SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

Southworth Associates
Recovery Enhancement Program (REP)

What is REP?

It is a program designed as an extension of residential treatment and is intended to help participants follow through with their aftercare recommendations. The Southworth Associates case managers provide extra support and resources in order to strengthen the recovery process. This service provides 12 months of aftercare case management. Southworth Associates is not a healthcare provider and the Recovery Enhancement Program is not a treatment program.

Who can participate?

Anyone. For example, participants range from students to engineers.

What does this program do for the participant and family?

- Provides disclosure of recovery progress through one case manager who serves as the mediator of information, drug screenings, reporting and follow-up for a client.
- Helps ensure follow through with treatment recommendations.
- Provides accountability and transparency which are valuable components of our program and a critical part of recovery. Self-reporting enhances recovery by keeping a participant responsible.

How do we set up a contract?

- The participant's treatment providers, along with Southworth Associates, will assist in this process.

What are the components of a contract?

- Recommendations from the treatment facility
- Recommendations from the family and/or appointed outside agency
- Participant contact information
- Releases of information for anyone who will be involved with their treatment program and aftercare program.

What are some typical requirements?

- Random drug screenings (additional cost)
- Attendance at 12 Step meetings
- Meetings with a 12 Step sponsor
- Meetings with a therapist/counselor/psychiatrist, as recommended (additional cost as determined by provider)
- Attendance at Aftercare or Outpatient services, recommended (additional cost as determined by provider)

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net
800-386-1695 **Toll Free**
866-460-9014 **24 Hr. Hotline**
208-323-9555 **Office**
208-323-9222 **Fax**

How does REP monitor these requirements?

- **Drug screening:** Participants are required to call in on weekdays to an automated system to find out if they are selected to submit to a drug screen. If they are chosen, they have on hand a list of approved testing sites. They are required to take along a pre-paid testing form called a Chain of Custody (COC) form.
    - Costs for the test are paid through the COC form
    - If a participant's drug screen comes back diluted or positive, it will be reviewed by a Medical Review Officer that will determine if the test clears or fails
- **Attendance at 12 Step meetings:** Participants are supplied with AA/NA slips that they take to their 12 Step meetings. Participants are required to have the slips signed by the meeting facilitator, and then mail the slips in a provided, pre-addressed envelope to REP monthly.
- **Meetings with a 12 Step sponsor:** In addition to having slips signed at 12 Step meetings, participants need to earmark meetings they attended with their sponsor by writing "sponsor" as the activity on their meeting slip and have their sponsor sign their slip each week.
- **Meetings with a therapist/counselor/psychiatrist:** If meeting with any of these professionals is a recommendation made by the treatment center or family, then REP will request updates from these individuals on either a monthly or quarterly basis, depending on the case.
- **Attendance at Aftercare or Outpatient services (if recommended):** If a participant needs to follow up with Aftercare or Outpatient services, REP will request monthly treatment updates from the provider.

How does follow-up occur with REP?

If a participant is non-compliant with any of these requirements, the appropriate source will be notified, i.e. family member, etc. We also send out monthly compliance letters to the involved parties updating them on the participant's program progress for the previous month.

Case Management Level II:

For those people who are looking for a more intensive level of care, we also offer a second level of case management services that involves the whole family.

- A program designed to give the addict and their family the support and resources they deserve while they are all learning about life in recovery together
- Accountability for the addict and the entire family
- Monitoring of individualized recovery plans, including, but not limited to, drug and alcohol testing, attendance at 12-step meetings, meetings with therapist/psychiatrist/addictionologist
- Individualized self-assessments to determine areas of needed support and resources
- Worldwide referrals available for a variety of treatment needs
- Interactive online recovery program:
    - monthly recovery related topics followed by weekly assignments
    - readings, assignments, 12-step and recovery related resources tailored for each family member

