LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

WAIVER OF LIABILITY

I, _____, acknowledge the contagious nature of
(printed name)
the Coronavirus/COVID-19 and that the Center for Disease Control (CDC) and other public health authorities still recommend practicing social distancing. I am the parent/guardian of _____ and have the legal authorization to
(printed name)
sign on their behalf.

I acknowledge that Livingston County Catholic Charities (LCCC) has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that LCCC cannot guarantee that I, or my family member, will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself or others, including, but not limited to, LCCC employees, other program clients or their families. If appropriate, I have been made aware of other service delivery options, such as telephone, Zoom or referral.

I voluntarily seek services provided by LCCC and acknowledge that I am increasing my risk, or the risk of my participating family member, to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all organizational procedures to reduce the spread while attending my appointment. I attest that I or my participating family member:

- Are not experiencing any symptoms of illness such as cough, shortness of breath or other difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- Have not traveled internationally within the last 14 days.
- Have not traveled to a highly impacted area within the USA in the last 14 days.
- To the best of our knowledge, have not been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- Have not been diagnosed with Coronavirus/Covid-19 and not yet been cleared as non-contagious by state or local public health authorities.
- Are following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Livingston County Catholic Charities harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the program, or that may otherwise arise in any way in connection with any services received from LCCC. I understand that this release discharges LCCC from any liability or claim that I, my heirs, or any personal representatives may have against the program with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from LCCC. This liability waiver and release extends to the program together with all partners, and LCCC employees.

_____ _____
Signature Date

_____ _____
LCCC Signature Date

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

PARENT/GUARDIAN PERSONAL HISTORY FORM FOR CHILD/ADOLESCENT (Ages 17 & Under)

TO BE FILLED OUT BY THE PARENT OR GUARDIAN. THE INFORMATION THAT YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE DIFFICULTY WITH ANY OF THE QUESTIONS, YOUR CHILD'S THERAPIST WILL REVIEW THEM WITH YOU. THANK YOU!

Child's Name: _____ Age: _____ Date: _____

Person completing form for client: _____ Relationship to Client: _____

The following information is needed for data collection purposes only, and is a requirement of various funding sources. We would very much appreciate your answers, so that we can supply data reports to our funders. **Please check one.** Thank You.

Race/Ethnicity: ☐ Caucasian ☐ Asian ☐ African-American ☐ Hispanic ☐ Other ethnic minority

Religious Affiliation: ☐ Catholic ☐ Protestant ☐ Baptist ☐ Lutheran ☐ Episcopal ☐ Methodist ☐ Presbyterian ☐ 7th Day Adventist ☐ Christian ☐ Other ☐ None

Please take your time and complete this entire form. The information that you give us will help your therapist understand your child better. You may also use the back of this form if necessary. Thank you!

	FULL NAME	AGE	LIVING WITH YOU?	IF DECEASED, YEAR & CAUSE
CHILD'S MOTHER:				
CHILD'S FATHER:				
STEP-MOTHER:				
STEP-FATHER:				
BROTHERS & SISTERS: (INCLUDE STEP & HALF)				

Who else lives with you other than the ones checked above?

Child was raised by? _____

PROBLEM: Describe the problems the child is having (behaviors, feelings, attitudes, school performance, etc.):

_____

_____

_____

_____

What is the main problem that you are bringing your child in for? _____

How long has he/she been having these problems? _____

Why do you think your child is having these problems? _____

Whose idea was it to have your child brought to this clinic? _____

What would you or they like to see done for this child? _____

Describe how your child's problems affect you, other family members and others: _____

_____

SYMPTOMS: Check all the number of all items that apply to you now or within past month

