

# Tennessee Community Counseling Services, Inc.

951 Eastgate Loop

Suite 100

Chattanooga, Tennessee 37411

423-296-6451 Fax 423-296-6515

## OUT-OF-STATE DUI SCHOOL INFORMATION

1. You are pre-registered for the DUI SCHOOL on: \_\_\_\_\_  
**Saturday & Sunday 9:00am-7:00pm.** \_\_\_\_\_  
**\*\*\*PLEASE ARRIVE 15 MINUTES PRIOR TO THE START OF CLASS TO SIGN IN\*\*\***
2. Your \$250 fee must be paid in CASH or MONEY ORDER one week prior to your class date. Failure to pay on time may result in you losing your opportunity to attend this class and you will be subject to pay a \$75. rescheduling fee and pre-register for the next available class. (If you pay after this day you may be subject to a \$20 late fee. Please keep in mind that we will not hold your unpaid seat, therefore, failure to pay may result in your losing your seat.)
3. If you are absent or tardy from the above listed class, regardless of the nature or reason, will not be permitted to enter the class and will have to pay a \$75 rescheduling fee. If you are tardy returning from lunch or breaks you will not be permitted to return to class. You will have to pay \$75 and reschedule for the next available class and restart the class at 6:00 p.m.
4. If you must leave at any time during your scheduled DUI SCHOOL, regardless of the nature or reason, (this includes being asked to leave for any reason, including sleeping in class) you will be required to reschedule, make the appropriate payment, attend and complete another scheduled class. (The payment you have made will be forfeited and you will have to pay the fee in full in order to reschedule.)
5. You must bring a state approved photo identification with you on the day of your DUI SCHOOL.  
**NO ID, NO SCHOOL, NO EXCEPTIONS!!**
6. To complete an assessment, which is required by the State of Tennessee, you must bring with you to your class a six (6) month history of prescribed and frequently used over the counter medications and other drugs, including patterns of specific usage for the past thirty (30) days.
7. ***You may be breath tested.*** If you have any amount of alcohol in your system you will be asked to leave the class and reschedule. If you must reschedule the class due to alcohol or other drugs, you will be required to pay \$110 to reschedule. **(Be aware of and avoid the night before and morning of your class any over the counter products that contain alcohol ie...mouthwash, cough syrups, cold medications, etc. these may cause a positive reading for alcohol on your breath test causing you to be refused admittance.) Being rejected from DUI SCHOOL due to alcohol is not good behavior and is a direct violation of your suspended sentence!**
8. Failure to complete the MANDATORY penalties under a DUI conviction, may result in a warrant being issued by the judge. Therefore, you must serve your time, attend DUI SCHOOL and pay your fines and court costs.
9. It is your responsibility to submit a copy of your certificate to the agency requiring you to attend the DUI SCHOOL. (Be sure to keep the original for reinstatement purposes.) Extra copies are \$20 each.
10. If you were licensed in a state other than Georgia at the time of your DUI or received your DUI from a state other than Georgia it is your responsibility to contact the state in which you were licensed and or charged and verify that **this** Georgia State Approved / Tennessee State licensed DUI SCHOOL is recognized and accepted in that state for re-instatement or re-issuance of your drivers license. ***Tennessee Community Counseling Services, Inc. is not liable should another state not recognize State of Tennessee Licensure.***
11. ***If you have a court date for the judge to review your case please have with you your DUI SCHOOL certificate, proof of time served and your receipt showing that your fines and court costs are paid.***  
**ALL FEES PAID ARE NON-REFUNDABLE!!**

**Tennessee Community Counseling Services, Inc.**  
**CLIENT GRIEVANCE PROCEDURE**

**In the event that a client has a grievance, there exists a mechanism by which that grievance is addressed and resolved.**

