Olivia Rose Perez MR SIR2024-62 DOB: 03/08/2008 Female Highmark BCBS of Pennsylvania F33.1 Major depressive disorder, Recurrent episode, Moderate,F41.1 Generalized anxiety disorder

Package: full chart

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Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 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
01/21/2024	Crystal Watson	n/a	n/a	n/a

Location: Step Into Recovery Centers INC

Admission Date	Referrer	Contact?	Anticipated Discharge Date
06/03/2024 04:00 PM		No	

Discharge/Transition Date	Discharge/Transition to
09/02/2024 06:00 AM	

PARTICIPANT INFORMATION HAS NOT BEEN VALIDATED - PLEASE VALIDATE

participant Information

Olivia Rose Perez

Current Address:
6528 WILBUR AVE #106
RESEDA, CA 91335 United States

Phone: 818-966-4730
Alternate phone: 818-462-6502
Email: lllllqueenbeellllll@yahoo.com
Portal Account Email: lllllqueenbeellllll@yahoo.com

Date of Birth: 03/08/2008 SSN: ***-**-2080

Birth Sex: Female

Pronouns:

Preferred Language:

Marital Status: Single

Race: Other not listed
Ethnicity: Mexican American

Occupation	Employer	Employer Phone
STUDENT		

Payment Method

Insurance

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Highmark BCBS of Pennsylvania	STM 136248980001	12/01/2023		Active	Primary

Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
15448 /	Blue Cross	10578198	PPO		

Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period
	HMRK001	610014			

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country
RESEDA	CA	91335	United States

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
LIZ JASMIN CORDOVA	Child	***-**-6931	05/18/1985	Female

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
6528 WILBUR AVE., 106		reseda

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
91335	CA	United States

Concurrent Reviews

Start Date	End Date	# of Days	Auth Date	Authorization Number		Status	Managed	Level of Care
06/03/2024	08/31/2024	90	06/03/2024			New	Yes	MH IOP

Next Review	Days of Week	Hours per Day	Days per Week	Frequency	LCD	Next LOC	Next LOC Date
08/30/2024				Weekdays Only	No		

Insurance Name	Insurance Policy No.
Highmark BCBS of Pennsylvania	STM 136248980001

Contacts

Type	Relationship
Emergency	Guarantor

Name	Phone
liz cordova	818-966-4730

Address
6528 wilbur ave unit 106

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: 06/03/2024 10:34 PM: Readmit: 142: SIR2024-4: Step Into Recovery Centers INC: Pre-Admission: Step Into Recovery Centers INC: 06/03/2024 04:00 PM: : Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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 Step Into Recovery 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 Step Into Recovery. 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 Step Into Recovery, 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 Step Into Recovery 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 Step Into Recovery, Inc.: In consideration of the opportunity afforded to me, by Step Into Recovery, 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 Step Into Recovery.

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

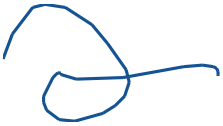
occur as a result of my (or my dependent/ward) participation in the activities described herein and agree to release, waive, discharge, and covenant not to sue Step Into Recovery, its officers, agents, employees, and volunteers from any and all liability or claims that may be sustained by me or a third 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 Step Into Recovery, 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 Step Into Recovery, 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, Step Into Recovery 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 Step Into Recovery: The undersigned client shall at all times hereafter indemnify, hold harmless and, at Step Into Recovery Attorney's option, defend or pay for an attorney selected by Step Into Recovery to defend Step Into Recovery, 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, Step Into Recovery, 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 Step Into Recovery.

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.



Jennifer Rosa, Administrator (Staff), 01/23/2024 03:03 PM

liz cordova (Guarantor), 01/23/2024 03:04 PM

Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:40 PM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

Confidentiality Policy

The following information is provided to assist you in your counseling experience at Step Into Recovery.

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

We work from a team approach at Step Into Recovery. 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 Step Into Recovery 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.

liz cordova (Guarantor), 01/23/2024 03:05 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:41 PM

Olivia Rose Perez (participant), 02/20/2024 06:41 PM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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

liz cordova (Guarantor), 01/23/2024 03:06 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:41 PM

Olivia Rose Perez (participant), 02/20/2024 06:42 PM
Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

Consent for Treatment

I authorize Step Into Recovery to perform all clinical services deemed necessary in the evaluation of program/client appropriateness.

I have been advised and understand that Step Into Recovery 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 Step Into Recovery 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, Step Into Recovery 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 Step Into Recovery to contact that party should such an emergency occur.

liz cordova (Guarantor), 01/23/2024 03:06 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:42 PM

Olivia Rose Perez (participant), 02/20/2024 06:42 PM
Staff present: Jennifer Rosa, Administrator

This form expires on 02/19/2025 06:42 PM.

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

Drug and Alcohol Use Policy

I, Olivia Rose Perez hereby agree to participate fully in all aspects of my treatment while at Step Into Recovery.

I understand that while I am in treatment at Step Into Recovery, I am expected to:

Please initial the following statements:

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

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

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

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

OP 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.

OP 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.

oP 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 Step Into Recovery and agree to abide by the conditions stated above.

liz cordova (Guarantor), 01/23/2024 03:06 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:42 PM

Olivia Rose Perez (participant), 02/20/2024 06:42 PM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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 Step Into Recovery or to family, significant others, etc., may be subject to discharge from this program.

liz cordova (Guarantor), 01/23/2024 03:07 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:42 PM

Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:43 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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

Step Into Recovery 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 Step Into Recovery’s duties with respect to the privacy of PHI, Step Into Recovery’s use of and disclosure of PHI, client rights, and contact information for comments, questions, and complaints.

Step Into Recovery’S PRIVACY PROCEDURES AND LEGAL OBLIGATIONS

Step Into Recovery 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.

Step Into Recovery is required by law to provide you with this notice and to abide by the terms of the Notice currently in effect. Step Into Recovery 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.

Step Into Recovery is required by law to maintain the privacy of PHI. Step Into Recovery 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, Step Into Recovery 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, Step Into Recovery will not use or disclose your PHI without your written authorization. The authorization form is available from Step Into Recovery (at the address and phone number below). You have the right to revoke your authorization at any time, except to the extent that Step Into Recovery has taken action in reliance on the authorization.

