound, and unspecified
- Brucellosis
- Chikungunya fever, locally acquired
- Cholera (*Vibrio cholerae* type O1)
- Dengue fever
- Diphtheria
- Glanders
- *Haemophilus influenzae* invasive disease in children <5 years old
- Hantavirus infection
- Hemolytic uremic syndrome (HUS)
- Hepatitis A
- Herpes B virus, possible exposure
- Influenza A, novel or pandemic strains
- Influenza-associated pediatric mortality in children <18 years old
- Listeriosis
- Measles (rubeola)
- Melioidosis
- Meningococcal disease
- Neurotoxic shellfish poisoning
- Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)
- Pertussis
- Plague
- Poliomyelitis
- Rabies, animal or human
- Rabies, possible exposure
- Ricin toxin poisoning
- Rubella
- Severe acute respiratory disease syndrome (SARS) associated with coronavirus infection
- Smallpox
- Staphylococcal enterotoxin B poisoning
- *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- Syphilis in pregnant women and neonates
- Tularemia
- Typhoid fever (*Salmonella* serotype Typhi)
- Typhus fever, epidemic
- Vaccinia disease
- Venezuelan equine encephalitis
- Viral hemorrhagic fevers
- Yellow fever
- Zika fever

Other: n/a

Modifiable diseases or conditions which are to be reported within**48 hours** to the County Health unit are listed below:

- Acquired immune deficiency syndrome (AIDS)
- Arsenic poisoning
- Babesiosis
- Botulism, infant
- California serogroup virus disease
- Campylobacteriosis
- Cancer, excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors
- Carbon monoxide poisoning
- Chancroid
- Chikungunya fever
- Chlamydia
- Ciguatera fish poisoning
- Congenital anomalies
- Conjunctivitis in neonates <14 days old
- Creutzfeldt-Jakob disease (CJD)
- Cryptosporidiosis
- Cyclosporiasis
- Eastern equine encephalitis
- Ehrlichiosis/anaplasmosis
- *Escherichia coli* infection, Shiga toxin-producing
- Giardiasis, acute
- Gonorrhea
- Granuloma inguinale
- Hansen's disease (leprosy)
- Hepatitis B, C, D, E, and G
- Hepatitis B surface antigen in pregnant women and children <2 years old
- Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old
- Human immunodeficiency virus (HIV) infection
- HIV-exposed infants <18 months old born to an HIV-infected woman
- Human papillomavirus (HPV)-associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children ≤12 years old
- Lead poisoning (blood lead level ≥5 µg/dL)
- Legionellosis
- Leptospirosis
- Lyme disease
- Lymphogranuloma venereum (LGV)
- Malaria
- Meningitis, bacterial or mycotic
- Mercury poisoning
- Mumps
- Neonatal abstinence syndrome (NAS)
- Pesticide-related illness and injury, acute
- Psittacosis (ornithosis)
- Q Fever
- Rocky Mountain spotted fever and other spotted fever rickettsioses
- St. Louis encephalitis
- Salmonellosis
- Saxitoxin poisoning (paralytic shellfish poisoning)
- Shigellosis
- *Streptococcus pneumoniae* invasive disease in children <6 years old
- Syphilis
- Tetanus
- Trichinellosis (trichinosis)
- Tuberculosis (TB)
- Varicella (chickenpox)
- Vibriosis (infections of *Vibrio* species and closely related organisms, excluding *Vibrio cholerae* type O1)
- West Nile virus disease

Other: n/a

LeQuion Ulrich (participant), 07/14/2024 11:42 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:42 PM

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D&T Wellness

Consent for Treatment

I authorize D&T Wellness to perform all clinical services deemed necessary in the evaluation of program/client appropriateness.

I have been advised and understand that D&T Wellness adheres to all Federal Laws of confidentiality and any suspected violations of the law must and will be reported.

I give my consent for the duration of my treatment and 90 days after discharge for D&T Wellness to release information regarding my progress and location in treatment to Referring Agencies, Probation, and Officers of the Court for the purpose of assuring my compliance with an order for treatment (if requested).

I agree to submit a urine/take an alcohol test, if requested, for drug testing. I understand that failure to do so could result in negative termination. Urine/alcohol results may be utilized as treatment interventions or may be completed as determined by external requirements.

I understand that I am responsible for all fees for the duration of my program.

I understand that if I fail to follow any communicable-disease-related referrals, D&T Wellness will need to report such to the County Health Department.