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

Registration Check List

- ☐ Complete the "Client Information" sheet containing demographic information.
- ☐ Complete the Recovery Enhancement Program contract, based on continuing care recommendations. Testing rates and meeting rates should be determined based on the treatment provider or family's recommendations. The recommended rate to begin testing is 3-4 times per month with the possibility that the client can request to reduce that rate after three months of compliance. Please indicate the contract details in the frequency/comment sections. The client may write Not Applicable (N/A) if a contract requirement will not be utilized. The client should initial next to each requirement they will be participating in, also next to each paragraph on the left hand side.
- ☐ Complete the Case Management Planning Worksheet by filling in goals applicable to the program.
- ☐ Take the Prescription Drug List sheet to your medical provider and have them fill in all current prescribed medication. Please return via fax at 208-323-9222 or by mail at the address listed below. It does not need to be completed at the time the rest of the enrollment packet is sent in to start the program, but we do ask that you return it within one week of your start date.
- ☐ Whoever will be responsible for the payment of testing fees, will need to complete and sign the "Urinalysis Fees" sheet. Please note the client cannot begin testing until payment is arranged.
- ☐ Read and sign the Southworth Associates Recovery Enhancement Program Agreement.
- ☐ Complete the provided Releases of Information (ROI) for all individuals and/or entities involved in the client's continuing care and include all known contact information; including any physical address/email/fax as well as a phone number. Also, complete the treatment center section if the client has been in treatment within the last year. Please make as many copies of the ROI as needed. The client should also fill out a release for anyone whom they would like monthly reports of their progress sent to: family members, employers, significant others, etc.
- ☐ Include a copy of current ID (driver's license, ID card, passport, etc) and copy of current insurance card.
- ☐ The treatment provider or client will need to provide us with a copy of client's most recent clinical intake assessment or BioPsych Social assessment to have in client's file.
- ☐ Complete the Consent for Payment of Services form, if applicable.
- ☐ If the client is signing up for Case Management Level II services, please call our office and we will help make those arrangements.
- ☐ If returning by mail please use the address listed below. You may also fax the entire packet to (208) 323-9222, attention REP.
- ☐ The client may retain the original "Contract" or make copies for their records.

Once the information is received, we will register the client with FirstLab, our testing agency, and send them a startup packet which includes all of the information they need to begin the program. The packet includes testing locations in the client's area, two testing forms along with instructions for checking in and testing, and the REP meeting attendance forms, which the client will use to document their 12 step/sponsor meetings.

Please feel free to contact the office at any time with any questions/concerns.

Southworth Associates
5530 W. Emerald
Boise, ID. 83706

Phone: (208) 323-9555 ext. 400
Toll Free: (800) 386-1695 ext. 400
Fax: (208) 323-9222

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

RECOVERY ENHANCEMENT PROGRAM (REP)

Client Information

Participant's Name: _____

Date of Birth: _____

Sex: _____

SSN#: _____

Marital Status: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Sobriety Date: _____

Primary Drug of Choice: _____

Other Drugs of Choice: _____

Treatment Center: _____

Admission Date into Treatment: _____

Prospective Discharge Date: _____

*Southworth Associates is not a healthcare provider and the Recovery Enhancement Program is not a treatment program.

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net

800-386-1695 **Toll Free**
866-460-9014 **24 Hr. Hotline**

208-323-9555 **Office**
208-323-9222 **Fax**

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

Recovery Enhancement Program (REP) Case Management Level II Contract

I, _____ agree to attend or participate in other treatment activities as outlined below:

ACTIVITY	FREQUENCY	COMMENTS	INITIAL
Random UA tests	Suggested 3-4 x month or TBD	_____	_____
Mutual Support Groups (AA/NA)	Suggested 90/90 to begin	_____	_____
Sponsor	Meet weekly to work the steps	_____	_____
Take online personal assessment		_____	_____
Read Recovery Materials and journal online	Weekly	_____	_____
Complete online interactive assignments	Weekly	_____	_____
Individual/Family Therapy	As Directed	_____	_____
Other		_____	_____

_____(initial) I agree to completely abstain from alcohol, marijuana, cocaine, stimulants, narcotics, sedatives, tranquilizers, and all other mind-altering and/or potentially addicting drugs or medications. In the event such medications may be needed as a legitimate part of my medical care, I agree to notify the Program staff within 24 hours and provide documentation of the prescription.