- ☐ 1. Speech difficulties
- ☐ 2. Nervous habits/behavior
- ☐ 3. Frequent headaches
- ☐ 4. Frequent stomach aches
- ☐ 5. Sleep disturbance
- ☐ 6. Difficulty making friends
- ☐ 7. Difficulty keeping friends
- ☐ 8. Little interest in friends
- ☐ 9. Little interest in activities
- ☐ 10. Disrespectful/argumentative
- ☐ 11. Temper tantrums
- ☐ 12. Ignores rules/chores
- ☐ 13. Defies authority
- ☐ 14. Threatening behavior
- ☐ 15. Gets in frequent fights
- ☐ 16. Throws/breaks things
- ☐ 17. Hurts animals
- ☐ 18. Sets fires
- ☐ 19. Steals
- ☐ 20. Lacks guilt/remorse
- ☐ 21. Lies a lot
- ☐ 22. Breaks curfew often
- ☐ 23. Runs away
- ☐ 24. Skips school
- ☐ 25. Doesn't complete schoolwork
- ☐ 26. Has problematic friends
- ☐ 27. Underactive
- ☐ 28. Overactive
- ☐ 29. Acts before thinking
- ☐ 30. Short attention span
- ☐ 31. Unable to sit still
- ☐ 32. Clowns a lot
- ☐ 33. Accident prone
- ☐ 34. Sucks thumb
- ☐ 35. Wets in bed
- ☐ 36. Wets/soils clothes
- ☐ 37. Bangs head
- ☐ 38. Grinds teeth
- ☐ 39. Separation problems
- ☐ 40. Worries a lot
- ☐ 41. Afraid/fearful
- ☐ 42. Seems insecure
- ☐ 43. Withdrawn
- ☐ 44. Shy
- ☐ 45. Sad/depressed
- ☐ 46. Cries frequently
- ☐ 47. Won't sleep in own bed
- ☐ 48. Seems too serious
- ☐ 49. Secretive
- ☐ 50. Looks "high" often
- ☐ 51. Keeps to him/herself
- ☐ 52. Avoids family activities
- ☐ 53. In his/her own world
- ☐ 54. Imaginary friends
- ☐ 55. Unusual behavior
- ☐ 56. Mentally slow
- ☐ 57. Nightmares
- ☐ 58. Acts spoiled
- ☐ 59. Too interested in sex
- ☐ 60. Disorganized/messy

Please explain the most important items that you circled: _____

_____

_____

_____

Has your child ever expressed a wish that he or she were dead?_____How recently? _____

Has your child ever threatened or attempted to seriously harm self or others?_____

Please explain (How, why):_____

INTERESTS/ACTIVITIES: (Check all that apply to you)

☐ Watch television	☐ Play sports	☐ Paint	☐ Skate	☐ Baby-sit
☐ Be with friends	☐ Ride bicycle	☐ Draw	☐ Write	☐ Imaginary play
☐ Play video games	☐ Roller blade	☐ Read	☐ Scouting	☐ Action figures
☐ Listen to music	☐ Build things	☐ Sing	☐ School	☐ Dolls
☐ Talk on telephone	☐ Collect things	☐ Dance	☐ Crafts	☐ Sew/knit

Other interests/activities:_____

Has your child lost interest in activities that he/she normally enjoyed? _____

EMPLOYMENT: Where does your child work? _____Hours per week: _____

Employment/training/work hours of each parent or guardian:

You: _____

Your spouse or partner:_____

LEGAL HISTORY (Describe any legal problems that your child has had in the past or present):

_____

EDUCATION: Name of school: _____ Grade: _____

School Address: _____ Phone: _____

Teacher: _____ Counselor: _____

Is this child in any special classes? _____ Since what grade? _____

Does child have any learning disabilities? _____

Has child repeated any grades? _____ Which ones? _____

Describe child's attendance: _____

Describe effort/attitude toward school: _____

Describe child's behavior in school: _____

Describe academic performance: _____

When did school behavior or academic performance change? _____

Why do you think it changed? _____

Education of each parent or guardian: _____

_____

ETHNIC/CULTURAL BACKGROUND (Child's): _____

RELIGIOUS/SPIRITUAL BACKGROUND (Child's): _____

SEXUAL/GENDER ISSUES (describe any sexual concerns or gender concerns you might have):

_____

PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

OUTPATIENT: Has your child seen a therapist or counselor for personal or family problems or alcohol/

Drug treatment? _____ When, where? _____

Reason:_____

INPATIENT: Has your child been in hospital or residential treatment for personal problems or alcohol/drug