In case of a severe medical emergency, I have listed an emergency medical contact on a release form and do authorize D&T Wellness to contact that party should such an emergency occur.

LeQuion Ulrich (participant), 07/14/2024 11:42 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:42 PM

This form expires on 07/14/2025 11:42 PM.

LeQuion Ulrich ♂ SIR2024-139

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D&T Wellness

Drug and Alcohol Use Policy

I, LeQuion Ulrich hereby agree to participate fully in all aspects of my treatment while at D&T Wellness .

I understand that while I am in treatment at D&T Wellness , I am expected to:

Please initial the following statements:

LU I understand that if I am prescribed any medication by any provider, I am expected to inform my attending clinician immediately.

LU Abstain from the use of all illegal/non-prescribed substances and alcohol.

LU I understand that frequent and random urinalysis and random breathalyzers are part of substance abuse treatment.

LU I agree to provide a urine sample and/or breathalyzer upon request.

LU I understand the refusal to provide a urinalysis or a breathalyzer when requested will be considered positive and may lead to discharge from the program.

LU I understand that absolutely no alcohol, drugs, or drug paraphernalia is permitted on the premises. I understand that anyone suspected of being under the influence of drugs or alcohol or who possesses any illicit drugs or alcohol may be required to leave the program immediately.

LU I understand that I cannot wear any clothing that glorifies or endorses the use of alcohol or drugs.

The above conditions have been explained to me and I fully understand my obligations while in treatment at D&T Wellness and agree to abide by the conditions stated above.

LeQuion Ulrich (participant), 07/14/2024 11:43 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:43 PM

LeQuion Ulrich ♂ SIR2024-139

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D&T Wellness

Group Confidentiality

To reinforce the feelings of closeness and willingness to share with others your feelings, thoughts, and consequences of your dependency, confidentiality is a must in group therapy. Use this as your golden rule: **What is said in Group, stays in Group** To break this rule violates the trust of the total group and the effectiveness of group therapy is lost.

The following guidelines will help you maintain this rule:

1. Group issues are not discussed with others outside your group.
2. Do not discuss group issues with your roommate unless he/she is in your group.
3. Do not discuss at any outside meetings or places where others may overhear you.

Your group therapists have the same responsibilities for group confidentiality as you, with the exception that your therapists share group issues and your participation in the group process with other staff members. This is a vital part of the staff team's approach to assist you in your recovery.

The staff values your confidentiality so highly that anyone who breaks confidentiality - whether to another patient of D&T Wellness or to family, significant others, etc., may be subject to discharge from this program.

LeQuion Ulrich (participant), 07/14/2024 11:43 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:43 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Liability Waiver for Gym, Pool, and Sporting Events

The undersigned and the undersigned's heirs, executors, and administrators hereby waive and forever release and discharge D&T Wellness , its owners, staff, and sponsors of and from any and all claims, suits, or rights for damages for personal property damage and/or physical injury which may be sustained or which occurs during participation in physical and/or recreational activities at either the gym or the pool utilized by or at D&T Wellness that may occur to or from the physical and/or recreational activity, whether or not such injury or property damage or loss is caused by, is connected to, or arises out of any acts or omissions or the negligence of D&T Wellness , its owners, staff, and sponsors.

According to Federal Regulations for Client Confidentiality and Protected Health Information, I agree not to disclose to any and all persons while at the gym that I am a client of D&T Wellness , about my own or others' purpose for being at and/or participating in any and all activities.

LeQuion Ulrich (participant), 07/14/2024 11:45 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:45 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the

purpose of payment or our operations with your health insurer.

- We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone’s health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: October 11, 2013

This Notice of Privacy Practices applies to the following organizations.

D&T Wellness

LeQuion Ulrich (participant), 07/14/2024 11:46 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:46 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Program Rules