- 1. The client should meet with the staff member involved to address the grievance. Every attempt will be made to resolve the grievance in that meeting.**
- 2. If the grievance is not successfully resolved in that meeting, the grievance should be clearly stated in writing and presented to the Director of Operations.**
- 3. The client will receive a written response from the Director of Operations within three (3) days.**
- 4. If the client is not satisfied with the response received, a meeting will be scheduled with the client, the President and the Director of Operations and possibly the staff member involved where final disposition of the grievance will be decided.**
- 5. Should the client be dissatisfied with the disposition of the grievance, he/she can appeal, in writing, to the State of Tennessee, Board of Licensing Health Care Facility, 283 Plus Park Blvd., Nashville, Tennessee 37247, or by phone At (615) 741-7221.**

CONSENT FOR TREATMENT

I give consent for family and/or individual treatment. I understand treatment is voluntary. I may discontinue services at any time. I understand that the agency encourages me to discuss any dissatisfactions or barriers to treatment prior to terminating services prematurely.

I have received a copy of the rules and the fee schedule.

**X** \_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

I, \_\_\_\_\_ have reviewed the intake with the client on \_\_\_\_\_  
TCCS STAFF SIGNATURE DATE

## EQUAL OPPORTUNITY IS THE LAW IN TENNESSEE

The Civil Rights Act of 1964 was passed to ensure the people of the United States equal treatment, rights and opportunities regardless of race, color, or national origin. Title VI of that Act prohibits discrimination in federally funded programs.

*"No person in the United States shall, on the basis of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."*

Included under National Origin is discrimination based on a person's inability to speak, read, write, or understand English. Persons whose primary language is not English can be Limited English Proficient or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter.

All programs and operations of entities that receive assistance from the federal government must comply.

It is important that all applicants and recipients of services know about their rights under the law, and those employees of TCCS as well as other agencies, organizations, institutions, and contractors providing services with state support understand what the law requires.

Any person who applies for or receives any benefit or service provided by TCCS may file a complaint if he or she has had unfair or different treatment because of race, color, or national origin.

Complaints must be filed in writing with the Title VI representative of the location of the alleged discrimination TCCS; or with the appropriate regional or central office of the Department of Mental Health and Substance Abuse Services; or with the Office of Civil Rights, 101 Marietta Tower, Suite 2706, Atlanta, Georgia 30323.

TCCS does not, because of race, color, or national origin:

1. Deny and individual any services, opportunity, or other benefit for which he is otherwise qualified;
2. Provide any individual with any service, or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
3. Subject any individual to segregated or separate treatment in any manner related to his/her receipt of service;
4. Restrict an individual in any way in the employment of services, facilities or any other advantage, privilege or other advantage, privilege or other benefit provided to others under the program;
5. Adopt methods of administration which would limit participation by any group of recipients or subject them to discrimination;
6. Address an individual in a manner that denotes inferiority because of race, color, or national origin.

For further information, contact TCCS Title VI Coordinator:

Kelli Mullins

951 Eastgate Loop, Suite 100

(423)296-6451

\_\_\_\_\_  
(Service Recipient's Printed Name)

\_\_\_\_\_  
(Service Recipient's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff Printed Name)

\_\_\_\_\_  
(Staff Signature)

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#### CLIENT RIGHTS AND RESPONSIBILITIES

1. Individuals should be accorded impartial access to the least restrictive treatment that is available and medically indicated, regardless of race, creed, sex, national origin, and religion.
2. The client has the right to considerate; respectful care at all times and under all circumstances, with recognition of his/her personal dignity and individuality.
3. The client has the right to individualized treatment including:
  - a. The provision of an individualized treatment plan
  - b. The periodic review of treatment plan;
  - c. When clinically appropriate, the active participation of the client.
4. The client has the right to request the opinion of a consultant at his/her expense, or to request an in-house review of his/her treatment.
5. The client has the right, within the law, to personal and informational privacy.  
He/she the right to:
  - a. Refuse to talk with or see anyone not directly involved in his/her care.
  - b. Be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy.
  - c. Expect that any discussion regarding his/her case will be conducted discreetly.
  - d. Have his/her medical record read only by those directly involved in his/her treatment or monitoring of its quality or by other individuals only with his/her written authorization as required by law.
  - e. Expect all communication and records pertaining to his/her care to be treated as confidential.
  - f. No identifiable photographs of him/her shall be used without the written and signed consent of him/her or his/her guardian.
6. The client has the right to know the identity and professional status of individuals providing service to him/her.
7. The client has the right to obtain from the Director of Programs complete and current information concerning his/her diagnosis (to the degree known), treatment, and any known prognosis. When it is clinically advisable to give such information to the client, the information shall be made available to a legally authorized individual.
8. The client has the right to participate in discussions involving his/her treatment. This should include concise explanation of his/her condition, and proposed services. He/she may refuse treatment to the extent of the law. Should this refusal prevent the provision of appropriate care in accordance with ethical and professional standards, the facility's relationship with the client may be terminated upon reasonable notice.
9. The client has the right to an itemized and detailed explanation of his total bill for services and rendered when appropriate, or to his/her legally authorized representation.
10. The client has the right to complete explanation of the need for transfer to another facility and any continuing health care requirements following discharge.
11. The client has the right to wear personal clothing and religious or other symbolic items, as long as they do not interfere with the diagnostic procedures of treatment.