_____(initial) I agree to attend the meetings as requested by the REP. I will document the meeting attendance (i.e. 12-step, sponsor, IOP, therapy, and/or psychiatry) by submitting monthly meeting attendance reports for the previous month's attendance to the REP by the 5th of each month.

_____(initial) I agree to submit voluntarily, and without question, to random urinalysis (UA) tests, as requested by the REP staff. I understand that if I miss a urine drug screen collection, I should immediately notify REP. I agree to give at least one week's written notice to REP Staff if I am unavailable to UA test on a certain day and to give an explanation satisfactory to the Program, otherwise the missed test will be considered positive. I will be responsible for payment of these regular drug screens.

_____ (initial) I also understand that if my specimen is dilute or positive it will be given to the Medical Review Officer for review possibly resulting in a failed review that indicates non-compliance with this contract and an extra charge for review services.

_____(initial) I agree that if I fail to meet the conditions of this contract, I will lose the advocacy of the Program and changes may be made to this contract. I recognize that I have a disease that is subject to relapse. If I relapse, I will inform the Program Coordinator or staff immediately for help and stabilization.

_____(initial) I may request a change in my contract at any time, by placing the request in writing.

_____(initial) I hereby release and hold harmless all members of the Program staff and any of its agents, representatives, attorneys, members, employees or consultants from any claims, liability, damages or expenses of any kind or nature relating to or arising out of any decision, opinion, investigation, recommendation or any other action if such decision, opinion, investigation, recommendation or action was taken within the scope of their duties and functions and when such decision, opinion, investigation, recommendation or action was taken without malice

_____ (initial) I acknowledge that I paid for REP's services under this Contract when I paid for services to my initial treatment provider. I understand this money is non-refundable and that a substantial possibility exists that a participant may regret the help being sought and return to a state of denial which is part of the disease of alcoholism and/or addiction and/or codependency. However, REP may have invested resources and sustained expenses in order to deliver services under this Contract. Accordingly, I expressly waive any claim for refund of any monies paid to REP for any reason whatsoever.

_____(initial) I voluntarily seek case management services and hereby authorize Southworth Associates and/or any of its agents or contractors (collectively referred to as "Provider") to render telehealth care, case management, and related services (collectively referred to as "services"). I agree to cooperate with all reasonable requests of Provider in connection with the Provider's rendition of services. I acknowledge the right to refuse specific services. I am at least 18 years of age, an emancipated minor or a minor with parental consent.

_____(initial) I understand that the Southworth Associates staff has a duty to contact emergency authorities and/or family members or contacts listed on the Releases of Information if they believe that I am in a situation where I may harm myself or someone else, or if I disclose any abuse of a minor, an elderly person or a person with disabilities. The staff will also contact the proper authorities if they believe I am in need of immediate medical attention, both physical and psychiatric.

Participant Signature	Date	Treatment Professional (if applicable)	Date

*Southworth Associates is not a healthcare provider and the Recovery Enhancement Program is not a treatment program.

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

CASE MANAGEMENT PLANNING WORKSHEET

This worksheet is meant to be used as a tool to aide you in your sobriety. Please try to focus on the purpose and scope of this program when thinking of goals. You may list others but the Recovery Enhancement Program may not always be able to assist you with non-program related goals.

Name: _____ Date: _____

A. Please list, in order of importance, the areas YOU would like to address with the Recovery Enhancement Program:
1. _____
2. _____
3. _____

B. In the terms of Case Management services and the program you signed up for, please define three (3) goals you would like to achieve in this program:
1. _____
2. _____
3. _____

C. What are your strengths and how will they help you in your recovery process?
1. _____
2. _____
3. _____

D. What do you consider to be barriers that will make it more difficult for you to be successful at this program and function as a sober member of the community?
1. _____
2. _____
3. _____

E. Is there anything else you would like us to know about you? ◯ NO ◯ YES
If YES, explain:

_____
_____
_____
_____

Client Signature: _____ Date: _____

Case Manager: _____ Date Reviewed: _____

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net
800-386-1695 Toll Free
866-460-9014 24 Hr. Hotline
208-323-9555 Office
208-323-9222 Fax

Southworth Associates Recovery Enhancement Program (REP) AGREEMENT

THIS AGREEMENT by and between **First Hospital Laboratories Inc. dba FirstSource Solutions**, a Virginia Corporation and Participant is made as of the date of the execution of this document.