1. The use of alcohol or other drugs is grounds for immediate discharge from the program.
2. Possession of weapons, sharp objects, acts of violence, or threats of violence are grounds for immediate discharge.
3. Smoking, vaping, or the use of smokeless tobacco products are allowed in designated outside areas only.
4. All Clients must sign out and in whenever they leave or return, as well as their destination.
5. Clients must attend all treatment activities unless excused by staff.
6. If you drive your car to the facility, keys must be turned into and kept by staff at all times. The use of your vehicle is by staff permission only.
7. Negative contracts involving major rule violations not reported to staff will result in consequences or discharge.
8. Clients will respect the personal property of other Clients and staff. Clients will not borrow the property of others.
9. Clients are responsible for their behavior and are expected to communicate, cooperate, and show respect to other Clients and staff.
10. Failure to abide by the rules may result in the restriction of privileges. In more serious cases, repeated violations, or disregard for program rules will result in an administrative discharge.
11. Being on time for all scheduled activities is required.
12. All treatment assignments are to be completed in a timely manner.
13. All assigned work responsibilities must be completed.
14. When you do not know what to do, do not assume…..ask the staff.
15. No profanity or verbal abuse of staff or other Clients is allowed.
16. Gambling is not permitted.
17. Logos on clothing that are explicit, gang, or drug-related are not permitted.
18. No tank tops, halter-tops, backless or low-cut clothing. No short shorts or other tight clothing is permitted.
19. Undergarments must be worn at all times.
20. No cameras, tape recorders, or other recording devices are permitted.
21. No material other than recovery related material.
22. Knowledge and awareness of all rules are expected.
23. All passes and clinical visits must be approved by the clinical staff and the Clinical Director.
24. All pass requests must be turned in weekly to the designated staff member each week.
25. No perfumes or any glass bottles are permitted.
26. No straight edge razors are permitted, electric razors are permitted.

27. No alcohol-based hand sanitizers are permitted.
28. No stuffed animals are permitted.
29. No safety pins or knives are permitted.
30. No mouthwash with alcohol is permitted.
31. I understand that if I am suspected of using alcohol/drugs, I will be asked to undergo a blood and/or urine test. If the results are positive, I may be asked to leave the program with an appropriate referral.
32. I am aware that regular attendance is a requirement of the program; I understand that breaking this rule can result in discharge from the program.
33. I understand that information discussed in groups is confidential and should not be discussed outside of the program.

Behavior that undermines treatment rules and expectations will not be tolerated. Violation of these rules will result in consequences and may result in dismissal from the program. Illegal activity is subject to criminal prosecution.

D&T Wellness rules have been explained to me so that I understand them and I have received a copy of these rules.

LeQuion Ulrich (participant), 07/14/2024 11:46 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:47 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Uses and Disclosure of Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice is effective as of April 15, 2003

USES AND DISCLOSURE OF HEALTH INFORMATION

D&T Wellness is committed to protecting the privacy of the personal and health information we collect or create as part of providing health care services to our clients, known as “Protected Health Information” or “PHI”. PHI typically includes your name, address, date of birth, billing arrangements, care, and other information that relates to your health, health care provided to you, or payment for the health care provided to you. PHI DOES NOT include information that is de-identified or cannot be linked to you.

This notice of Health Information Privacy Practices (the “Notice”) describes D&T Wellness ’s duties with respect to the privacy of PHI, D&T Wellness ’s use of and disclosure of PHI, client rights, and contact information for comments, questions, and complaints.

D&T Wellness ’S PRIVACY PROCEDURES AND LEGAL OBLIGATIONS

D&T Wellness obtains most of its PHI directly from you, through care applications, assessments, and direct questions. We may collect additional personal information depending upon the nature of your needs and consent to make additional referrals and inquiries. We may also obtain PHI from community health care agencies, other governmental agencies, or health care providers as we set up your service arrangements.

D&T Wellness is required by law to provide you with this notice and to abide by the terms of the Notice currently in effect. D&T Wellness reserves the right to amend this Notice at any time to reflect changes in our privacy practices. Any such changes will

be applicable to and effective for all PHI that we maintain including PHI we created or received prior to the effective date of the revised notice. Any revised notice will be mailed to you or provided upon request.

D&T Wellness is required by law to maintain the privacy of PHI. D&T Wellness will comply with federal law and will comply with any state law that further limits or restricts the uses and disclosures discussed below. In order to comply with these state and federal laws, D&T Wellness has adopted policies and procedures that require its employees to obtain, maintain, use and disclose PHI in a manner that protects client privacy.

USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as outlined below, D&T Wellness will not use or disclose your PHI without your written authorization. The authorization form is available from D&T Wellness (at the address and phone number below). You have the right to revoke your authorization at any time, except to the extent that D&T Wellness has taken action in reliance on the authorization.

The law permits D&T Wellness to use and disclose your PHI for the following reasons without your authorization:

For Your Treatment: We may use or disclose your PHI to physicians, psychologists, nurses and other authorized healthcare professionals who need your PHI in order to conduct an examination, prescribe medication, or otherwise provide health care services to you.