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12. The client has the right to review their chart upon the approval of the Director of Programs.
13. The client has the right to voice grievances to staff of the facility, to the licensee, and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal.
14. The client has the right to protected by the licensee from neglect: from physical, verbal and emotional abuse (including corporal punishment); and from all forms of misappropriation and/or exploitation.
15. The client has the right to be assisted by the facility in the exercise of their civil rights.
16. The client has the right to be free of any requirement by the facility that they perform services which are ordinarily performed by facility staff.
17. The client has the right to privacy while receiving services.
18. The client has the right to have their personal information kept confidential in accordance with state and federal confidentiality laws.
19. The client has the right to ask the facility to correct information in their records. If the facility refuses, the client may include a written statement in the records of the reasons they disagree.
20. The client has the right to be informed about their care in a language they understand.
21. The client has the right to vote, make contracts, buy or sell real estate or personal property or sign documents, unless the law or a court removes these rights.
22. The client has the right to participate fully, or to refuse to participate, in community activities including cultural, educational, religious, community services, vocational, and recreational activities.
23. The client has the right to participate in the development of the client's individual program or treatment plans and to receive sufficient information about proposed and alternative interventions and program goals to enable them to participate effectively.
24. The client has the right to be accorded privacy and freedom for the use of bathrooms when needed.
25. The clients shall be permitted to retain and use personal clothing, and appropriate possessions including books, pictures, games, toys, radios and crafts materials, religious articles, jewelry and letters.