Problems? ____ When, Where?_____

_____

Reason:_____

Were any of your child's treatment experiences helpful? ___ _____

What medications was your child prescribed for emotional or behavioral problems? _____

_____

Which of those medications were helpful? _____

List any of child's relatives (parents, grandparents, aunts, uncles, cousins, brothers, and sisters) who have

been hospitalized for personal or substance abuse problems:

Who, when, where?_____

_____

_____

PHYSICAL HEALTH: Child's Physician: _____

Physician's Address: _____ Phone: _____

Date child last saw physician: _____ Reason: _____

Results of Physicians visit/tests: _____

Medications child is on: _____

Immunizations up to date? _____

Child's Height: _____ Weight: _____ Appetite: _____ Recent weight gain? _____ Loss? _____

Does child ever over-eat? _____ Binge? _____ Purge? _____ Energy /activity level: _____

Food or medication allergies: _____

If your child had any serious illnesses, injuries, surgeries or medical hospitalizations, please explain:

_____

_____

_____

DEVELOPMENTAL HISTORY:

Was your pregnancy desired? _____

Was this child born after a normal pregnancy and delivery?_____

Did this child meet developmental milestones (walking, talking, etc.)?_____

_____

Were there any parent/child separations?_____

Were there any major family stressors during childhood?_____

_____

Describe the child as an infant and toddler: _____

_____

Adolsescent Males: Age the child's voice changed: _____ Age that child developed body hair:_____

Adolescent Females: Age of first menstruation:_____ Age developed breasts:_____

FAMILY RELATIONSHIPS: How do you get along with your child? _____

How does your spouse/partner get along with your child? _____

If one or both of child's parents are out of the home, describe each one's current relationship with child:

Father: _____ Mother: _____

How does child get along with brothers & sisters? _____

RULES/RESPONSIBILITIES/CONSEQUENCE:

How does child deal with rules, responsibilities, and chores? _____

Does child obey curfew? _____ Has child threatened/attempted to run away or stay out all night? _____

How do you deal with your child's misbehavior? _____

How does your spouse/partner deal with child's misbehavior? _____

Do you or your spouse/partner believe in physical discipline? _____

Has the family ever been involved with Protective Services? _____

Are there any situations at home that might have an effect on child's behavior? _____

_____

Drinking/drug usage: If child drinks or uses drugs, Please also complete the following questionnaire:

Type of drug	Age of first use	At what ages were you using it regularly	Average number of days used each week	Usual amount used on an average day	Number of days used in past 30 days	Amount used in the last 48 hours	Date you last used
Coffee, Cola, Caffeine pills							
Beer, wine							
Liquor							
Marijuana							
Crack cocaine							
Cocaine powder							
Heroin: Shoot(IV)							
Methadone							
Pain pills: type							
Codeine: Tylenol 3, 4 other							
Muscle relaxers: Soma, Flexural, Other							

Tranquilizers: Valium, Librium, Other							
Glue, poppers, aerosol							
Type of drug	Age of first use	At what ages were you using it regularly	Average number of days used each week	Usual amount used on an average day	Number of days used in past 30 days	Amount used in the last 48 hours	Date you last used
Metha-amphetamine, Speed, Ritalin							
Phenobarbital sleeping pills							
Steroids:							
Aerosol:							
PCP, LSD, Mescaline:							

Other:							
Other:							

Parent/Guardian Signature: _____ Date: _____

Therapist/Credentials:_____ Date: _____

Consultant/Psychiatrist:_____ Date: _____

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

ADOLESCENT SELF-REPORT HISTORY

(Ages 13-17)

Date: _____

Client's Name: _____Age: _____Birthdate: _____
Clients Address: _____ Zip Code:_____
Client Telephone #: Home_____Work_____Other_____

Name of parent of Guardian who brought you:_____

Was it your idea to come here? _____ If not, whose idea was it? _____

Why do you think you are coming here?_____

How do you feel about coming here?_____

What do you think your family will say the problem is?_____

What do you think the real problem is?_____

What do you like about yourself? _____

What do other people like about you? _____

What don't you like about yourself? _____

What don't other people like about you? _____

_____

Name the three things in your life that upset or bother you the most:

_____

_____

_____

SYMPTOMS: Check the number of all items that apply to you now or within past month

- ☐ 1. Depression
- ☐ 2. Crying Spells
- ☐ 3. Hopelessness
- ☐ 4. Relationship problems
- ☐ 5. Relationship breakup
- ☐ 6. Loneliness
- ☐ 7. Emptiness
- ☐ 8. Loss of appetite
- ☐ 9. Sleep Disturbance
- ☐ 10. Nightmares
- ☐ 11. Hearing voices
- ☐ 12. Feeling controlled
- ☐ 13. Feeling talked about
- ☐ 14. Seeing things others don't
- ☐ 15. Unusual thoughts
- ☐ 16. Increased alcohol use
- ☐ 17. Increased drug use
- ☐ 18. Blackouts/memory loss
- ☐ 19. Withdrawal symptoms

LOSS OF CONTROL IN:

- ☐ 20. Alcohol use
- ☐ 21. Drug or medication use
- ☐ 22. Food bingeing
- ☐ 23. Purging
- ☐ 24. Yelling
- ☐ 25. Hitting
- ☐ 26. Endangering others
- ☐ 27. Endangering self
- ☐ 28. Gambling
- ☐ 29.Spending
- ☐ 30. Nervous/anxious
- ☐ 31. Panic attacks
- 32. Can't concentrate
- 33. Confusion
- 34. Mood swings
- ☐ 35. Racing thoughts
- ☐ 36. Fear of dying
- ☐ 37. Job stress
- ☐ 38. Decreased activity
- ☐ 39. Decreased self-care
- ☐ 40. Not seeing friends
- ☐ 41. Guilt/shame
- ☐ 42. Financial worries
- ☐ 43. Sexual problems
- ☐ 44. School problems

INTERESTS/ACTIVITIES (What do you enjoy doing?):

- ____ Watch television
- ____ Movies/videos
- ____ Play video games
- ____ Listen to music
- ____ Talk on phone
- ____ Sing
- ____ Dance
- ____ Draw
- ____ Build Things
- ____ Write
- ____ Read
- ____Play instrument
- ____ Be with friends
- ____ Be with girlfriend
- ____ Be with boyfriend
- ____ Be with family
- ____ Be by myself
- ____ Go shopping
- ____ Get into trouble
- ____ Just about anything
- ____ Pray
- ____ Church activities
- ____ Sew, knit, embroider
- ____ Scouting
- ____ Eat
- ____ Sleep
- ____ Get into fights
- ____ Exercise/workout
- ____ School sports
- ____ Street sports
- ____ Cheer-leading
- ____ Other school activities
- ____ Drink
- ____ Get high
- ____ Diet
- ____ Baby-sit

What else do you enjoy doing? _____

Are there activities that you would like to do but are afraid to do? _____

Have you lost interest in activities that you normally enjoy? _____

What do you hate doing? _____

What makes you feel happy?_____

What makes you feel angry? _____

What makes you feel sad? _____

What makes you feel scared? _____

What do you worry about? _____

What keeps you from feeling happy? _____

What do you wish could be different in your life? _____

Do you ever think about running away or going to live with someone else? _____

Do you ever wish that you were dead or that you were never born? _____

Have you ever thought of seriously hurting or killing yourself? _____ When? _____

Have you ever attempted to seriously hurt or kill yourself? _____ When? _____

What did you do? _____

Have you ever felt that someone in your family wanted to get rid of you? _____ Who? _____

Do you get bullied by other kids? _____ Rejected by other kids? _____

Have you ever thought of seriously hurting another person or animal? _____

Have you ever actually hurt another person or animal? _____

Do you like to set fires? _____ Are you in a gang? _____ Ever carry a weapon? _____

LEGAL: Have you ever gotten into trouble with the law? _____ How many times? _____

How did you get in trouble? _____ Were you ever placed on probation? _____

COUNSELING: Have you ever seen a counselor for personal or family problems or school problems?_____ Where, when? _____