WHEREAS, The Participant is under an administrative obligation to submit at Participant's own expense to random drug and/or alcohol tests directed by REP, and

WHEREAS, the REP has entered into an agreement with FIRSTSOURCE SOLUTIONS to provide drug testing services for the REP;

NOW, THEREFORE, in consideration of the mutual promises contained in this Agreement and for other good and valuable consideration, and in order to facilitate compliance with the REP's requirements, the parties agree as follows:

A. FIRSTSOURCE SOLUTIONS will:

1. Secure a forensic toxicology testing laboratory acceptable to the REP.
2. Assist in securing collection sites that are convenient and that employ certified collectors that meet FirstSource Solution's standards.
3. Provide testing kits and chain of custody forms to be used in the collection process.
4. Use information provided by the REP to establish testing levels and frequencies for random selection.
5. Perform computer random selection at the testing frequencies established.
6. Provide a toll-free 800-telephone number and website for Participant to call Mon. Tue. Wed. Thu. Fri. to see if Participant has been selected for testing.
7. Provide a Medical Review Officer to review confirmed non-negative test results as requested.
8. Send all test results to the REP and immediately fax all positive results directly to the Administrator, or designee of the REP.
9. Charge Participant monthly for services such as specimen analysis, collection site fees, Medical Review Officers fees, Return Check fee, etc.

B. The Participant will:

1. Complete the registration form and return/submit it to REP who will forward it to FIRSTSOURCE SOLUTIONS.

2. Call IVR (Inter-Active Daily Voice Response) and/or log on to the FirstSource Solutions Test Notification web site at a designated time between 4:00 AM and 4:00 PM MT Mon. Tue. Wed. Thu. Fri. to see whether Participant has been selected for testing that day.

3. If selected for testing, report to a FIRSTSOURCE SOLUTIONS approved testing site and be tested that same day. Should Participant's professional schedule make testing before the collection site's operating hours unreasonable, Participant must make arrangements for after-hours collection. Approval of the case management program is required for this variance and the cost of the collection at such a site is the responsibility of the participant.

4. Agree that failure to call or test will be considered a lack of compliance with the REP's administrative agreement requiring such testing and will result in reporting that lack of compliance to the REP.

5. Keep Participant's account with FIRSTSOURCE SOLUTIONS current. FirstSource Solutions will charge the Participant once a month for all tests that were reported to FirstSource Solutions during the previous month. This will take place on the 14 of each month. If this date falls on a weekend, processing will take place on the following Monday. Immediately upon a credit or debit card rejection, FirstSource Solution's Finance Department will suspend the

Participant's access to the Testing Notification message. Upon call-in or login to our Test Notification System, Participant will be alerted that their account is on credit hold. Participant will have the ability to clear up their balance at that time. If the Participant clears their balance, he/she will be removed from suspension and advised if they have been selected for testing that day. The REP is notified when a Participant is placed on suspension due to non-payment as it may result in non-compliance with the case management requirements.

6. Present chain of custody form and valid government issued photo I.D. to collection site at time of collection.

C. Participant authorizes FIRSTSOURCE SOLUTIONS to disclose or release any information in its possession concerning Participant, including without limitation, the results of any drug screening tests, to the REP. This authorization is subject to revocation at any time, except to the extent that FIRSTSOURCE SOLUTIONS already has taken action in reliance on it. If not previously revoked, this authorization will terminate upon written confirmation to FIRSTSOURCE SOLUTIONS by the REP that the administrative obligation to the REP under which this Agreement has been executed has been terminated.

D. FIRSTSOURCE SOLUTIONS will take all reasonable efforts to insure confidentiality and protect the integrity of the program. FIRSTSOURCE SOLUTIONS further agrees that all knowledge and information that FIRSTSOURCE SOLUTIONS may receive from the REP, their employees or consultants, shall for all time and for all purposes be regarded by FIRSTSOURCE SOLUTIONS as strictly confidential and held by FIRSTSOURCE SOLUTIONS in confidence, and solely for its benefit and use, and shall not be directly or indirectly disclosed to any person whatsoever, except to the REP, or anyone authorized by the REP. The obligations hereunder with respect to confidentiality will survive and continue after this Agreement terminates or expires.