X \_\_\_\_\_  
PARTICIPANTS SIGNATURE

\_\_\_\_\_  
DATE

X \_\_\_\_\_  
TCCS STAFF SIGNATURE

\_\_\_\_\_  
DATE

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### **Advocacy Services**

#### **Hamilton County Adult Center**

601 Cumberland Street, Chattanooga, TN 37404  
Office: 423-266-6751  
Fax: 423-763-4742

#### **Hamilton County Child and Adolescents Center**

6055 Shallowford Rd., Chattanooga, TN 37421  
Office: 423-266-6751  
Fax: 423-763-4662

#### **Hamilton County Administrative Building**

6049 Shallowford Rd., Chattanooga, TN 37421  
Office: 423-266-6751  
Fax: 423-763-4650

#### **Free Health Clinics (some sliding scale)**

##### *Hamilton County Health Department*

921 E. 3<sup>rd</sup> Street, Chattanooga, TN 37403  
Phone: 423-209-8000

##### *\*Southside Community Health Center – Chattanooga*

100 East 37<sup>th</sup> Street, Chattanooga, TN 37410  
Phone: 423-778-2700

##### *\*Tennhelp Homeless Health Care Center*

717 East 11<sup>th</sup> Street, Chattanooga, TN 37401  
Phone: 423-265-5708

##### *\*TC Thompson Children's Care Center*

910 Blackford Street, Chattanooga, TN 37403  
Phone: 423-778-6011

##### *\*The Partnership For Families Children and Adults*

1800 McCallie Ave., Chattanooga, TN 37404  
Phone: 423-755-2822

##### *\*Family Justice Center*

5705 Uptain Rd., Chattanooga, TN 37411  
Phone: 423-643-7600

##### *\*Family Health Clinic*

921 East 3<sup>rd</sup> Street, Chattanooga, TN 37403  
Phone: 423-209-8050

##### *\*Dodson Avenue Community Health Center*

1200 Dodson Ave., Chattanooga, TN 37406  
Phone: 423-778-2800

##### *\*Chattanooga VA Clinic-Tennessee Valley Healthcare System*

6098 Debra Rd, Ste. 5200, Bldg. 6200, Chatt., TN 37411  
Phone: 423-893-6500, Fax: 423-892-3621

##### *\*Volunteers In Medicine Chattanooga Inc.*

5705 Marlin Rd., Chattanooga, TN 37411  
Phone: 423-855-8220

##### *\*Safe Space Chattanooga Hamilton Outreach*

801 East 8<sup>th</sup> Street, Chattanooga, TN 37403  
Phone: 423-209-8000

##### *\*Hastings House*

1402 Bailey Ave., Chattanooga, TN 37404  
Phone: 423-209-8232

##### *\*Community Kitchen Homeless Care Center*

711 East 11<sup>th</sup> Street, Chattanooga, TN 37403  
Phone: 423-209-8232

##### *\*Salvation Army*

*The Salvation Army Social Services Ministry*  
2140 East 28<sup>th</sup> Street, Chattanooga, TN 37407  
Phone: 423-305-6200

##### *Main office*

800-822 McCallie Ave., Chattanooga, TN 37404  
Phone: 423-756-1023

##### *\*The Cleveland Corps and Social Services*

437 Inman Street, Cleveland, TN 37311  
Phone: 423-308-3467  
Website: <http://csarmy.org/>

### **Mobile Crisis Services**

#### *Volunteer Behavioral Health Care System*

413 Spring Street, Chattanooga, TN 37405  
Phone: 1-800-704-2651  
Website: <https://www.vbhcs.org/>

### **Food Banks**

#### *Chattanooga Area Food Bank*

2009 Curtain Pole Rd., Chattanooga, TN 37406  
Phone: 423-622-1800  
Website: <http://www.chattfoodbank.org/>

### **Transportation**

#### *Southeast Tennessee Human Resource Agency (SETHRA)*

P.O. Box 909  
312 Resource Rd., Dunlap, TN 37327  
Toll free: 1-800-852-6155  
Office: 423-949-2191, Fax: 423-949-4023  
Email: [info@sethra.us/](mailto:info@sethra.us/)  
Website: <http://sethra.us/>

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## Advocacy Services

### Adult Protective Services

311 E. M L King Blvd.  
Chattanooga, TN 37402  
Phone: (423)634-6624  
*Suspected abuse?*  
Hotline: (888) APS-TENN (888-277-8366)  
Online reports: <https://reprtadulthood.dhs.tn.gov/>

### Office of Aging

*Southwest Tennessee Agency on Aging and Disability (AAAD)*  
Mailing Address: P O Box 4757, Chattanooga, TN 37405  
Physical Address: 1000 Riverfront Pkwy, Chattanooga, TN 37402  
Email: <http://www.setaaad.org/www>

### Local Ombudsman (long-term care)

Southeast Tennessee (Region 3)  
Ashley Pelham  
*Partnership for Families, Children & Adults*  
5600 Brainerd Rd., Ste B42  
Chattanooga, TN 37411-5347  
Phone: (423) 755-2877  
Email: [apelham@partnershipfca.com](mailto:apelham@partnershipfca.com)  
Website: [www.partnershipfca.com](http://www.partnershipfca.com)

Further contact...

