LTBB Behavioral Health
Crooked Tree Wellness Clinic

Client Rights and Responsibilities

Client Rights

You have a right to ask questions about any part of your treatment, suggest changes in our services, and expect us to look into your complaints.

You have a right to be informed of the limitations of the therapist's practice/areas of expertise.

You have a right to receive an explanation of services offered.

You have a right to expect your privacy and civil rights will be protected through federal, state and tribal laws.

You have a right to take part in formulation your treatment plan and goal setting.

You have a right to requestion copies of your records or make an amendment to your records; however, this request could be denied if potential harm or inaccuracy could result.

You have a right to terminate therapeutic services at any time.

You have a right to refuse services offered to you and to be informed of any potential consequence.

You have a right to be informed what behaviors or violations could lead to termination of services.

You have a right to be informed of the laws and limitations related to confidentiality and how your protected health information will be used.

Client Responsibilities

You have a responsibility to follow the policies and procedures of the clinic.

You have a responsibility to set and keep appointments with your therapist.

You have a responsibility to help plan your treatment goals and follow through with them.

You have a responsibility to terminate your therapeutic relationship before starting to see another therapist.

You have a responsibility to treat staff and other clients in a respectful manner.

You have a responsibility to provide accurate information.

2.13.23 lm

INFORMED CONSENT TO TREATMENT (BEHAVIORAL HEALTH)

Name of Person Served ______________________ DOB: ______________ HRN:________

- Welcome to the LTBB Crooked Tree Wellness Clinic – Behavioral Health Program. This document contains important information about the services provided to you through our program. Please read it carefully; if you have any problems with your eyesight or have difficulty reading this document, please let us know. When you sign this document, it represents an agreement between us.

- There are many different methods we may use to work with the problems that you hope to address. For the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Your participation in your treatment is most important in producing positive outcomes.

- Referrals may be made to accommodate services that cannot be accomplished at Crooked Tree Wellness Clinic, and this is at the discretion of your therapist and upon consent from you.

- If for any reason you are involved in legal proceedings, a separate consent form will be presented for you to sign. Crooked Tree Wellness Clinic Behavioral Health Program does not engage in custody opinions.

- Our first few sessions will involve an evaluation of your needs and developing a therapeutic relationship that will offer an opportunity to plan your treatment and goals to offer solutions to your specific problems. The evaluation process involves 2 to 4 sessions. It will be important to attend all your sessions to be successful in your healing process. Continued sessions are typically 60 minutes and will follow the evaluation based on a decision made by you and your therapist.

- Discharges or transitions are determined by you and your therapist as well. If for any reason you feel you have reached your desired stage of change or if you need to temporarily leave therapy for a time, discuss this with your therapist to develop a transition plan.

- Discharges may be initiated by the therapist if you are disrespectful toward other clients and/or staff; miss 2 appointments consecutively without informing the program; fail to give 24 hours' notice consecutively with missed appointments; use inappropriate language or threaten others; smoke inside the building or other non-designated areas outside; bring illegal drugs or alcohol or weapons into the building; or come to the program intoxicated or high.

- Our normal Behavioral Health Program are Tuesday and Wednesday, 7:30am – 5:30pm. There are times when you or your therapist may need to cancel a session. It is standard that a 24-hour notice is given, when possible, at these times and effort is made to reschedule your session at a reasonable time and duration.

- Crooked Tree Wellness Clinic will bill Medicaid for services.

Conditions of Treatment

I, ______________________________, agree to the following as conditions for my continued treatment at LTBB Crooked Tree Wellness Clinic:

I understand that should any alcohol and/or mood-altering chemicals be used at any time during the course of my treatment (except in such instances that the chemicals are being taken under the direction of a medical doctor), I can be discharged from this program or be referred to another program. Also, my referent can be informed of this chemical use/misuse/abuse.

NOTE – The rationale behind this condition is as follows:

1. Persons served who do not presently suffer from an alcohol or chemical related disorder should experience little difficulty with this restriction.
2. Those persons served with an addictive disorder need to abstain from all mood-altering chemicals and alcohol to arrest the progression of the substance use disorder.
3. This restriction is also included to ensure that a person served does not attend therapy while under the influence of alcohol or a mood-altering chemical, as this is not conducive to good assessment or therapy.