E. It is expressly understood and agreed by the parties hereto that the reports prepared and issued by the testing laboratory or the MRO shall be the sole responsibility of the issuer, and that FIRSTSOURCE SOLUTIONS assumes no responsibility for such reports. Each testing laboratory shall be an independent contractor, not an employee of FIRSTSOURCE SOLUTIONS. It is further understood and agreed by the parties that no liability is assumed by FIRSTSOURCE SOLUTIONS for the accuracy of the processed data, except for the correction of its work; however, every precaution will be taken to insure the accuracy of the processed data. Any reasonable delay in performing under this Agreement due to disaster, weather, or mechanical failure will also cause no liability to FIRSTSOURCE SOLUTIONS.

F. Participant agrees to indemnify and hold harmless FIRSTSOURCE SOLUTIONS, its directors, officers and employees from and against any and all claims, actions, and liabilities of any nature which may be asserted against it or them in connection with the performance of FIRSTSOURCE SOLUTIONS, its directors, officers, employees, and agents pursuant to this Agreement.

G. This Agreement shall remain in effect until either of the following, whichever occurs first in time:

(1) The Agreement between FIRSTSOURCE SOLUTIONS and the Program Title is canceled; or (2) the REP confirms in writing to FIRSTSOURCE SOLUTIONS that Participant is no longer obligated to the REP for such a program.

H. This Agreement shall be governed and construed in accordance with the laws of the Commonwealth of Virginia.

_____ _____

(Participant's Signature) **(Date)**

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

Prescription Drug List

Please have the practitioner who is prescribing your medications fill out this form and **fax/mail/email it directly to our office**. Not providing us with this documentation may result in your drug screens being determined as "positive" by our Medical Review Officer. You will also need to provide this information to the Medical Review Officer if asked. Please keep in mind that you need to send us a copy of any new medications you are prescribed in the future.

_____

(Printed Participant's Name)

Prescription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I have been informed that this patient is involved in a monitoring program. I understand that his/her drug(s) of choice is/are: _____

_____ _____

Practitioner's Name (Please print) Practitioner's Signature

_____ _____

Practitioner's Phone Number Date

_____

Practitioner's Address

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net

800-386-1695 Toll Free
866-460-9014 24 Hr. Hotline

208-323-9555 Office
208-323-9222 Fax

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

URINALYSIS FEE SHEET

There is no cost for registering with FirstLab for urinalysis testing, but FirstLab requires a credit card authorization on file for testing fees, which currently run at $60.30. This fee includes both the cost of the urinalysis test ($48.30) and the site collection fee ($12.00) for all tests conducted at Quest Diagnostics locations. *In order to use non-Quest Diagnostics locations, clients must get the test site approved and pay an additional fee at the time of specimen collection*. Credit cards are billed once a month on the 14th for all testing occurring during the previous month. Any alternate forms of drug screens can also be paid for in this manner. If those fees are greater than $60.30, they will be discussed with you prior to implementation. FirstLab will also bill for any alternate collection site fees and Medical Review Officer positive determinations at that time. Any payment alternatives for testing fees need to be directed to FirstLab customer service at (800) 732-3784

Name of Participant: _____ SSN of participant: _____

Address:_____ City _____ State _____ Zip _____

Phone Number: _____ Email: _____

Credit Card Information:
Name as it appears on Credit Card: _____

Billing Street Address: _____ **Zip/Postal Code**: _____

Card Number: _____ **Expiration Date:** _____/_____

Card ID Number: _____ ***(Visa & MasterCard – last three digits on back of card, Amex- 4 digits on front)***

Authorized Signature: _____ **Date:** _____

This page should be faxed to Southworth Associates at (208) 323-9222 or mailed to the address listed below:

Southworth Associates
5530 W. Emerald St.
Boise, ID 83706
(800) 386-1695

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize the Southworth Associates Recovery Enhancement/Case Management Program to release/exchange information about me to the following **treatment center:** _____ for the purpose of creating a service plan for the monitoring/case management program.
Street Address:_____City: _____ State:_____ Zip:_____
Phone Number: _____Fax Number:_____
Treatment Center Contact Name: _____ Email Address: _____

I agree to the following release(s) of information:
Note: The client must initial next to each item they wish to authorize for release.