To Obtain Payment: We may use or disclose your PHI to insurance companies, government agencies, or health plans to assist us in getting paid for our services. For example, we may release information such as dates of treatment to an insurance company in order to obtain payment.

For Our Health Care Operations: We may use or disclose your PHI in the course of activities necessary to support our health care operations such as performing quality checks on your employee services. We may also disclose PHI to other persons not in D&T Wellness 's workforce or to companies who help us perform our health services (referred to as "Business Associates") we require these business associates to appropriately protect the privacy of your information.

As Permitted or Required By The Law: In some cases, we are required by law to disclose PHI. Such as disclosers may be required by statute, regulation court order, government agency, we reasonably believe an individual to be a victim of abuse, neglect, or domestic violence: for judicial and administrative proceedings and enforcement purposes.

For Public Health Activities: We may disclose your PHI for public health purposes such as reporting communicable disease results to public health departments as required by law or when required for law enforcement purposes.

For Health Oversight Activities: We may disclose your PHI in connection with governmental oversight, such as for licensure,

auditing, and the administration of government benefits.

To Avert Serious Threat to Health and Safety: We may disclose PHI if we believe in good faith that doing so will prevent or lessen a serious or imminent threat to the health and safety of a person or the public.

Disclosures of Health-Related Benefits or Services: Sometimes we may want to contact you regarding service reminders, health-related products or services that may be of interest to you, such as health care providers or settings of care or to tell you about other health-related products or services offered at D&T Wellness . You have the right not to accept such information.

Incidental Uses and Disclosures: Incidental uses and disclosures of PHI are those that cannot be reasonably prevented are limited in nature and that occur as a by-product of a permitted use or disclosure. Such incidental uses and disclosures are permitted as long as D&T Wellness use reasonable safeguards and use or disclose only the minimum amount of PHI necessary.

To Personal Representatives: We may disclose PHI to a person designated by you to act on your behalf and make decisions about your care in accordance with state law. We will act according to your written instructions in your chart and our ability to verify the identity of anyone claiming to be your personal representative.

To Family and Friends: We may disclose PHI to persons that you indicate are involved in your care or the payment of care. These disclosures may occur when you are not present, as long as you agree and do not express an objection. These disclosures may also occur if you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other person that may be involved in caring for you. You have the right to limit or stop these disclosures.

YOUR RIGHTS CONCERNING PRIVACY

Access to Certain Records: You have the right to inspect and copy your PHI in a designated record set except where State law may prohibit client access. A designated record set contains medical and billing and case management information. If we do not have your PHI recordset but know who does, we will inform you how to get it. If our PHI is a copy of the information maintained by another health care provider, we may direct you to request the PHI from them. If D&T Wellness produces copies for you, we may charge you up to $1.00 per page up to a maximum fee of $50.00. Should we deny your request for access to the information contained in your designated record set, you have the right to ask for the denial to be reviewed by another healthcare professional designated by D&T Wellness .

Amendments to Certain Records: You have the right to request certain amendments to your PHI if, for example, you believe a mistake has been made or a vital piece of information is missing. D&T Wellness is not required to make the requested amendments and will inform you in writing of our response to your request.

Accounting of Disclosures: You have the right to receive an accounting of disclosures of your PHI that were made by D&T Wellness for a period of six (6) years prior to the date of your written request. This accounting does not include for purposes of treatment, payment, health care operations, or certain other excluded purposes, but includes other types of disclosures, including disclosures for public health purposes or in response to a subpoena or court order.

Restrictions: You have the right to request that we agree to restrictions on certain uses and disclosures of your PHI, but we are not required to agree to your request. You cannot place limits on uses and disclosures that we are legally required or allowed to make.

Revoke Authorizations: You have the right to revoke any authorizations you have provided, except to the extent that D&T Wellness has already relied upon the prior authorization.

Delivery by Alternate Means or Alternate Address: You have the right to request that we send your PHI by alternate means or to an alternate address.

Complaints & How to contact us: If you believe your privacy rights have been violated, you have the right to file a complaint by contacting D&T Wellness at the address and/or phone number indicated below. You also have the right to file a complaint with the Secretary of the United States Department of Health and Human Services in Washington, D.C. D&T Wellness will not retaliate against you for filing a complaint.