Expectations

- I am expected to be on time for all appointments. If an appointment cannot be kept, I am expected to contact Anishinaabe Life Services at least 24 hours prior to appointment. A cancellation received on the day of the appointment will constitute a missed appointment. A no call/no show or short notice (less than 24 hours) will constitute a missed appointment. Two missed appointments or short notice cancellations will be considered that the person served is no longer interested in receiving treatment from the program, will be discharged and referent informed.

- I am expected to give information (about myself) as clearly and honestly as possible. Persons served who intentionally give false information or misrepresent themselves may be discharged and referent informed.

- I am expected to respect the confidentiality of other persons served at this facility. Any person served who breaks the confidentiality of another person served may be discharged and referent informed.

- I am expected to maintain respect toward department staff and other persons served, and any aggressive behavior is grounds for discharge from the program and referent informed.

I hereby voluntarily give my consent for treatment at the LTBB Crooked Tree Wellness Center. I have read the expectations and/or have had them read to me, in a language I understand, and/or have had them explained to me. I have received my copy and I understand them and agree to abide by them.

______________________________ ______________________________

Signature of Person Served Date

LTBB Behavioral Health
Crooked Tree Wellness Clinic

Receipt of Recipient Rights and Statement of Confidentiality

I hereby certify by my signature below that I have provided with my copy of the KNOW YOUR RIGHTS brochure on recipient rights, the HIPPA Notice of Privacy Practices brochure, and the LTBB CTWC Client Rights form.

I understand that I have rights as a recipient of Behavioral Health services and that I can get more information about my rights from the Recipient Rights Advisor. I understand that if I have a grievance against my counselor/therapist, I must first attempt to resolve the grievance with my counselor/therapist. If it is not resolved to my satisfaction, I must meet with the Manager of LTBB Behavioral Health Services and attempt to resolve the grievance at that level. If it is still not resolved to my satisfaction, I will contact the Recipient Rights Advisor at Northern Michigan Regional Entity, 800-843-3393. I further understand that if I do not follow this chain of resolution for my grievance, the grievance is null and void, and I will need to start the process over if necessary.

I understand my rights and responsibilities as a recipient of Behavioral Health Serives and that I am willing to fulfill the responsibilities expected of me as a client at Crooked Tree Wellness Clinic. I have been given an opportunity to ask questions regarding my recipient rights.

I understand that Behavioral Health records are kept confidential and are protected by federal law. I have a right to request my records at any time. This request must be made in writing. If, however, for any reason LTBB/CTWC professionals feel that any information contained in my records are harmful to me or someone else, the program may decline the release of those records.

I understand that a Release of Information (ROI) must be signed for each family member or other outside entity that I wish to be involved in my treatment. I may revoke a signed release at any time by providing LTBB/CTWC written notice of this change.

I understand that Behavioral Health programs are an integrated model of care that addresses mental, physical, emotional, and spiritual health. Thus, there may be times when information is shared with physicians, psychologists, and spiritual healers to serve my needs.

Your therapist has an ethical and legal obligation to break confidentiality under the following circumstances:

a. If there is reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
b. If there is reason to believe that the client has serious intent to harm themselves or someone else, or to destroy property by a violent act.

c. It the therapist is directly informed by a pregnant cline that prenatal exposure to controlled substances has occurred that are potentially harmful to the fetus/baby.
d. If records are subpoenaed by a court of law.
e. If the client is having a medical emergency.
f. If the client's records are being audited by an accreditation or grant funding agency.

It is important to remember that electronic communication such as email, faxes, cell phone calls, and text messages are not guaranteed to be secure. Please keep this in mind when you use one of these forms of communication with program staff.

I certify that I have read and understand the Statement of Confidentiality. I agree to disclose personal information with this information in mind.