Why did you see a counselor? _____

SCHOOL: How do you feel about going to school? _____

Are you having any problems with your schoolwork? _____

How much effort do you make in your classes and on your homework to get good grades? _____

Do you skip many classes? _____ What do you do when you skip classes? _____

Are you expecting to pass all of your classes this semester? _____

Do you get along with your teachers? _____ With your classmates? _____

Are you having any other problems in school? _____

EMPLOYMENT: Where do you work? _____ How many hours a week? _____

RELIGIOUS/SPIRITUAL:

Do you have religious or spiritual beliefs? _____ Do you go to church or synagogue?_____

Do you pray? _____ Do you have any religious concerns? _____

SEX: Are you sexually active? _____ Do you use protection? ____

When was your first sexual experience? _____

Do you have any sexual problems or worries? _____

DRINKING/DRUG USAGE:

Do you smoke cigarettes? _____ Since what age? _____ How many a day? _____

Did you ever get high? _____ At what age? _____

What did you get high on? _____

What do you drink or use now? _____ How many days a week? _____

How much (amount) do you drink or use now?_____

How much have you drunk or uses in the last 2 days? _____

If you drink or use drugs, do your parents know? _____

What do they think, or what would they think about you drinking or getting high? _____

Do you think you need help with your drinking or drug usage? _____

FAMILY/RESPONSIBILITIES/RELATIONSHIPS:

Who are you closest to in your family? _____

Who don't you get along with in your family? _____

Why don't you get along? _____

What chores do you have to do at home? _____

Do you do them willingly? _____

Do you obey the rules at home? _____ Do you think the rules are fair? _____

What do your parents do when you break the rules or neglect your chores? _____

Are you having any problems with your family? _____

Are you having any boyfriend or girlfriend problems? _____

CLIENT SIGNATURE: _____ DATE: _____

THERAPIST/CREDENTIALS: _____ DATE:_____

CONSULTANT/PSYCHIATRIST SIGNATURE: _____ DATE: _____

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW 2020 E. Grand River, Suite 104, Howell, MI 48843 (517) 545-5944 Fax: (517) 545-7390

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMTION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the personal and mental health privacy of all persons served by Livingston County Catholic Charities. All of our employees, contractors, and volunteers are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected social and mental health information for purposes of treatment, payment or practice operations only with your written consent. For example, we may contact your primary care physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to child protection and law enforcement authorities, courts and administrative tribunals, purchasers or service, licensing or accrediting bodies.

With your consent, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Your have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected information and to provide you with notice of our legal duties and privacy practices with respect to protected information.

We are required to abide by the terms of the most current notice in effect.

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice in person or by mail prior to the date of any changes.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

For more information about this notice, please contact: John Furey, Clinical Director

This notice is effective April 14, 2003.
The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

_____	_____	_____
Client/Guardian Signature	Address/City/State/Zip	Date

Provider Name & Address:

LIVINGSTON COUNTY CATHOLIC CHARITIES
2020 E. Grand River Ave . Sui te 104 Howe ll, MI 48843

Patient's Name:________________________________ **Date of Birth:**____/____/____

INITIAL

____

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORIVIATION: We are committed to protecting the personal and mental health privacy of all persons served by Livingston County Catholic Charities. All of our employees, contractors, and volunteers are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected social and mental health information for purposes of treatment, payment or practice operations only with your written consent. You may revoke your consent or authorization any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect. We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to child protection and law enforcement authorities, courts and administrative tribunals, purchasers of service, licensing, quality control or accrediting bodies. **You have the right to:** access and amend your information, request an accounting of any disclosures , request restrictions on use and disclosure of your information, request a copy of tris Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

With your consent, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

We are required by law to maintain the privacy of protected information and to provide you with notice of our legal duties and privacy practices with respect to protected information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice in person or by mail prior to the date of any changes. If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint. For more information about this notice, please contact: John Fuery, Clinical Director(517-545-5944).

__________ **Insurance/Grant Authorization to Release Information:** I authorize the release of any medical or other information necessary to process my insurance claims.