The law permits Step Into Recovery 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 Step Into Recovery'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 Step Into Recovery. 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 Step Into Recovery 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 Step Into Recovery 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 Step Into Recovery.

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. Step Into Recovery 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 Step Into Recovery 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 Step Into Recovery 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 Step Into Recovery 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. Step Into Recovery 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.

liz cordova (Guarantor), 01/23/2024 03:10 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:44 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:44 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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 Step Into Recovery, 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 Step Into Recovery 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 Step Into Recovery, 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 Step Into Recovery, about my own or others' purpose for being at and/or participating in any and all activities.

liz cordova (Guarantor), 01/23/2024 03:07 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:43 PM

Olivia Rose Perez (participant), 02/20/2024 06:43 PM
Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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.

Step Into Recovery

liz cordova (Guarantor), 01/23/2024 03:09 PM
Staff present: Crystal Watson

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:43 PM

Olivia Rose Perez (participant), 02/20/2024 06:43 PM
Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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.

Step Into Recovery rules have been explained to me so that I understand them and I have received a copy of these rules.

liz cordova (Guarantor), 01/23/2024 03:10 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:43 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:44 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

Safety Contract

I, Olivia Rose Perez, 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.

liz cordova (Guarantor), 01/23/2024 03:10 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:44 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:44 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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 Step Into Recovery 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 Step Into Recovery.

Name of Facility: Step Into Recovery

Client's Full Name: Olivia Rose Perez

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, Olivia Rose Perez, is currently a client at the Partial Hospitalization or Intensive Outpatient Program operated by Step Into Recovery. This Client will be participating in the Transportation Services provided by Step Into Recovery. 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, Olivia Rose Perez (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 Step Into Recovery,** 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 Step Into Recovery or otherwise.**

The undersigned Client, Olivia Rose Perez, (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 Step Into Recovery: The undersigned Client (or his/her parent/guardian) shall at all times hereafter indemnify, hold harmless and, at Step Into Recovery's Attorney's option, defend or pay for an attorney selected by the Board to defend Step Into Recovery, 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, Step Into Recovery, 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 Step Into Recovery.

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, Olivia Rose Perez, have read and fully understand the contents herein.

Executed this 02/20/2024.

liz cordova (Guarantor), 01/23/2024 03:10 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:46 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:46 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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

liz cordova (Guarantor), 01/23/2024 03:11 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:46 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:46 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery

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.

liz cordova (Guarantor), 01/23/2024 03:11 PM
Staff present: Crystal Watson

Olivia Rose Perez (participant), 02/20/2024 06:46 PM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 02/20/2024 06:46 PM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Problem List 06/05/2024 10:12 AM

Date of Service: 06/05/2024 10:12 AM

Problem List: Total Problems: 3

Problem	Status	Behavioral Definition/As evidenced by
Substance Use Disorders	Active	• Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance. • Reports suspension of important social, recreational, or occupational activities because they interfere with using.
Unipolar Depression	Active	• Engages in addictive behavior as a means of escaping from feelings of sadness, worthlessness, and helplessness.
Anxiety	Active	• Abuses substances in an attempt to control anxiety symptoms. • Excessive and/or unrealistic worry that is difficult to control, occurring more days than not for at least 6 months about a number of events or activities.

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Clinical Individualized Treatment Plan - Anxiety 06/05/2024 10:12 AM

Date Established: 06/05/2024 10:12 AM

Problem (in patient's own words):

Client stated being unable to cope with their anxiety

Modality: Clinical

Problem: Anxiety

Goal 1

End addiction as a means of escaping anxiety and practice constructive coping behaviors.

Objective 1

Describe the history of anxiety symptoms.

Plan 1

Assess the client's frequency, intensity, duration, and history of panic symptoms, fear, and avoidance (e.g., the Anxiety Disorders Interview Schedule-Adult Version) (or assign "Anxiety Triggers and Warning Signs" in the Addiction Treatment Homework Planner by Finley and Lenz).

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:15 AM

Plan 2

Develop a level of trust with the client toward creating a good working alliance; provide support and empathy to encourage the client to feel safe in expressing his/her experiences with anxiety.

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:15 AM

Client Statement: I have participated in the development and review of this treatment plan, have received a copy of this treatment plan and I agree to participate in this part of my treatment to the best of my ability.

Olivia Rose Perez (participant), 07/19/2024 10:15 AM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Pre-Admission Assessment 07/19/2024 06:34 AM

Date/Time of Assessment: 07/19/2024 06:34 AM

Race: Other

Marital Status: Single

Number of Marriages:

0

Living Arrangements

With whom does the patient live:

no one

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

Does the client have children?

yes 1 child, female

Are you pregnant? Denied

Are you employed? No

Does your employer know you are here? No

If yes, when are you supposed to return to work? N/A

Do you have any mobility issues/concerns? Denied

Are you ambulatory? Yes

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

Olivia is a 16 male struggling from F33.1 Major depressive disorder, Recurrent episode, Moderate, F41.1 Generalized anxiety disorder.

Contributing Factors Leading to Seeking Treatment:

- Inability to Maintain Employment
- Financial Problems
- Deterioration of Family Relationships

Outpatient Providers

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

Previous Substance Abuse/Psychiatric Treatments

Treatment History: ☑ None

Medical History

Current Medical Conditions: None

Current Medications: ☑ None

Allergies:

No Known Allergies/NKA

Psychiatric Conditions:

Client stated depression and anxiety.

Substance Abuse History

Substance History:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued)
Alcohol	NA					
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

None , Cravings, scale::
0

History of High Risk/Severe Withdrawal Symptoms:

Neurovegetative Signs and Symptoms

Sleep Patterns: Good ☐ Fair ☐ Poor ☑

Hours per Night:

5

Sleep Interruptions: Insomnia , Disturbed Sleep

Appetite: Good ☐ Fair ☑ Poor ☐

Unanticipated weight gain? No

Unanticipated weight loss? No

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

Suicidal/Homicidal Lethality Risk Assessment

Suicidal Ideation: None

How long has the client had these thoughts? n/a

Does the Client have a plan? No

Past history of suicide attempts? No

How was the attempt made? No attempt

Homicidal Ideation? None

History of Violent Behavior (describe) None

Self Abuse History

Does patient have a history of self mutilation? No

How and where does client typically disfigure him/herself? Denies

Eating Disorders: None

Preadmission Mental Status

Speech: Soft

Judgment: Poor

Insight: Rationalization

Thought Process: Preoccupied

Memory: Recent
Impaired

Attention: Distracted

Affect: Anxious

Family History

Father: Mental
Illness

Mother: Actively Drinking , Healthy
Support

Siblings: None

Spouse: None

Children: None

Other: None

Rationale for Treatment
Admission:

N

Jennifer Rosa, Administrator (Staff), 07/19/2024 07:22 AM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery Centers INC

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s), Highmark BCBS of Pennsylvania, be made directly to Step Into Recovery Centers INC 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.