*Partnership for Families, Children and Adults*  
1800 McCallie Ave., Chattanooga, TN 37404  
Tel: 423-755-2822, Fax: 423-697-3812  
Email: [info@partnershipfca.com](mailto:info@partnershipfca.com)

### Licensure

*Tennessee Department of Mental Health  
And Substance Abuse Services (TDMHSAS)*  
Marie Williams, Commissioner  
500 Deaderick St., Nashville, TN 37243  
Email: [OCA.TDMHSAS@tn.gov](mailto:OCA.TDMHSAS@tn.gov)  
Phone: (615) 532-6500 (Dept. Operator)  
Website: <https://www.tn.gov/behavioral-health/>

### Department of Children's Services

Bonnie Hommich  
UDS Tower, 10<sup>th</sup> Floor  
315 Deadrick St., Nashville, TN 37243  
Ph: 615-7419701, Email: [DCSCustsrv@tn.gov](mailto:DCSCustsrv@tn.gov)  
Website: <https://www.tn.gov/dcs>  
***Suspected child abuse? Hotline: 877-237-0004***  
Online reports: <https://apps.tn.gov/carat>

### Disability Law & Advocacy Center of Tennessee (TALS)

50 Vantage Way, Ste. 250, Nashville, TN 37228  
Phone: 888-395-9297, Fax: 615-627-0964  
Website: <https://www.tals.org/node/172/disability-law-advocacy-center-tennessee>

### Community Mental Health Centers/Hospitals

*Moccasin Bend Mental Health Institute*  
Mary C. Young, Chief Executive Officer  
100 Moccasin Bend Rd., Chattanooga, TN 37405  
Phone: 423865-2271  
Website: <https://www.tn.gov/behavioral-health/topic/moccasin-bend>

### Centerstone Tennessee

Information and Appointments:  
Nashville area 615-460-4357 (HELP)  
Toll-free 888-291-4357 (HELP)  
Crisis Line: 800-681-7444  
44 Vantage Way, Ste 400, Nashville, TN 3728  
Phone: 615463-6610, Fax: 615-463-6612  
Website: <https://centerstone.org>

### Johnson Mental Health

Director: Melissa Wilson  
420 Bell Ave., Chattanooga, TN 37405  
Phone: 423-634-8884, Fax: 423-634-0813  
Website: <https://www.vbhcs.org/>  
24 Hour Crisis line: 1-800-704-2651

### Parkridge Valley

2333 McCallie Ave., Chattanooga, TN 37404  
Phone: 423-894-4220

### Parkridge Valley Adult and Senior Campus

7351 Courage Way, Chattanooga, TN 37421  
Phone: 423-894-4220

### Parkridge Valley Child and Adolescent Campus

2200 Morris Hill Rd., Chattanooga, TN 37421  
Phone: 423-894-4220

### Helen Ross McNabb Center

*The lighthouse*  
509 South Highland Park, Chattanooga, TN 37404  
Phone: 423-756-1295

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



*Tennessee Community Counseling Services, Inc.*  
*5600 Brainerd Road*  
*Suite B-42*  
*Chattanooga, Tennessee 37411*  
*(423) 296-6451 Fax (423) 296-6515*

<b>FOR TCCS USE ONLY</b>	
REFERRED BY:	_____
FOR: _____	# SESSIONS: _____
CLASS: _____	TIME: _____
START DATE:	_____
COMMENTS:	_____

**CLIENT OUT-OF-STATE DUI INTAKE FORM**

Today's Date: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Referred By: (P.O.'s Name or Judge) \_\_\_\_\_

Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_  
(SOCIAL SECURITY) (DATE OF BIRTH)

Street Address: \_\_\_\_\_  
(POST OFFICE BOX)

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
(LIST NAME)

Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Spouse or Significant Other's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_  
(POST OFFICE BOX)

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Street Address: \_\_\_\_\_  
(POST OFFICE BOX)

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ (POST OFFICE BOX)

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Department: \_\_\_\_\_ Shift Hours Worked: \_\_\_\_\_

Parent or Legal Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ (POST OFFICE BOX)

Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Are you: MARRIED SINGLE DIVORCED WIDOWED

Have you ever served in the military? \_\_\_\_\_ When? \_\_\_\_\_ Branch: \_\_\_\_\_

Are you under a doctor's care? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

What are you being treated for? \_\_\_\_\_

Are you taking prescription medications? \_\_\_\_\_ Over the counter? \_\_\_\_\_ Vitamins? \_\_\_\_\_ Nutritional Supplements? \_\_\_\_\_  
If yes, please advise staff