If you believe your privacy rights have been violated, you may make a complaint by contacting_____, HIPAA Privacy Officer at (___) ___-____ or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

The U.S.Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll-Free: 1-877-696-6775

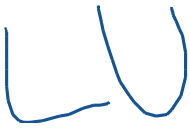
RESTRICTION REQUEST:

I request a restriction on the Use or Disclosure of my following information:

n/a

CLIENT TO BE GIVEN A COPY ALONG WITH A COPY TO FILED IN CLIENT CHART

I acknowledge that I have received a copy of this notice regarding the use and disclosure of my health information.



LeQuion Ulrich (participant), 07/14/2024 11:47 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:47 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Safety Contract

I, LeQuion Ulrich, understand and agree to comply with the following recommendations. I understand that this contract has been created for my safety and well-being. By signing this contract, I agree to the following:

- I will take my medication as prescribed.
- I will inform an appropriate professional to call 911 (or transport me to the hospital) if I am in crisis.
- I will go to an appropriate professional to discuss any dangerous thoughts or feelings; such as suicidal ideations or thoughts of self-harm.
- At this time, I do not have any suicidal or homicidal thoughts or plans and my safety needs are being met.
- I am committed to leading a healthy lifestyle and recognize that I am a valuable and worthwhile person.
- I am committing myself to honor this contract for the remainder of my time in this program.
- I understand that my emergency contact will be called in the event that I need to be safely transitioned to a facility that is more appropriate to handle my mental health needs.

I understand that if I do not comply with these requirements, I will be referred to a facility that will appropriately meet my mental health needs.

LeQuion Ulrich (participant), 07/14/2024 11:47 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:48 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Transportation Release and Waiver of Liability

Notice: This form contains a release and waiver of liability and when signed is a contract between the undersigned Client and D&T Wellness with legal consequences. Please read this agreement in its entirety carefully before signing your name. This form must be signed in the presence of a witness who will sign as a witness.

Client's Information:

Activities: This includes, but is not limited to Transportation to the facility from the Client's residence, from the facility to the Client's residence, medication pick-up, and transportation to the nearest mental health Receiving Facility.

Date of execution of Release and Waiver of Liability: n/a. The undersigned agrees that this Release and Waiver of Liability Agreement is valid from the date of execution through the date of discharge from D&T Wellness .

Name of Facility: D&T Wellness

Client's Full Name: LeQuion Ulrich

Parent/Guardian's Full Name: n/a

Client/Parent/Guardian Phone Number: n/a

Name and telephone number of emergency contact: n/a

Acknowledgments and Representations by Client:

The undersigned Client, LeQuion Ulrich, is currently a client at the Partial Hospitalization or Intensive Outpatient Program operated by D&T Wellness . This Client will be participating in the Transportation Services provided by D&T Wellness . This includes, but is not limited to Transportation to the facility from the Client's residence, from the facility to the Client's residence, medication pick-up, emergency medical care, and transportation to the nearest mental health Receiving Facility.

The undersigned client, LeQuion Ulrich (or parent/guardian of the individual named herein), does knowingly, freely, and voluntarily assume all liability for any and all damage or injury that may occur as a result of his/her (or his/her dependent's/ward's) participation in the activities described herein and agrees to **release, waive, discharge, and covenant not to bring suit against D&T Wellness ,** its officers, agents, employees, and volunteers from/for any and all liability or claims that may be sustained by me or by a third party, directly or indirectly, in connection with or arising out of his/her (or his/her dependent's/ward's) participation in the activities described herein, **whether caused in whole or in part by the negligence of D&T Wellness or otherwise.**

The undersigned Client, LeQuion Ulrich, (or parent/guardian of the individual named herein), has read the form, fully understands its terms, and understand that he/she (or his/her dependent/ward) has given up substantial rights by signing it and has signed it freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of any and all liability to the greatest extent allowed by law and agree that if any portion of this contract is held to be invalid, the balance notwithstanding shall continue in full legal force and effect.

Indemnification of D&T Wellness : The undersigned Client (or his/her parent/guardian) shall at all times hereafter indemnify, hold harmless and, at D&T Wellness 's Attorney's option, defend or pay for an attorney selected by the Board to defend D&T Wellness , its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused by negligent act or omission of the Client, other clients, D&T Wellness , its employees, agents, servants, or officers, or accruing, resulting from, or related to the undersigned Client in the following situations including, but not limited to, Transportation to the facility from the Client's residence, from the facility to the Client's residence, medication pick-up, medical emergency, and transportation to the nearest mental health Receiving Facility, including, without limitation, any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. The provisions of this section shall survive the expiration or earlier termination of this agreement or the discharge of the client from D&T Wellness .