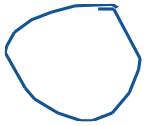
In addition, I authorize Step Into Recovery Centers INC to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible parties; at the determination of Step Into Recovery Centers INC. Such disclosure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

I hereby release Step Into Recovery Centers INC 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 Step Into Recovery Centers INC 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.
- Step Into Recovery Centers INC is acting in filing for insurance benefits assigned to Step Into Recovery Centers INC 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 Step Into Recovery Centers INC for billing and collection purposes.
- Step Into Recovery Centers INC 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.
- Step Into Recovery Centers INC 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:



Olivia Rose Perez (participant), 07/19/2024 06:34 AM
Staff present: Jennifer Rosa, Administrator

Jennifer Rosa, Administrator (Staff), 07/19/2024 06:35 AM

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery Centers INC

Coordination of Benefits and Pre-existing Conditions

Date of Admission: 06/03/2024

This will confirm that upon admission to Step Into Recovery Centers INC, I, Olivia Rose Perez:

☐ 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;

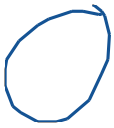
☐ Am presently employed with n/a (employer), but DO NOT have any hospital/medical/health insurance coverage;

☐ The only benefits available to me during my stay at Step Into Recovery Centers INC is from n/a , (Name of Insurance);

☐ I have never been treated for this condition prior to my admission to Step Into Recovery Centers INC;

☐ 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.



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Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Bio-psychosocial Assessment 07/19/2024 07:08 AM

Date/Time: 07/19/2024 07:08 AM

I. SOCIAL AREA

A. Family of Origin

1. Where were you raised and by whom?

RAISED IN RESEDA BY MOM AND DAD

2. Do you have any siblings?

	Name	Age	Grew Up Together?
	Richard	10	Y

3. How were the relationships between family members in the immediate family/in the household?

Client stated fair

4. Who do you feel closest to in the family and why?

Client stated "I feel closest to mom because they were the only person I felt I could talk to."

5. Is there any history of the following:

Mother: Substance Abuse

Father: Mental Health Problems

Step-Parent: None

Siblings: None

Other: None

If YES to any of the above, elaborate:

Client stated "My mother struggled with substance abuse and my father struggled with mental health problemesthroughout my life."

B. Family of Choice

1. Are you involved in a significant relationship? No

If YES, are you satisfied with relationship with partner? No relationship

2. Marriage History: ☑ None

3. Do you have any children? ☑ None

4. Are you satisfied with your relationship with your children? ☐ Yes ☐ No ☑ N/A

5. Is there any history of the following:

Partner: None

Past Partner: None

Children: None

If YES to any of the above, elaborate: No to All

C. Cultural Influences

1. Were you raised in any specific culture? No

2. Do you identify with any specific cultural group? No

3. Do you currently practice any specific cultural rituals? No

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D. Spirituality/Religious Assessment

1. Is religion or spirituality important in your life?

Client stated "My spirituality is very important in my life, but the more I became consumed by my addiction, the more I began to lose the connection I had built with my spirituality."

2. Do you use prayer/meditation?

Client stated "I use meditation and prayer."

3. How does your faith help you cope with problems in your

life?

Client stated "Faith helps me cope with the problems I am dealing with in my life by knowing there has to be a better path planned for me by my higher power."

II. LEGAL HISTORY

1. Is Client currently involved in the Criminal Justice System? No

2. Have you ever been incarcerated? ☐ Yes ☑ No

If YES, list incarceration history, most recent first: ☑ None

3. Do you currently owe any restitution? No

4. How much will your legal situation influence your progress in treatment: N/A

5. What is the urgency of your legal situation? N/A

6. Is the legal situation related to your current issues with substance use or mental illness? N/A

III. EDUCATIONAL / VOCATIONAL / MILITARY ISSUES

A. Educational History

1. What is the highest grade completed / degree or certificate obtained?

10th grade

2. Are you currently enrolled and attending school?

YES, HOMESCHOOLED, WITH K12 - CAVA

3. Do you have any future educational goals?

Yes, work on a better GPA and take some college courses, so when I graduate high school, I will have obtained an AA and go to an out-of-state university to study forensic science for a 4-year degree. Continue to excel in my cadet program and get more ribbons through the LAPD Jeopardy program as well. Complete volunteer hours and possibly gain a rank.

B. Employment History

1. Has Client ever been employed? ☐ Yes ☑ No

If YES, list employment history (most recent first): ☑ None

2. Do you need/want any specific vocational training? No

3. Have you ever received any vocational training? No

C. Military Service

1. Have you ever served in the Military? ☐ Yes ☑ No

If YES: ☑ None

Additional information / comments concerning Educational / Vocational Issues: None

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IV. SEXUAL / ABUSE / TRAUMA HISTORY

Describe your present sexual orientation:

assigned gender at birth/ straight

Check all that apply:

For all checked, describe below.

- None

If YES, was it alcohol/drug related? ☐ Yes ☐ No ☑ N/A

Explain any checked items above: None

Are you currently in or have you ever been involved in an abusive relationship?

Client stated no

TRAUMA ASSESSMENT:

Have you ever experienced any of the following types of trauma?

Significant death of a family member or friend: ☑ Yes ☐ No

Witnessing an Accident: ☐ Yes ☑ No

Community Violence: ☑ Yes ☐ No

Domestic Violence: ☐ Yes ☑ No

Childhood Trauma: ☐ Yes ☑ No

Natural Disaster: ☐ Yes ☑ No

Family Violence: ☐ Yes ☑ No

Neglect: ☐ Yes ☑ No

Any type of physical, sexual or emotional abuse: ☐ Yes ☑ No

School Violence: ☐ Yes ☑ No

Do you have a history of past or current types of trauma listed above, or sexual, psychological or physical abuse or any other type of abuse, and/or neglect, trauma or exploitation explain below:

Client stated "Yes, I have experienced a significant death of a family member or friend and community violence throughout my life."