Are you HIV positive? \_\_\_\_\_ Do you have Hepatitis? \_\_\_\_\_ Do you have Tuberculosis? \_\_\_\_\_

Do you have any communicable diseases/STD's/etc...? \_\_\_\_\_

Have you ever attended Drug and Alcohol Treatment Programs? \_\_\_\_\_ Where: \_\_\_\_\_

When: \_\_\_\_\_ Did you complete the program? \_\_\_\_\_

Who was your counselor/case manager/doctor? \_\_\_\_\_

Reason for coming here? \_\_\_\_\_

LIST ALL FAMILY MEMBERS PRESENTLY IN YOUR HOUSEHOLD:

NAME	AGE	RELATION

What court were you in? \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_

Judge \_\_\_\_\_ Date of Arrest \_\_\_\_\_ Charges \_\_\_\_\_

Sentence \_\_\_\_\_ Next Court Date \_\_\_\_\_ Amount of fines and Costs \_\_\_\_\_

Attorney's Name \_\_\_\_\_ Have you ever been arrested for DUI before? When? \_\_\_\_\_

What state? \_\_\_\_\_ In what state were you licensed to drive? \_\_\_\_\_

At the time of THIS DUI arrest, in what state did you live? \_\_\_\_\_

At the time of THIS DUI arrest, in what state were you licensed to drive? \_\_\_\_\_

I give my permission for family and/or individual treatment.

X \_\_\_\_\_

CLIENT SIGNATURE

\_\_\_\_\_

DATE

Client Name \_\_\_\_\_ SSN \_\_\_\_\_

In which State did you get your DUI (even if it was reduced to reckless driving) and/or/ Drug Possession Charge that you will be attending DUI School? \_\_\_\_\_

In which State were you currently licensed at the time of the above DUI/ and/or Drug Possession arrest? \_\_\_\_\_

Was the actual charge for DUI (even if it was reduced to reckless driving) or Drug Possession? \_\_\_\_\_

If the charge was for DUI, have you had any other DUI charges in the past 10 years, even if they were reduced to reckless driving charges? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you *personally* contacted the State(s) DMV to determine your specific reinstatement requirements? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any other driving related citations or arrests since the above DUI /and/or Drug Possession Charge? Yes \_\_\_\_\_ No \_\_\_\_\_

If you have had other citations or arrests in what State did they occur and what was the charge?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any driving related charges that are currently pending that you have not yet plead? Yes \_\_\_\_\_ No \_\_\_\_\_

I do understand and accept if the offense occurred OR if I was licensed in Georgia, North Carolina, South Carolina or Kentucky, I must do the RISK REDUCTION CLASS of 20 HOURS in order to reinstate? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you know if you are required to have an Alcohol and Drug Assessment? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have to have an Interlock Device on your vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Tennessee Community Counseling Services, Inc.**  
**CLIENT RIGHTS**

You have the right to be treated with respect for your dignity, individuality, and humanity.

You have the right to confidentiality in your treatment and in your personal lives.

You have the right to be informed of available program services and the charges for those services.

You have the right to be fully informed of your rights and of the rules and expectations of the program.

You have the right to participate in the development of your treatment plan.

You have the right to receive sufficient information for informed consent prior to treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences of such refusal.

You have the right to continuity of care and impartial access to treatment regardless of race, creed, sex, national, HIV/AIDS status or sources of payment for care.

You have the right to expect adequate humane services.

You have the right to receive treatment in the least restrictive environment for your particular needs and safety.

You have the right to make emergency phone calls.

You have the right to an individual treatment plan that is reviewed on a monthly basis.

You have the right to be provided with an adequate number of competent, qualified, and experienced professional staff to implement and supervise treatment.

You have the right to voice opinions, recommendations, and grievances in relation to the policies and procedures offered by the program.

You have the right to have your family and/or significant other as well as yourself be given information when appropriate regarding your condition, proposed treatments/services, problems related to recuperation, alternative treatments/services and any business relationships among individuals/organizations/health care provider/educational institutions involved in treating you or providing services.