Venue: This Agreement shall be interpreted and constructed in accordance with and governed by the laws of the State o n/a . Venue for litigation concerning this agreement shall be in County.

I, LeQuion Ulrich, have read and fully understand the contents herein.

Executed this n/a.

LeQuion Ulrich (participant), 07/14/2024 11:48 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:48 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Universal Precautions for HIV

Universal Precautions refer to the usual and ordinary steps we need to take in order to reduce the risk of infection with HIV, the virus that causes AIDS. These measures are intended to prevent transmission of HIV.

The prevention of the transmission of HIV is based on the avoidance of skin and mucous membrane contact with blood and body fluids.

Protecting yourself from HIV

- Avoid risky behavior
- Protect yourself from sharp injuries
- Wear gloves when in contact with body fluids, if possible
- Wear mask and eye protection when splash injuries are possible
- Call on trained individuals to clean up blood spills

LeQuion Ulrich (participant), 07/14/2024 11:48 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:48 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Universal Precautions for Infection Control

Universal Precautions refer to the usual and ordinary steps you need to take in order to reduce the risk of infectious diseases such as HIV or Hepatitis C.

The prevention of transmission of infectious diseases is based on the avoidance of skin and mucous membrane contact with blood and other body fluids.

AVOID UNNECESSARY RISKS

- If a fellow patient or client needs assistance, please call a staff member immediately.
- When avoidable, don't expose yourself to another person's blood or body fluids.
- Never share needles, razors, or any other*personal* sharp objects.
- Always call on trained individuals to clean up blood or other body fluid spills.

PROTECT YOURSELF

- Use barrier protection to prevent skin and mucous membrane contact with blood and other body fluids.
- Wear face protection if blood or body fluid droplets may be generated during a procedure.
- Wear protective clothing if blood or body fluids may be splashed during a procedure.
- Wash hands and skin immediately and thoroughly if contaminated with blood or body fluids.
- Wash hands immediately after gloves are removed.
- Use care when handling sharp instruments and needles. Place used sharps in labeled, puncture-resistant containers.
- If you have sustained an exposure or puncture wound, immediately flush the exposed area and notify a staff member.

LeQuion Ulrich (participant), 07/14/2024 11:48 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:48 PM

LeQuion Ulrich ♂ SIR2024-139

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Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Pre-Admission Assessment 07/14/2024 11:49 PM

Date/Time of Assessment: 07/14/2024 11:49 PM

Race:

Marital Status:

Number of Marriages:

Living Arrangements

With whom does the patient live:

Does the patient wish to return to current living situation? ☐ Yes ☐ No

Does the client have children?

Are you pregnant?

Are you employed?

Does your employer know you are here?

If yes, when are you supposed to return to work?

Do you have any mobility issues/concerns?

Are you ambulatory?

Presenting Problem/Crisis/Precipitating Events leading to seeking treatment at this time:

Contributing Factors Leading to Seeking Treatment:

Outpatient Providers

	Name of Treating Providers	Phone Numbers and/or Locations	Last Visit (Month/Year)
Psychiatrist			
Therapist/Counselor			
PCP/Other Specialist			

Previous Substance Abuse/Psychiatric Treatments

Treatment History:

	Facility (include Location)	Treatment Dates	Level(s) of Care	Length of Treatment	Outcome	How long did they stay abstinent?

Medical History

Current Medical Conditions:

Current Medications:

	Medication	Prescribed for	Dosage & Frequency	Prescribed by	Last Visit	Compliant	Able to bring in?

Allergies:

No Known Allergies/NKA

Psychiatric Conditions:

Substance Abuse History

Substance History:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued)
Alcohol						
Marijuana						
Cocaine (Powder)						
Crack Cocaine						
Crystal Meth						
Heroin						

Suboxone/Zubsolv						
Oxycontin						
Methadone						
Other Opiates						
Benzodiazepines						
Hallucinagens						
Amphetamines						
Inhalants						
Ketamine (Special K)						
Triple C's						
Codeine						
Ecstasy						
Bath Salts						
Flakka						
MDMA/Molly						
Steroids						
K2Spice						
Kratom						
Kava						
Other OTC drugs						
Other						

Current Signs and Symptoms of Withdrawal

History of High Risk/Severe Withdrawal Symptoms:

Neurovegetative Signs and Symptoms

Sleep Patterns: Good ☐ Fair ☐ Poor ☐

Hours per Night:

Sleep Interruptions:

Appetite: Good ☐ Fair ☐ Poor ☐

Unanticipated weight gain?