Do you feel that this trauma may interfere with treatment and/or has led to past relapses? None

Do you have a history of sexual, psychological or physical abuse or any other type of abuse, neglect, trauma or exploitation – Is the facility going to provide Trauma Therapy:

- **NO**. If NO, referral is to be made and problem is to be deferred on Problem List.

V. LEISURE/RECREATIONAL ACTIVITIES

List any hobbies, recreational interests, sports, games or other leisure activities you enjoy:

cadet program, volunteer work.

What effect has your substance use had on your leisure time?

no interests

No interest

VI. CURRENT SOCIAL ENVIRONMENT

Current Social Situation/Environment (present living arrangement & environment, identify significant relationships with family members, support systems, current social / peer groups and community resources):

Ct stated with family

VII. CURRENT FINANCIAL STATUS

Current Financial Status & How did you pay for Drug/Alcohol Addiction?

Ct stated borrowed money.

VIII. CONSEQUENCES OF ADDICTION

1. Describe client's consequences of addiction:

Physical

NA

Emotional

NA

Spiritual

NA

Value System

NA

Legal

NA

Financial

NA

Social

NA

Mental

NA

Behavioral

NA

IV. SUBSTANCE USE HISTORY & ASSESSMENT

Substance History:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued, Mental/Behavioral)
Alcohol	NA					
Marijuana	NA					
Cocaine (Powder)						
Crack Cocaine						
Crystal Meth						
Heroin						
Suboxone/Zubsolv						
Oxycontin						
Methadone						
Other Opiates						
Benzodiazepines						
Hallucinogens						
Amphetamines						
Inhalants						
Ketamine (Special K)						
Triple C's						
Codeine						
Ecstasy						
Bath Salts						
Flakka						
MDMA/Molly						

Steroids						
K2/Spice						
Kratom						
Kava						
Other OTC Drugs						

Other Drugs Used: ☑ None

Assessment for Other Addictive Disorders

History of Other Addictive Behaviors:

Eating Disorders? Denied

Have you ever received treatment for an Eating Disorder? ☐ Yes ☑ No

Is Eating Disorder still an issue for you? ☐ Yes ☐ No ☑ N/A

Do you have a history of Gambling? None

Do you feel that gambling is an issue for you? ☐ Yes ☐ No ☑ N/A

Are there other addictive behaviors (work, nicotine, sex, caffeine, shopping, and/or exercising) that the you have a problem with? None

Are there any other addictive disorders that will need to be addressed in treatment? None

List Drugs of Choice:

Preference	Class	Substance(s)
Primary	Alcohol	Wine
Secondary	Stimulants	Methamphetamines
Tertiary		

Drug Craving: (Range 0-10, 10 being highest)

8

Treatment History

Number of Times:

0

Previous Treatment: ☑ None

Describe your treatment and relapse history, including AA experiences and attempts at abstinence/recovery:

Client stated having never been in treatment but has heard of AA/NA and has experienced relapses in the past from attempting to get sober on their own.

What precipitating events lead to relapse (i.e. triggers)?

Client stated the events leading up to my relapse were my inability to maintain employment, financial problems, and deterioration of family relationships.

X. TREATMENT ACCEPTANCE / RESISTANCE DIMENSION

1. Describe your external motivation for Treatment?

Client stated their external motivation for treatment is rebuild health connections with her family, take better care of her health, and become financially stable.

2. Describe your internal motivation for Treatment?

Client stated their internal motivation for treatment is to learn how to manage their anxiety and depression, rebuild their self-esteem, and have a more positive outlook on life.

3. Relapse/Continued Use Potential

Client's Strengths:	Willingness to seek treatment , Willingness to comply with treatment , Ability to benefit from treatment
Client's Weaknesses:	Lacks coping skills , Poor impulse control , Low self esteem
Barriers to Treatment:	Psychiatric diagnosis

XI. RECOVERY ENVIRONMENT

1. Do you have an existing positive support system?

Client stated he does not have a positive support system because he has no friends in sobriety and his family creates more stress than positivity.

2. Is your current living environment conducive to progress in therapy? Yes

3. Are you currently engaged in any substance-free leisure activities or hobbies?

Client stated "No, I gave up all of my hobbies because I didn't have time for them anymore, since it all went to my addiction."

4. What strengths do you have that will assist you in regards to recovery?

Client stated some of the strengths she has that will assist her in her recovery are being extremely motivated, persistent, friendly, and goal oriented.

5. Additional information / comments concerning recovery environment issues: None

XV. INTERVIEW WITH SIGNIFICANT FAMILY MEMBER

(When available in person or by phone)

1. Does family member / significant other view Client's behavior and/or usage as a problem?

Yes, family did find their behavior/usage a problem because they become withdrawn

2. Has any family member / significant other attempted to address/intervene in Client's behavior and/or usage? ☑ Yes ☐ No

Why or Why Not?

Yes, family held an intervention.

3. Has family member / significant other noticed any changes in Client's behavior?

Yes, family noticed a change in their behavior when they first began abusing substances.

4. Have there been any traumatic events in the family or specific to the Client?

Family stated yes, but does not feel comfortable discussing it at this time.

5. Is family member / significant other willing to participate in Client's treatment? Yes

CLINICAL IMPRESSIONS:

Include the impact of spirituality on the ability of the individual to receive care/services/determination of any barriers to treatment and/or affiliation with certain types of self-help groups, and if any further assessments are needed.