____ ________________

Client Signature Date

____ ________________

Parent/Guardian Signature Date

Crooked Tree
Wellness Clinic
2390 Mitchell Park Dr. Suite D
Petoskey, MI 49770
231.242-1760 (p)
978.367.5563 (f)

Cancellations, No Shows, and Late Arrivals

- CTWC requires a 24-hour notice for appointment cancellation. If this is not possible, you must notify CTWC of the need to cancel as soon as possible.

- Cancellations made within 24 hours of a scheduled appointment will be considered a late cancellation.

- Arriving 10 (or more) minutes past the given arrival time is considered a no-show. You will be asked to reschedule the appointment to another day.

- Repetitive no-shows and cancellation may result in termination of the patient-provider relationship.

Little Traverse Bay Bands of Odawa Indians
Crooked Tree Wellness Clinic
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ______________________________, hereby authorize LTBB Crooked Tree Wellness Clinic, it's Medical Director, or designated official to:

_________ release information to

_________ receive information from

the individual or organization and only under the conditions listed below.

Parties to exchange information:

____

____

Representative contact information:

____

____

Extent or nature of information to be exchanged (check all that apply): **(Client initials)**

☐ **Results of Urine Drug Screening, Plasma or Hair Drug Testing** __________

☐ **Assessment information, intake summary, diagnosis, recommendations** __________

☐ **Presence & progress in programming, attendance record, and engagement status** __________

☐ **Lab results, Genesight (or equivalent) testing results** __________

☐ **Medication History** __________

☐ **Additional specified information:** ____________________ __________

The purpose or need for such disclosure: ______________________________

____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Six (6) months after date signed or completion of treatment (specification of the date, event, or condition upon which this consent expires); form in which information can be released: written, verbal, or electronic.

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

__________ If initialed, this release allows two-way communication concerning the above-named individual.

______________________________ ______________
Client Signature Date

______________________________ ______________
Signature of parent, guardian, or authorized representative Date

______________________________ ______________
Witness signature Date

BDI-II

Name ______________________ Marital Status ____________ Date ____________

Occupation ______________________ Education __________ Age __________ Sex ____________

Date of Birth ____________ Clinician ______________________ HRN ____________

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. **Be sure that you do not choose more than one statement for any group,** including <u>Item 16</u> (Changes in Sleeping Pattern) or <u>Item 18</u> (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

[ ] Subtotal Page 1

Continued on Back

11. Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty
0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

☐ Subtotal Page 1
☐ Subtotal Page 2
☐ Total Score

Scores:	
1-10	These ups and downs are considered part of life
11-15	Borderline Depression
16-19	Mild Depression
20-29	Moderate Depression
30-39	Severe Depression
40+	Extreme Depression

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432-

HELPS BRAIN INJURY SCREENING TOOL

Person Served: ____________________ **Date:** ____________________

Agency/Screener's Name: LTBB Substance Abuse/Mental Health-

H Have you ever **H**it your **H**ead or been **H**it on the **H**ead? ☐ Yes ☐ No

Note: Prompt client to think about all incidents that may have occurred at any age, even those that did not seem serious: vehicle accidents, falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse, and also for service related injuries. A TBI can also occur from violent shaking of the head, such as being shaken as a baby or child.

E Were you ever seen in the **E**mergency room, hospital, or by a doctor because of an injury to your head? ☐ Yes ☐ No

Note: Many people are seen for treatment. However, there are those who cannot afford treatment, or who do not think they require medical attention.

L Did you ever **L**ose consciousness or experience a period of being dazed and confused because of an injury to your head? ☐ Yes ☐ No.

Note: People with TBI may not lose consciousness but experience an "alteration of consciousness." This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P Do you experience any of these **P**roblems in your daily life since you hit your head? ☐ Yes ☐ No

Note: Ask your client if s/he experiences any of the following problems, and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.

