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.

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

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 Head? ☐ 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 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/ibi_toolkit/physicians/mtbi/diagnosis.htm.

This document was supported in part by Grant 6 H21 MC 00039-03-01 from the Department of Health and Human Services (DHHS) Health Resources and Services Administration, Maternal and Child Bureau to the Michigan Department of Community Health. The contents are the sole responsibility of the authors and do not necessarily represent the official views of DHHS.

Biographical Information Form—Child

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____

Personal History

1) Child's Name: _____ 2) Age: _____ 3) Gender: __M __F

4) Weight: _____ 5) Height: _____ 6) Eye color: _____ 7) Hair color: _____ 8) Race: _____

9) Address _____
Street & Number City State Zip

10) Today's Date: _____ 11) Date of Birth: _____

12) Home Phone: _____ 13) Year in School _____

14) Has the child been involved in previous counseling?: ___Yes ___No
If Yes, please describe: _____

15) Why is the child coming to counseling?: _____

16) How long has this problem persisted (from #15)?: _____

17) Under what conditions do the problems usually get worse?: _____

18) Under what conditions are the problems usually improved?: _____

Medical History

19) Name and Address of Physician(s):
Physician's Name: _____
Address: _____
Street & Number City State Zip
Most Recent Physical Exam: _____ Results: _____

20) List any major illnesses and/or operations: _____

21) List any physical concerns occurring at present (e.g., high blood pressure, headaches, dizziness, etc.): _____

22) List any physical concerns (e.g., head trauma, seizures, etc.) experienced in the past:

23) On average how many hours of sleep does the child receive daily?: _____

24) Does the child have trouble falling asleep at night? ___Yes ___No
If Yes, how long has this been a problem? _____

25) Describe the child's appetite (during the past week):
_____ poor appetite _____ average appetite _____ large appetite

26) What medications (and dosages) are being taken at present, and for what purpose?: _____

Are your child's immunizations current? ___ Yes ___ No
Date of last immunizations _____

Family History

27) Mother's age:_____ If deceased, how old was the child when she passed away?: _____
28) Father's age:_____ If deceased, how old was the child when he passed away?: _____
29) If parents are separated or divorced, how old was the child then?: _____
30) Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____
31) Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____
32) Child number _____ being in a family of _____ children.
33) Is the child adopted or raised with parents other than biological parents?: ___ Yes ___ No
34) Briefly describe the child's relationship with brothers and/or sisters:
Biological siblings: _____

Step and/or half siblings: _____

Other: _____

35) What is the family relationship between the child and his/her custodial parents?
Check all that apply:

____ Single parent mother	____ Single parent father	____ Parents unmarried
____ Parents married, together	____ Parents divorced	____ Parents separated
____ With mother and stepfather	____ With father and stepmother	
____ Child adopted	____ Other, describe	

36) Is there a history or recent occurrence(s) of child abuse to this child? ____ Yes ____ No
If Yes, which type(s) of abuse? ____ Verbal ____ Physical ____ Sexual
Comments: _____

37) Parents' occupations: Mother _____ Father _____

38) Briefly describe the style of parenting used in the household: _____

Developmental History

39) Briefly describe any problems in the child's mother's pregnancy and/or childbirth:

40) Please fill in when the following developmental milestones took place:

Behavior	Age began	Comments
Walking	_____	_____
Talking	_____	_____
Toilet trained	_____	_____

41) List any drugs and/or alcohol used by mother or father at time of conception, or by mother during pregnancy:

42) Please rate your opinion of the child's development (compared to others the same age) in the following areas:

	Below Average	About Average	Above Average
Social	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Intellectual	_____	_____	_____
Emotional	_____	_____	_____
Hearing	_____	_____	_____
Vision			

For each type of development that you rated above as *below* average, please describe current areas of concern. Be specific.

43) List the child's three greatest strengths:
1) _____
2) _____
3) _____

44) List the child's three greatest weaknesses or needed areas of improvement:
1) _____
2) _____
3) _____

45) List the child's main difficulties at school:
1) _____
2) _____
3) _____

46) List the child's main difficulties at home:
1) _____
2) _____
3) _____

47) Briefly describe the child's friendships: _____

48) What report card grades does the child usually receive?: _____
Have these changed lately?: ___ Yes ___ No If Yes, how?: _____