XII. ASSESSMENT OF MENTAL STATUS DURING INTERVIEW

APPEARANCE: Clean/neat

AFFECT: Appropriate

MOOD: Depressed , Anxious

BEHAVIOR: Cooperative

ORIENTATION: Person , Time , Place

INSIGHT: Fair

JUDGMENT: Immature

LEVELS OF IMPAIRMENT / SEVERITY RATINGS

RATE CLIENT'S LEVEL OF IMPAIRMENT & SEVERITY:

RATING/SEVERITY SCALE:

0 – Not at all
1 – Slightly
2 – Moderately
3 – Considerably
4 – Extremely

PROBLEMS: 2 – Moderately (2)

MEDICAL: 1 – Slightly (1)

EMPLOYMENT: 1 – Slightly (1)

PEER SUPPORT: 2 – Moderately (2)

DRUG/ALCOHOL USAGE: 3 – Considerably (3)

LEGAL: 0 – Not at all (0)

FAMILY/SOCIAL: 2 – Moderately (2)

PSYCHIATRIC - MENTAL HEALTH: 4 – Extremely (4)

TOTAL SCORE: (15)

OVERALL LEVEL OF IMPAIRMENT & SEVERITY

0	Not at all impaired
1-7	Slightly impaired
8-15	Moderately impaired
16-23	Considerably impaired
24 & OVER	Extremely impaired

RATIONALE FOR TREATMENT AT THIS LEVEL OF CARE:

REASON FOR TREATMENT AT THIS TIME / GOAL FOR TREATMENT:

INTEGRATED DIAGNOSTIC SUMMARY/CLINICAL IMPRESSION:

Diagnosis:

Diagnoses

F33.1 Major depressive disorder, Recurrent episode, Moderate,F41.1 Generalized anxiety disorder

List Problems Identified in Bio-Psychosocial:

Total Problems: 3

Problem	Status	Behavioral Definition/As evidenced by

Anxiety	Active	• Abuses substances in an attempt to control anxiety symptoms. • Excessive and/or unrealistic worry that is difficult to control, occurring more days than not for at least 6 months about a number of events or activities.
Unipolar Depression	Active	• Engages in addictive behavior as a means of escaping from feelings of sadness, worthlessness, and helplessness.
Substance Use Disorders	Active	• Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance. • Reports suspension of important social, recreational, or occupational activities because they interfere with using.

If a problem is identified, but not to be treated in treatment, add to Problem List and check to either Defer or Refer.

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4. Have there been any traumatic events in the family or specific to the Client? No

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Step Into Recovery Centers INC

Self Harm-Agreement

Client Name: Olivia Rose Perez **MR #: SIR2024-62** **DOB: 03/08/2008**

I agree to refrain from harming, injuring, and/or endangering myself in any way including attempting suicide while I remain in treatment at Step Into Recovery Centers INC.

I agree to seek the assistance of a staff member immediately if and when I have any thoughts of self-harm and/or harm to others, regardless of the time of day or night.

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) 07/19/2024 07:08 AM

Date: 07/19/2024

Columbia-Suicide Severity Rating Scale (C-SSRS)

The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The scale is evidence-supported and is part of a national and international public health initiative involving the assessment of suicidality. Available in 103 different languages, the scale has been successfully implemented across many settings, including schools, college campuses, military, fire departments, the justice system, primary care and for scientific research.

Several versions of the C-CCRS have been developed for clinical practice. The**Risk Assessment** version is three pages long, with the initial page focusing on a checklist of all risk and protective factors that may apply. This page is designed to be completed following the client (caller) interview. The next two pages make up the formal assessment. The C-SSRS Risk Assessment is intended to help establish a person's immediate risk of suicide and is used in acute care settings.

In order to make the C-SSRS Risk Assessment available to all Lifeline centers, the Lifeline collaborated with Kelly Posner, Ph.D., Director at the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute to slightly adjust the first checklist page to meet the Lifeline's Risk Assessment Standards. The following components were added: helplessness, feeling
trapped, and engaged with phone worker.

The approved version of the C-SSRS Risk Assessment follows. This is one recommended option to consider as a risk assessment tool for your center. If applied, it is intended to be followed exactly according to the instructions and cannot be altered.

Training is available and recommended (though not required for clinical or center practice) before administering the C-SSRS. Training can be administered through a 30-minute interactive slide presentation followed by a question-answer session or using a DVD of the presentation. Those completing the training are then certified to administer the C-SSRS and can receive a certificate,
which is valid for two years.

To complete the C-SSRS Training for Clinical Practice, visit http://c-ssrs.trainingcampus.net/

For more general information, go tohttp://cssrs.columbia.edu/

Any other related questions, contact Gillian Murphy atgmurphy@mhaofnyc.org.

COLUMBIA-SUICIDE SEVERITY RATING SCALE
(C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

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RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Treatment History

Other Risk Factors

Clinical Status (Recent)

Protective Factors (Recent)

Other Protective Factors

Describe any suicidal, self-injury or aggressive behavior (include dates):

Suicidal Ideation

Ask questions 1 & 2. If both are negative, proceed to “Suicidal Behavior” section. If the answer to question 2 is “yes,” ask questions 3, 4, and 5. If the answer to question 1 and/or 2 is “yes,” complete “Intensity of Ideation” section below.

1. Wish to be Dead

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you wished you were dead or wished you could go to sleep and not wake up?

Lifetime: Time He/She Felt Most Suicidal

Past 1 Month

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2. Non-Specific Active Suicidal Thoughts

General non-specific thoughts of wanting to end one’s life/commit suicide (e.g.*“I’ve thought about killing myself”*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you actually had any thoughts of killing yourself?

Lifetime: Time He/She Felt Most Suicidal

Past 1 Month

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3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*

Have you been thinking about how you might do this?

Lifetime: Time He/She Felt Most Suicidal

Past 1 Month

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4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts as opposed to *"I have the thoughts but I definitely will not do anything about them."*

Have you had these thoughts and had some intention of acting on them?

Lifetime: Time He/She Felt Most Suicidal

Past 1 Month

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5. Active Suicidal Ideation with Specific Plan and Intent

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Lifetime: Time He/She Felt Most Suicidal

Past 1 Month

Intensity of Ideation

The following features should be rated with respect to the most sever type of ideation (i.e. 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about the time he/she was feeling the most suicidal.

Lifetime – Most Severe Ideation

Description of Ideation

Recent – Most Severe Ideation

Description of Ideation

Frequency

How many times have you had these thoughts?

(1) Less than once a week

(2) Once a week

(3) 2-5 times in week

(4) Daily or almost daily

(5) Many times each day

Duration

When you have the thoughts how long do they last?