You have the right not to be abused, neglected or administered corporal punishment.

**X** \_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

**Tennessee Community Counseling Services, Inc.**  
**PROGRAM RULES**

*These rules are designed to provide structure and contribute to the sobriety of each participant. These rules describe the terms and conditions of the program you will be involved in. Please read carefully and sign. A staff member will assist you with any questions you may have.*

I understand that by signing this agreement I am committing myself to the following:

1. I agree to submit to random alcohol and/or other drug screening and will not attempt to dilute, mask or tamper with my specimen (including bringing urine in).
2. I agree to attend the program regularly and as outlined in my treatment plan.
3. I agree to smoke only in designated smoking areas.
4. I agree to abstain from all alcohol use and all illegal or mind altering substances while I am involved in and participating in the program.
5. I understand that abusive, rude or improper language or behavior to staff or other group members is not allowed and will not be tolerated.
6. I understand that I am prohibited from having drugs/intoxicants in my possession on these premises and will be arrested if in violation.
7. I agree to adhere to the program schedule and will be on time for program activities. Tardiness is not acceptable.
8. No drugs other than those prescribed for me by a licensed physician will be taken or allowed on these premises. Exceptions may be made for aspirins, antacids and some other over the counter medications not taken in an abusive fashion.
9. Tennessee Community Counseling Services, Inc. will not be responsible for any personal items left on the premises.
10. Gambling, violence or other activities prejudicial to the good order of the community are prohibited.
11. Telephones may be used for local calls only. Please ask for permission prior to using the phone and limit phone calls to three (3) minutes or less. **NO PRANK CALLS.**
12. I understand that any misuse of property belonging to TCCS or Eastgate Town Center will not be tolerated.
13. I agree not to bring any weapons (guns, knives, brass knuckles, etc...) on the premises, to include Eastgate Town Center property.

I understand that any violation of the above rules may be grounds for termination from the program.

**X**

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

**CONSENT FOR RANDOM DRUG SCREENING**

I, **X** \_\_\_\_\_, hereby consent to be tested for the presence of alcohol and/or illegal substances in my body to comply with a court order, probation/parole or to aid in the assessment process. I understand that a TCCS staff member (gender appropriate) will monitor my urine specimen screening by being present during this process. I understand that this consent is voluntary and that the results will be used as part of my treatment for chemical dependency.

I, **X** \_\_\_\_\_, understand that prior to any urine screen I am responsible for advising the staff member if I have HIV, AIDS, Hepatitis, Tuberculosis, or any other health related issues that could be spread by the possible contact of bodily fluids.

I, **X** \_\_\_\_\_, understand that the attempt to mask (use of powder, pills or large amounts of water) any urine screen will be considered a positive result. I understand that it is my right to challenge any returned drug results, however, I release TCCS from all responsibilities legally, financially and otherwise. I assume all associated cost in the additional re-testing of the original specimen that is being challenged.

**X** \_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

## NOTIFICATION OF CONFIDENTIALITY REGULATIONS

*I do hereby understand that section of the Federal Confidentiality Regulation (42 CRS, Part 2) which reads: "The Prohibitions of this part of disclosure of patient records or information contained therein apply to all individuals who are personnel of treatment programs, researchers, auditors, evaluators, service organizations, others having access to such records or information and continue to apply to such individuals with respect to such records or information after the termination of their employment or other relationship or activity giving rise to such access." I understand that this applies to written, oral and observable records of a patient's treatment at Tennessee Community Counseling Services, Inc. "Patient's Records" includes disclosure of the identity of patients observed in treatment.*

**I have read, or have had read to me, the above statement and understand its content and accept my responsibility for maintaining the confidentiality to which clients at Tennessee Community Counseling Services, Inc. are legally and ethically entitled. I also understand that violation of Federal Confidentiality Regulations carries a penalty of fines and/or imprisonment.**

**Your signature constitutes understanding and acceptance of the above regulations and penalties for violations of said regulations.**

**X**

CLIENT SIGNATURE

DATE