Unanticipated weight loss?

	Yes	No
Loss or gain over the following time period?	☐	☐

Suicidal/Homicidal Lethality Risk Assessment

Suicidal Ideation:

How long has the client had these thoughts?

Does the Client have a plan?

Past history of suicide attempts?

How was the attempt made?

Homicidal Ideation?

History of Violent Behavior (describe)

Self Abuse History

Does patient have a history of self mutilation?

How and where does client typically disfigure him/herself?

Eating Disorders:

Preadmission Mental Status

Speech:

Judgment:

Insight:

Thought Process:

Memory:

Attention:

Affect:

Family History

Father:

Mother:

Siblings:

Spouse:

Children:

Other:

Rationale for Treatment
Admission:

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

D&T Wellness

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s), Blue Cross Blue Shield of Oklahoma, be made directly to D&T Wellness for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

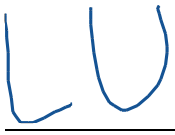
In addition, I authorize D&T Wellness to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible parties; at the determination of D&T Wellness . Such disclosure shall be for reimbursement purposes for those services received.

I hereby release D&T Wellness and its officers, agents, employees, and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes, or seek to take action for the referred payment for treatment services.
- I agree to participate and assist D&T Wellness or its designated representatives with any appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules, and regulations that provide for my right to the confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. In any event, this authorization will expire once reimbursement for services rendered is complete.
- D&T Wellness is acting in filing for insurance benefits assigned to D&T Wellness and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by D&T Wellness for billing and collection purposes.
- D&T Wellness is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- D&T Wellness shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form:



LeQuion Ulrich (participant), 07/14/2024 11:50 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:51 PM

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

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D&T Wellness

Coordination of Benefits and Pre-existing Conditions

Date of Admission: 07/12/2024

This will confirm that upon admission to D&T Wellness , I, LeQuion Ulrich:

☐ Have been employed for the past eighteen months and do not have Cobra coverage;

☐ Am presently unemployed, but did not work within the past eighteen months for the company identified below, but do not have Cobra coverage;

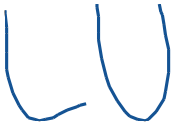
☐ Am presently employed with n/a (employer), but DO NOT have any hospital/medical/health insurance coverage;

☐ The only benefits available to me during my stay at D&T Wellness is from n/a , (Name of Insurance);

☐ I have never been treated for this condition prior to my admission to D&T Wellness ;

☐ Enrolled as a dependent of n/a , who is my n/a (Relationship).

IN WITNESS WHEREOF I have here executed this agreement as dated below.



LeQuion Ulrich (participant), 07/14/2024 11:51 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/14/2024 11:51 PM

LeQuion Ulrich ♂ SIR2024-139

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Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Blue Cross Blue Shield of Oklahoma	YUQ94721873 5			Active	Primary

Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
13123 /			PPO		

Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
LeQuion Ulrich	Self		06/03/1975	Male

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
4238 NE 1st St		Pryor

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
74361	OK	United States

Vital Signs

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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Date	Blood Pressure Systolic	Blood Pressure Diastolic	Temperature	Oxygen Saturation	Pulse	Respiration	Comments	Logged By	Logged At

Glucose Logs

No records available.

Weights

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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No height/weight records.

Heights

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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Date	Height	Logged By	Logged At

Orthostatic Vital Signs

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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	Lying		Sitting		Standing							
Date	BP	HR	BP	HR	BP	HR	Resp.	Temp.	O2	Comments	Logged At	Logged By

CIWA-Ar

No CIWA-Ar assessment logged

CIWA-B

No CIWA-B assessment logged

COWS

No COWS assessment logged

Medications Brought In

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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No Medications Brought In Logged.

Rounds

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

Allergies: No Known Allergies/NKA

Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
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MAT Orders

LeQuion Ulrich ♂ SIR2024-139

Birthdate: 06/03/1975

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Admission: 07/12/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Current/Active Order ***No Current/Active Order.***

Order History

Start Date	End Date	Phase	Order Type	Medication	Dose	Instructions	Ordered By	Entered By	Discontinued By	Status