(1) Fleeting – a few seconds or minutes

(2) Less than 1 hour/some of the time

(3) 1-4 hours/a lot of time

(4) 4-8 hours/most of day

(5) More than 8 hours/persistent or continuous

Controllability

Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts

(2) Can control thoughts with little difficulty

(3) Can control thoughts with some difficulty

(4) Can control thoughts with a lot of difficulty

(5) Unable to control thoughts

(0) Does not attempt to control thoughts

Deterrents

Are there things – anyone or anything (e.g. family, religion, pain of death) – that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide

(2) Deterrents probably stopped you

(3) Uncertain that deterrents stopped you

(4) Deterrents most likely did not stop you

(5) Deterrents definitely did not stop you

(0) Does not apply

Reasons for Ideation

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others

(2) Mostly to get attention, revenge, or a reaction from others

(3) Equally to get attention revenge, or a reaction from others and to end/stop the pain

(4) Mostly to end/stop the pain (you couldn't go on living with the pain or how you were feeling)

(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)

(0) Does not apply

Suicidal Behavior

(Check all that apply, so long as these are separate events; must ask about all types)

Actual Attempt:

A potentially self-injurious act committed with at least some wish to die,*as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***; just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Have you made a suicide attempt?

Have you made a suicide attempt?

Have you made a suicide attempt?

What did you do?

Did you_____ as a way to end your life

Did you want to die (even a little) when you_____?

Were you trying to end your life when you _____?

Or Did you think it was possible you could have died from_____?

Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

Lifetime

Past 3 Months

Has subject engaged in Non-Suicidal Self-Injurious Behavior?

Lifetime

Past 3 Months

Interrupted Attempt:

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).*

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?

Lifetime

Past 3 Months

Aborted or Self-Interrupted Attempt:

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?

Lifetime

Past 3 Months

Preparatory Acts or Behavior:

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?

Lifetime

Past 3 Months

Actual Lethality/Medical Damage:

(0) No physical damage or very minor physical damage (e.g., surface scratches).

(1) Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).

(2) Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).

(3) Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).

(4) Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).

(5) Death

Potential Lethality: Only Answer if Actual Lethality=0

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury

1 = Behavior likely to result in injury but not likely to cause death

2 = Behavior likely to result in death despite available medical care

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Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Assignment of Care Team - CUSTOMIZE 07/19/2024 07:08 AM

Date/Time of Assignment: 07/19/2024 07:08 AM

Primary Therapist:

Primary Therapist	Assigned on
None	

Case Manager:

Case Manager	Assigned on
None	

Primary Nurse:

Primary Nurse	Assigned on
None	

Primary Physician:

Primary Physician	Assigned on
None	

Tester:

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Educational Learning Assessment 07/19/2024 07:08 AM

Evaluation Date: 07/19/2024

SECTION A: Educational Learning Assessment

Pre-Treatment Teaching

Did you participate in any pre-treatment education?

Knowledge of Disease:

Knowledge:

Barriers To Learning:

Religious/Cultural Practices

Do you have any religious or cultural practices that may alter your care?

Language/Cognition

Communicate in:

Reading Ability:

Reading Preference:

Readiness for Learning.
Check all that apply:

Individual Educational Needs / Patient & Family.
Check all identified needs that apply:

Preferred Learning Style:

SECTION B: Teaching Needs

Includes but not limited to the following:

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Fagerstrom Test for Nicotine Dependence 07/19/2024 07:08 AM

Is smoking "just a habit" or are you addicted? Take this test and find your level of dependence on nicotine.

Date/Time: 07/19/2024 07:08 AM

1. How soon after you wake up do you smoke your first cigarette? ()

(After 60 minutes = 0; 31-60 minutes = 1; 6-30 minutes = 2; Within 5 minutes = 3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden? ()

(No = 0; Yes = 1)

3. Which cigarette would you hate most to give up? ()

(The first one in the morning = 1; Any other than the first one in the morning = 0)

4. How many cigarettes per day do you smoke? ()

(10 or less = 0; 11 to 20 = 1; 21 to 30 = 2; 31 or more = 4)

5. Do you smoke more frequently during the first hours after awakening then during the rest of the day? ()

(No = 0; Yes = 1)

6. Do you smoke even if you are so ill that you are in bed most of the day? ()

(No = 0; Yes = 1)

Total Score: ()

Your level of dependency on nicotine is:

☐ Score 1-2: Low dependence ☐ Score 3-4: Low to moderate dependence ☐ Score 5-7: Moderate dependence

☐ Score 8+: High dependence

Heatherton, TF, Kozlowski LT, Frecker RC, Fagerstrom K.O. The Fagerstrom test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire, British Journal of Addictions 1991; 86:1119-27

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Initial Aftercare Plan 07/19/2024 07:08 AM

Date: 07/19/2024

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1) After treatment I will

2) After treatment I will

3) I want to develop _____ in treatment

4) I need help with

5) Therapeutic Resources

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Legal Assessment 07/19/2024 07:08 AM

Date/Time: 07/19/2024 07:08 AM

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1. Have you ever committed a crime?

---

2. What was the first crime you ever committed?

---

3. How old were you the first time you committed?

Sell to Dealers:

Manufactured Drugs:

Shoplifting:

Robbery (including drugs):

Motor Vehicle/Grand Theft Auto:

Con Game:

Petty Theft:

Stolen Goods (sell, trade, own):

Weapon:

Other Crime:

Other Theft (including drugs):

Smuggle Drugs:

Sell to Users:

Burglary:

Prostitution (for drugs or money):

Pickpocket:

Bad Paper (Rx, check, credit card):

Unarmed Assault:

Other Assault:

---

4. Have often did you commit the following crimes?

Sell to Dealers:

Manufactured Drugs:

Shoplifting:

Robbery (including drugs):

Motor Vehicle/Grand Theft Auto:

Con Game:

Stolen Goods (sell, trade, own):

Weapon:

Other Crime:

Other Theft (including drugs):

Smuggle Drugs:

Sell to Users:

Burglary:

Prostitution (for drugs or money):

Pickpocket:

Bad Paper (Rx, check, credit card):

Unarmed Assault:

Other Assault:

---

5. Describe the first time you were arrested:
Specify age, offense, impaired, co-defendant, outcome/disposition: never prosecuted, found not guilty, suspended sentence, probation, incarceration, probation/parole, community control, community service, conditions of probation

6. How many times have you been arrested in your lifetime?

7. How old were you when you were first incarcerated? ***Specify age and timeframe***

8. Describe current legal situation (*probation/parole; child welfare involvement; DUI; restraining order, community control; conditions of probation*). If currently involved, give name of probation/parole officer/community control officer; length of probation/parole; conditions of probation/parole:

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Social Risk Assessment 07/19/2024 07:08 AM

Evaluation Date: 07/19/2024 07:08 AM

Instructions: Ask the Client the following questions and indicate below with a check on the Yes or No box.