___Discharge documents (including, but not limited to, discharge summary, evaluation, assessment, medication information)

___Program progress ____ Correspondence sent/received

___Other: _____

I, _____ authorize the Southworth Associates Recovery Enhancement/Case Management Program to release/exchange information about me to _____ for the purposes of monitoring.
Relationship to client: _____
Street Address:_____City: _____ State:_____ Zip:_____
Phone Number: _____Fax Number: _____
Email Address: _____

I agree to the following release(s) of information:
Note: The client must initial next to each item they wish to authorize for release.

____Medication information ____Correspondence sent/received

____Program progress ____ Drug Screen Results

____Meeting Attendance Reports ____Other: _____

All releases will remain in effect for the period of 14 months from the signing of the release, unless otherwise noted. This release will expire on _____.

Any request to rescind this release must be made in writing and sent to Southworth Associates by fax or mail. All written requests will be acknowledged and implemented upon receipt.
To the extent possible under federal and state law, I consider all my medical records, including records concerning my activity with the Southworth Associates Recovery Enhancement/Case Management Program, to be privileged and confidential. I, therefore, give my permission for the Program representatives to give reports to and receive reports from the person(s) or agencies listed above. I understand these reports will contain information regarding my involvement with the Program and will include information regarding any chemical dependence and/or mental health issues in addition to information regarding my progress in recovery. Any limitations regarding the content of information in these reports are as defined above. I further acknowledge that the purposes of these reports were explained to me and that this consent is given of my own free will.

_____ _____
Client Signature Date

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net
800-386-1695 Toll Free
866-460-9014 24 Hr. Hotline
208-323-9555 Office
208-323-9222 Fax

SOUTHWORTH ASSOCIATES

Lending a hand...
any time, any place

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize the Southworth Associates Recovery Enhancement/Case Management Program to release/exchange information about me to _____ for the purposes of monitoring.
Relationship to client: _____
Street Address:_____City: _____ State:_____ Zip:_____
Phone Number: _____Fax Number:_____
Email Address: _____

I agree to the following release(s) of information:
Note: The client must initial next to each item they wish to authorize for release.

____Medication information ____Correspondence sent/received

____Program progress ____ Drug Screen Results

____Meeting Attendance Reports ____Other: _____

I, _____ authorize the Southworth Associates Recovery Enhancement/Case Management Program to release/exchange information about me to _____ for the purposes of monitoring.
Relationship to client: _____
Street Address:_____City: _____ State:_____ Zip:_____
Phone Number: _____Fax Number: _____
Email Address: _____

I agree to the following release(s) of information:
Note: The client must initial next to each item they wish to authorize for release.

____Medication information ____Correspondence sent/received

____Program progress ____ Drug Screen Results

____Meeting Attendance Reports ____Other: _____

All releases will remain in effect for the period of 14 months from the signing of the release, unless otherwise noted. This release will expire on _____.

Any request to rescind this release must be made in writing and sent to Southworth Associates by fax or mail. All written requests will be acknowledged and implemented upon receipt.
To the extent possible under federal and state law, I consider all my medical records, including records concerning my activity with the Southworth Associates Recovery Enhancement/Case Management Program, to be privileged and confidential. I, therefore, give my permission for the Program representatives to give reports to and receive reports from the person(s) or agencies listed above. I understand these reports will contain information regarding my involvement with the Program and will include information regarding any chemical dependence and/or mental health issues in addition to information regarding my progress in recovery. Any limitations regarding the content of information in these reports are as defined above. I further acknowledge that the purposes of these reports were explained to me and that this consent is given of my own free will.

_____ _____
Client Signature Date

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net
800-386-1695 Toll Free
866-460-9014 24 Hr. Hotline
208-323-9555 Office
208-323-9222 Fax