__________ **Insurance/Grant Authorization to Pay:** I authorize payment of medical benefits to the above Physician or Supplier for services provided. *I understand that any unpaid insurance balance is my responsibility. It is YOUR responsibility to know your Insurance Policy including exclusions, deductibles and copayments.*

__________ **ACKNO WLEDGMENT: RECEIPT OF CLIENT RIGHTS AND RESPONSIBILITIES POLICY.**
Client acknowledges that they have received, read, and understand the Client Rights and Responsibilities Policy provided.

__________ **Acknowledgement: Receipt of Livingston County Catholic Charities Faith - Based Notice**

__________ **CONFIDENTIALITY NOTICE:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature to verify Initials _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DATE _ _ _ _ _
Patient or Guardian if patient is a min or

Therapist Signature:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DATE_ _ _ _ _

Problem Gambling Institute of Ontario

camh
Centre for Addiction and Mental Health

The NODS-CLiP*
Short Problem Gambling Screen

Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?

☐ Yes ☐ No

Have you ever tried to stop, cut down, or control your gambling?

☐ Yes ☐ No

Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?

☐ Yes ☐ No

If "Yes" to one or more questions, further assessment is advised.

* Volberg, R. A., Munck, I. M., & Petry, N. M. (2011). A quick and simple screening method for pathological and problem gamblers in addiction programs and practices. *The American Journal on Addictions*, 20, 220–227.

LIVINGSTON COUNTY CATHOLIC CHARITIES
Primary Care Physician (PCP) Communication Form

Consent to Exchange Information (to be completed by client) **Client Number:** _____

I,_____, Date of Birth_____, Social Security #_____XXXXXXX_____ *(optional)*

[CHECK ONE OF THE FOLLOWING]

☐ **Will Notify My Doctor Myself**

☐ **Do Not Authorize Communication With My Doctor**

☐ **Authorize** LIVINGSTON COUNTY CATHOLIC CHARITIES, its Director or designee, or clinical counselor to exchange information regarding my Mental Health/Substance Abuse treatment and Medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care/substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

Primary Care Physician Name _____

Address:_____ City:_____ State:_____Zip_____

Phone Number:_____

_____ _____
Client's Signature ***Date***

_____ _____
Signature of parent or guardian (if Client is a minor) *Date*

_____ _____
Witness ***Date***

****

Provider Information (to be completed by the provider)
LIVINGSTON COUNTY CATHOLIC CHARITIES
2020 East Grand River, Suite 104, Howell, MI 48843 (517) 545-5944 FAX: (517) 545-7390

DSM IV Diagnosis code & name_____

Treatment Plan: Type _____Frequency_____Est length of Tx_____
(i.e. ind, family, group, meds) (I.e. weekly, etc)

Medication(s) Prescribed or Changed: _____

_____

Comments: _____

_____

_____
Clinician Signature **Telephone Number**

NOTICE: This information has been disclosed to you from Records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGNIAL IN THE CLIENT'S CHART

Date Sent:_____ **By:**_____

LIVINGSTON COUNTY CATHOLIC CHARITIES

Client Number:_____

IMPORTANT NOTICE TO ALL CLIENTS

IT IS **YOUR** RESPONSIBILITY TO KNOW YOUR INDIVIDUAL INSURANCE POLICY. MANY INSURANCE POLICIES HAVE EXCLUSIONS, AND MOST HAVE DEDUCTIBLE AND CO-PAYMENTS. SOME INSURANCE POLICIES MAY NOT BE COVERED BY OUR SERVICES.

IT IS IMPORTANT FOR **YOU** TO CHECK WITH YOUR INSURANCE CARRIER TO DETERMINIE IF THE PROVIDER YOU ARE SEEING IS LISTED AS AN "IN NETWORK" PROVIDER. IF THEY ARE NOT LISTED AS AN "IN NETWORK" PROVIDER, YOU MAY HAVE A HIGHER DEDUCTIBLE OR CO-PAYMENT.

REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR ANY AND ALL BILLS NOT COVERED BY YOUR INSURANCE POLICY.