1. Have you ever taken drugs using a needle?	☐ Yes ☐ No
2. Are you the sex partner of a person diagnosed with HIV/AIDS?	☐ Yes ☐ No
3. Have you ever had sex while using non-injecting drugs?	☐ Yes ☐ No
4. Have you ever had sex in exchange for money, drugs, etc?	☐ Yes ☐ No
5. Do you currently have a sexually transmitted disease (STD)?	☐ Yes ☐ No
6. Have you ever been diagnosed with an STD?	☐ Yes ☐ No
7. Are you the child of a woman who has HIV/AIDS?	☐ Yes ☐ No
8. Did you receive any blood or blood products between 1977 and 1985?	☐ Yes ☐ No
9. Have you been exposed to HIV/AIDS through the Health Care Industry?	☐ Yes ☐ No
10. Have you had sex with more than one person in the past year?	☐ Yes ☐ No
11. Are you a survivor of a sexual assault?	☐ Yes ☐ No
12. Have you ever had sexual relations with an injection drug user?	☐ Yes ☐ No
13. Have you ever had sex with a man you know had sex with another man in the past?	☐ Yes ☐ No
14. Have you ever had sex with a person who would be considered at risk for HIV/AIDS?	☐ Yes ☐ No
15. Have you ever been tested for HIV/AIDS?	☐ Yes ☐ No
16. Have you tested positive for HIV/AIDS?	☐ Yes ☐ No

If Yes, give date:

17. Have you ever shared needles or "works"? ☐ Yes ☐ No

18. Have you ever experienced blackouts when under the influence of a drug and/or alcohol? ☐ Yes ☐ No

19. Have you ever had Herpes, Hepatitis B, Syphilis, Gonorrhea, Chlamydia or Genital Sores (sores on the sex organs)? ☐ Yes ☐ No

20. Would you like to be referred for HIV testing? ☐ Yes ☐ No

---

If the Client answers Yes to Question #20, the Client must be referred for HIV testing.

If the Client answers Yes to 5 or more questions, they may be at high risk for HIV – Encourage the Client to be referred for testing.

Location of Referral:

Date of Referral:

HIV pre and post counseling will be provided by this facility: ☐ Yes ☐ No

---

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Spiritual Assessment 07/19/2024 07:08 AM

Date: 07/19/2024

Note: The following assessment is to be used for informational purposes only. It is not intended to reflect anything else other than the client's spiritual inclination.

A. SOURCES OF HOPE

1. What are your sources of hope and strength?

2. What do you hold on to during difficult times?

3. What sustains you and keeps you going?

B. RELIGIOUS BACKGROUND AND BELIEFS

1. Did you practice any religion when you were growing up? ☐ Yes ☐ No

2. Do you practice a religion currently?

3. Do you believe in God or a Higher Power? ☐ Yes ☐ No

4. How would you describe God/Higher Power? Personal or impersonal? Loving or stern?

C. SPIRITUAL MEANING AND VALUES

1. Do you follow any spiritual path or practice?

2. What significant spiritual experiences have you had?

D. PRAYER/MEDITATE EXPERIENCES

1. Do you pray or meditate? ☐ Yes ☐ No

2. When do you pray or meditate?

E. FAITH AND BELIEFS

1. Do you consider yourself spiritual or religious? ☐ Yes ☐ No

2. What are your spiritual or religious beliefs?

3. What things do you believe in that give meaning to your life?

F. IMPORTANCE AND INFLUENCE

1. Is religion/spirituality important in your life? ☐ Yes ☐ No

2. How have your religion/spirituality influenced your behavior and mood during your recovery?

G. COMMUNITY

1. Are you part of a spiritual or religious community? ☐ Yes ☐ No

Explain:

Spiritual Assesment Summary

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Trauma Assessment 07/19/2024 07:08 AM

Date/Time: 07/19/2024 07:08 AM

This test is to help determine your symptoms of trauma. ***Please answer True or False for each of the following.***

1. Have you experienced or been exposed to a traumatic event? ()

Please list your traumas:

2. During the traumatic event, did you experience or witness serious injury or death, or the threat of injury or death? ()

3. During the traumatic event did you feel intense fear, helplessness, and/or horror? ()

4. Do you regularly experience intrusive thoughts or images about the traumatic event? ()

5. Do you sometimes feel like you are re-living the event or that it is happening all over again? ()

6. Do you have recurrent nightmares or distressing dreams about the traumatic event? ()

7. Do you feel intense distress when something reminds you of the traumatic event, whether it's something you think about or something you see? ()

8. Do you try to avoid thoughts, feelings, or conversations that remind you of the traumatic event? ()

9. Do you try to avoid activities, people, or places that remind you of the traumatic event? ()

10. Are you unable to remember something important about the traumatic event? ()

11. Since the trauma took place, do you feel less interested in activities or hobbies that you once enjoyed? ()

12. Since the trauma took place, do you feel distant from other people or have difficulty trusting them? ()

13. Since the trauma took place, do you have difficulty experiencing or showing emotions?	()
14. Do you feel that your future will not be "normal" -- that you won't have a career, marriage, children, or a normal life span?	()
15. Since the traumatic event, have you had difficulty falling or staying asleep?	()
16. Have you felt irritable or have you had outbursts of anger?	()
17. Have you had difficulty concentrating, since the trauma?	()
18. Do you feel guilty because others died or were hurt during the traumatic event but you survived it?	()
19. Do you often feel jumpy or startle easily?	()
20. Do you often feel hypervigilant, that is, are you constantly feeling and acting ready for any kind of threat?	()
21. Have you been experiencing symptoms for more than one month?	()
22. Do your symptoms interfere with normal routines, work or school, or social activities?	()
23. Do your symptoms interfere with ability to stay sober/clean?	()

Score: ()

1 - 3	Mild Symptoms
4 - 9	Moderate Symptoms
10 - 23	Severe Symptoms

Clinical Assessment

This section to be completed by a Licensed Professional - (Include: Recommendations, Actions, Treatment plan, and/or Referral to be made and/or addressed during treatment & how symptoms may or may not effect treatment, treatment outcome and recovery)

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Clinical Individualized Treatment Plan - Substance Use Disorders 07/19/2024 10:15 AM

Date Established: 07/19/2024 10:15 AM

Problem (in patient's own words):

Client stated wanting to continue learning how to maintain long term sobriety.