49) Briefly describe the child's hobbies and interests: _____

50) Describe how the child is disciplined: _____

51) For what reasons is the child disciplined? _____

Behaviors of Concern

52) Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

1) Loses temper easily	___Never	___Rarely	___Sometimes	___Frequently
2) Argues with adults	___Never	___Rarely	___Sometimes	___Frequently
3) Refuses adults' requests	___Never	___Rarely	___Sometimes	___Frequently
4) Deliberately annoys people	___Never	___Rarely	___Sometimes	___Frequently
5) Blames others for own mistakes	___Never	___Rarely	___Sometimes	___Frequently
6) Easily annoyed by others	___Never	___Rarely	___Sometimes	___Frequently
7) Angry/resentful	___Never	___Rarely	___Sometimes	___Frequently
8) Spiteful/vindictive	___Never	___Rarely	___Sometimes	___Frequently
9) Defiant	___Never	___Rarely	___Sometimes	___Frequently
10) Bullies/teases others	___Never	___Rarely	___Sometimes	___Frequently
11) Initiates fights	___Never	___Rarely	___Sometimes	___Frequently
12) Uses a weapon	___Never	___Rarely	___Sometimes	___Frequently
13) Physically cruel to people	___Never	___Rarely	___Sometimes	___Frequently
14) Physically cruel to animals	___Never	___Rarely	___Sometimes	___Frequently
15) Stealing	___Never	___Rarely	___Sometimes	___Frequently
16) Forced sexual activity	___Never	___Rarely	___Sometimes	___Frequently
17) Intentional arson	___Never	___Rarely	___Sometimes	___Frequently
18) Burglary	___Never	___Rarely	___Sometimes	___Frequently
19) "Cons" other people	___Never	___Rarely	___Sometimes	___Frequently
20) Runs away from home	___Never	___Rarely	___Sometimes	___Frequently
21) Truant at school	___Never	___Rarely	___Sometimes	___Frequently
22) Doesn't pay attention to details	___Never	___Rarely	___Sometimes	___Frequently
23) Several careless mistakes	___Never	___Rarely	___Sometimes	___Frequently
24) Does not listen when spoken to	___Never	___Rarely	___Sometimes	___Frequently
25) Doesn't finish chores/homework	___Never	___Rarely	___Sometimes	___Frequently
26) Difficulty organizing tasks	___Never	___Rarely	___Sometimes	___Frequently
27) Loses things	___Never	___Rarely	___Sometimes	___Frequently
28) Easily distracted	___Never	___Rarely	___Sometimes	___Frequently
29) Forgetful in daily activities	___Never	___Rarely	___Sometimes	___Frequently
30) Fidgety/squirmy	___Never	___Rarely	___Sometimes	___Frequently
31) Difficulty remaining seated	___Never	___Rarely	___Sometimes	___Frequently
32) Runs/climbs around excessively	___Never	___Rarely	___Sometimes	___Frequently
33) Difficulty playing quietly	___Never	___Rarely	___Sometimes	___Frequently
34) Hyperactive	___Never	___Rarely	___Sometimes	___Frequently
35) Difficulty awaiting turn	___Never	___Rarely	___Sometimes	___Frequently
36) Interrupts others	___Never	___Rarely	___Sometimes	___Frequently
37) Problems pronouncing words	___Never	___Rarely	___Sometimes	___Frequently
38) Poor grades in school	___Never	___Rarely	___Sometimes	___Frequently
39) Expelled from school	___Never	___Rarely	___Sometimes	___Frequently
40) Drug abuse	___Never	___Rarely	___Sometimes	___Frequently
41) Alcohol consumption	___Never	___Rarely	___Sometimes	___Frequently
42) Depression	___Never	___Rarely	___Sometimes	___Frequently
43) Shy/avoidant/withdrawn	___Never	___Rarely	___Sometimes	___Frequently
44) Suicidal threats/attempts	___Never	___Rarely	___Sometimes	___Frequently
45) Fatigued	___Never	___Rarely	___Sometimes	___Frequently
46) Anxious/nervous	___Never	___Rarely	___Sometimes	___Frequently
47) Excessive worrying	___Never	___Rarely	___Sometimes	___Frequently
48) Sleep disturbance	___Never	___Rarely	___Sometimes	___Frequently
49) Panic attacks	___Never	___Rarely	___Sometimes	___Frequently
50) Mood shifts	___Never	___Rarely	___Sometimes	___Frequently

53) For each of the behaviors noted on the previous page as occurring FREQUENTLY, or if it causes significant impairment, write a brief description of how it impacts the child's or other people's lives. Give examples. Use the back of this page as needed.

Behaviors of Concern	Impact on Child or Others

54) Briefly describe the child's ways of expressing the following emotions or behaviors:

ANGER: _____

HAPPINESS: _____

SADNESS: _____

ANXIETY: _____

55) List the child's behaviors that you would like to see change: _____

56) Additional information you believe would be helpful: _____

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO
THIS OFFICE AT LEAST TWO DAYS BEFORE THE NEXT APPOINTMENT.