- ☐ headaches
- ☐ dizziness
- ☐ anxiety
- ☐ depression
- ☐ difficulty concentrating
- ☐ difficulty remembering
- ☐ difficulty reading, writing, calculating
- ☐ poor problem solving
- ☐ difficulty performing your job/school work
- ☐ change in relationships with others
- ☐ poor judgment (being fired from job, arrests, fights)

S Any significant **S**ickness? ☐ Yes ☐ No

Note: Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by medical conditions, such as: brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

Scoring the HELPS Screening Tool

A HELPS screening is considered positive for a *possible* TBI when the following 3 items are identified:

1. An event that could have caused a brain injury (yes to H, E or S), **and**
2. A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), **and**
3. The presence of two or more chronic problems listed under P that were not present before the injury.

Note:

- A positive screening is **not sufficient to diagnose TBI** as the reason for current symptoms and difficulties-other possible causes may need to be ruled out.
- **Some individuals could present exceptions** to screening results, such as people who do have TBI-related problems but answered "no" to some questions.
- Consider positive responses within the context of the person's self-report and documentation of altered behavioral and/or cognitive functioning

The original HELPS TBI screening tool was developed by M. Picard, D. Scarisbrick, R. Paluck, 9/91, International Center for the Disabled, TBI-NET, U.S. Department of Education, Rehabilitation Services Administration, Grant #H128A00022. The Helps Tool was updated by project personnel to reflect recent recommendations by the CDC on the diagnosis of TBI. See http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm.

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LTBB Behavioral Health
Crooked Tree Wellness Clinic

CONFIDENTIAL

HIV/AIDS Assessment Screening

Person Served: ______________________________ Date: ________________

Are you at risk for HIV/AIDS? Your healthcare provider is your best source for information and advice, but this assessment screening can help give you an overall idea of your risk level.

Complete the questions below:

1. Are you sexually active? ☐ YES ☐ NO
2. Do you have a sexually transmitted disease, such as syphilis, chlamydia, or gonorrhea?
   ☐ YES ☐ NO
3. Have you, even once, had unprotected sex with someone who was not proven to be HIV-negative? ☐ YES ☐ NO
4. Have you ever had sex while under the influence of alcohol or other drugs?
   ☐ YES ☐ NO
5. Do you use intravenous (injected) drugs?
   ☐ YES ☐ NO
6. Have you, even once, shared or reused a needle used by someone else?
   ☐ YES ☐ NO
7. Do you have contact in you work place, or elsewhere, with body fluids such as blood, semen, organs or tissue from other people and do not always take precautions when handling them?
   ☐ YES ☐ NO
8. Have you received a blood transfusion or other blood products prior to 1985?
   ☐ YES ☐ NO
9. Have you ever been tested for HIV?
   ☐ YES ☐ NO
10. If you answered "YES" to #9, do you know the results of that testing?
    ☐ YES ☐ NO

(Answering "YES" to 2 or more questions increases risk and possible need for referral)

Risk Assessment: ☐ LOW ☐ MODERATE ☐ HIGH

03/23 lmm

LTBB Behavioral Health
Crooked Tree Wellness Clinic

Confidentiality of Alcohol and Drug Abuse Person Served Records

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

1. The person served consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
4. The person served commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do no protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. 290dd-dd for Federal laws and 42 C.F.R. Part 2 for Federal regulations.)

I have received a copy of this form. I understand if I have any questions in regard to this form, I can contact the Manager of the LTBB Behavioral Health services.

______________________________ ______________
Signature of Person Served Date

______________________________ ______________
Signature of Parent/Guardian, if minor Date

03/23 lmm

LTBB Behavioral Health
Crooked Tree Wellness Clinic

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL

I, ____, hereby consent to communication between Crooked
(Name of Defendant/Person Served)

Tree Wellness Clinic and ____.
(Court, Probation, Parole, and/or Referring Agency)

The purpose of, and need for, the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my assessment, diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, monthly reports, drug/alcohol screen results, discharge summary, and ____

____.

I understand that this consent will remain in effect and cannot be revoked by me until:

☐ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

☐ ____
(specify other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. 2900dd--; 42 C.F.R. Part 2) and that recipients of this information may re-disclose it only in connection with their official duties.

____ ____________________
Defendant/Persons Served Signature Date

____ ____________________
Parent, Legal Guardian, or Authorized Representative Signature Date
if required

Person Served ID______________