Modality: Clinical

Problem: Substance Use Disorders

Goal 1

Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.

Objective 1

Implement relapse prevention strategies for managing possible future situations with high risk for relapse.

Plan 1

Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:22 AM

Plan 2

Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:22 AM

Plan 3

Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills,

and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the Adult Psychotherapy Homework Planner by Jongsma).

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	 Olivia Rose Perez, 07/19/2024 10:22 AM

Plan 4

Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for gambling and/or substance abuse (or assign "Relapse Triggers" in the Adult Psychotherapy Homework Planner by Jongsma).

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	 Olivia Rose Perez, 07/19/2024 10:22 AM

Client Statement: I have participated in the development and review of this treatment plan, have received a copy of this treatment plan and I agree to participate in this part of my treatment to the best of my ability.

Olivia Rose Perez (participant), 07/19/2024 10:22 AM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Clinical Individualized Treatment Plan - Unipolar Depression 07/19/2024 10:23 AM

Date Established: 07/19/2024 10:23 AM

Problem (in patient's own words):

Client stated they don't know why they experience severe depression or how to stop it.

Modality: Clinical
Problem: Unipolar Depression

Goal 1

Alleviate depressive symptoms and return to previous level of effective functioning.

Objective 1

Describe current and past experiences with depression and other mood episodes, including their impact on function and attempts to resolve or treat them.

Plan 1

Assess current and past mood episodes including their features, frequency, intensity, and duration; impact on role functioning; previous treatments; and response to treatments (e.g., Clinical Interview supplemented by the Inventory to Diagnose Depression).

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:24 AM

Plan 2

Utilize a graphic display, such as a timeline, to help the client identify the pattern of his/her mood symptoms.

Plan Status

Target date	Status	Date/Comment	By	Signature
06/12/2024	Open		Jennifer Rosa, Administrator 07/19/2024	Olivia Rose Perez, 07/19/2024 10:24 AM

Client Statement: I have participated in the development and review of this treatment plan, have received a copy of this treatment plan and I agree to participate in this part of my treatment to the best of my ability.

Olivia Rose Perez (participant), 07/19/2024 10:25 AM

Staff present: Jennifer Rosa, Administrator

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Golden Thread

	Date Established	Status	Updated At
Anxiety - (Active)			
Clinical: Treatment Plan	**07/19/2024**	**Active**	**07/19/2024**
Goal: End addiction as a means of escaping anxiety and practice constructive coping behaviors.	06/05/2024	in progress	07/19/2024
Objective: Describe the history of anxiety symptoms.	07/19/2024		
Intervention: Assess the client's frequency, intensity, duration, and history of panic symptoms, fear, and avoidance (e.g., the Anxiety Disorders Interview Schedule-Adult Version) (or assign "Anxiety Triggers and Warning Signs" in the Addiction Treatment Homework Planner by Finley and Lenz).	07/19/2024		
Status: Open	07/19/2024		
Intervention: Develop a level of trust with the client toward creating a good working alliance; provide support and empathy to encourage the client to feel safe in expressing his/her experiences with anxiety.	06/12/2024		
Status: Open	07/19/2024		
	06/12/2024		
Unipolar Depression - (Active)			
Clinical: Treatment Plan	**07/19/2024**	**Active**	**07/19/2024**
Goal: Alleviate depressive symptoms and return to previous level of effective functioning.	07/19/2024	in progress	07/19/2024
Objective: Describe current and past experiences with depression and other mood episodes, including their impact on function and attempts to resolve or treat them.	07/19/2024		
Intervention: Assess current and past mood episodes including their features, frequency, intensity, and duration; impact on role functioning; previous treatments; and response to treatments (e.g., Clinical Interview supplemented by the Inventory to Diagnose Depression).	07/19/2024		
Status: Open	07/19/2024		
Intervention: Utilize a graphic display, such as a timeline, to help the client identify the pattern of his/her mood symptoms.	06/12/2024		

Status: Open	07/19/2024		
	06/12/2024		

Substance Use Disorders - (Active)

Clinical: Treatment Plan	**07/19/2024**	**Active**	**07/19/2024**
Goal: Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.	07/19/2024	in progress	07/19/2024
Objective: Implement relapse prevention strategies for managing possible future situations with high risk for relapse.	07/19/2024		
Intervention: Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.	07/19/2024		
Status: Open	07/19/2024		
	06/12/2024		
Intervention: Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.	07/19/2024		
Status: Open	07/19/2024		
	06/12/2024		
Intervention: Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the Adult Psychotherapy Homework Planner by Jongsma).	07/19/2024		
Status: Open	07/19/2024		
	06/12/2024		
Intervention: Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for gambling and/or substance abuse (or assign "Relapse Triggers" in the Adult Psychotherapy Homework Planner by Jongsma).	07/19/2024		
Status: Open	07/19/2024		
	06/12/2024		

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Highmark BCBS of Pennsylvania	STM 136248980001	12/01/2023		Active	Primary

Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
15448 /	Blue Cross	10578198	PPO		

Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period
	HMRK001	610014			

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country
RESEDA	CA	91335	United States

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
LIZ JASMIN CORDOVA	Child	***-**-6931	05/18/1985	Female

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
6528 WILBUR AVE., 106		reseda

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
91335	CA	United States

Vital Signs

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Date	Blood Pressure Systolic	Blood Pressure Diastolic	Temperature	Oxygen Saturation	Pulse	Respiration	Comments	Logged By	Logged At

Glucose Logs

No records available.

Weights

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

No height/weight records.

Heights

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

Date	Height	Logged By	Logged At

Orthostatic Vital Signs

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

	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

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

No Medications Brought In Logged.

Rounds

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 Care Team

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

MAT Orders

Olivia Rose Perez ♀ SIR2024-62

Birthdate: 03/08/2008

Allergies: No Known Allergies/NKA

Admission: 06/03/2024 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