_____ _____

Signature of Patient and/or Guardian Date

_____ _____

Therapist Signature and Credentials Date

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

ASSIGNMENT OF BENEFITS

Provider Name: LIVINGSTON COUNTY CATHOLIC CHARITIES

Provider Address: 2020 E. Grand River Ave. Suite 104
Howell, MI 48843

Patient's Name: _____

Patient's Date of Birth: ____/____/_____

Authorization to Release Information:

I authorize the release of any medical or other information necessary to process my insurance claims.

Date: ____/____/_____ Signed _____
Patient or Guardian if patient is a minor

Authorization to Pay:

I authorize payment of medical benefits to the above Physician or Supplier for services provided. I understand that any unpaid insurance balance is my responsibility.

Date: ____/____/_____ Signed _____
Patient or Guardian if patient is a minor

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

2020 East Grand River, Suite 104, Howell, MI 48843 (517) 545-5944 FAX: (517) 545-7390

AUTHORIZATION AND RELEASE OF INFORMATION

I, _____, Date of Birth: _____ SSN: _____N/A_____

Authorize Livingston County Catholic Charities to ____ Release, _____ Obtain, and/or _____Exchange protected information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, and communicable and infectious disease as directed by the Michigan Department of Public Health Code 1989, No. 174. The content of the information to be released is confined to that specified below.

I understand that authorizing the request/disclosure of information in my records is voluntary, and that my services will not be affected if I choose not to sign this form.

Other Name under which record may be filed: _____

Name of person/organization:

Name: _____ Relationship: Insurance Company

Address: _____ City/State _____ Zip Code: _____

Phone Number: ( ) _____ FAX: ( ) _____

Specific type of information to be disclosed:

____ Psychosocial History/Evaluation	____ Aftercare plan	____ HIV/AIDS Related
____ Initial Assessment/Diagnosis	____ Psychiatric Evaluation	____ Medications
____ Dates of Treatment	____ Psychiatric Treatment	____ Lab Results
____ Treatment Plan	____ Psychological Testing Information	____ Urine screens, Breathalyzer
____ Individual Progress	____ Physical Exam	____ Leave a message
____ Group Progress	____ School Records (Specify) _____	
____ Discharge Information/Summary	__x_ Other: __Billing Purposes_____	

The purpose and need of such disclosure:

___ Coordination of Care	___ Employment/Job Stability	___ Medication Review	___ Treatment Transfer
___ Family Contact	___ Legal (PO/Court/Attorney)	___ School Requirements	___ Personal Records
___ Comprehensive Treatment	___ Aftercare Planning	___ Continuation of Care	

_x_ Other (specify): ___Billing Purposes

Revocation of Authorization

This authorization may be revoked in writing at any time except to the extent that information has already been released or disclosed. Without expressed revocation this authorization expires after one year or sooner for any one or more of the following:
A. Date: _____ B. Event: _____ C. Condition: _____

I understand that my protected health information disclosure under this Authorization may be subject to redisclosure by the individual or organization named above; and its privacy may no longer be protected by Federal Confidentiality Laws.

Client Signature _____ Date: _____

Parent/Guardian _____ Date: _____
(Legal papers must accompany in the case of guardianship)

Witness Signature: _____ Date: _____

LIVINGSTON COUNTY
CATHOLIC
CHARITIES
HELPING LIVES GROW

2020 East Grand River, Suite 104, Howell, MI 48843 (517) 545-5944 FAX: (517) 545-7390

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____ Treatment Plan	____ Psychological Testing Information	____ Urine screens, Breathalyzer
____ Individual Progress	____ Physical Exam	____ Leave a message
____ Group Progress	____ School Records (Specify) _____	
____ Discharge Information/Summary	__x_ Other: __Emergency Information_____	

The purpose and need of such disclosure:

___ Coordination of Care	___ Employment/Job Stability	___ Medication Review	___ Treatment Transfer
___ Family Contact	___ Legal (PO/Court/Attorney)	___ School Requirements	___ Personal Records
___ Comprehensive Treatment	___ Aftercare Planning	___ Continuation of Care	

_x_ Other (specify): ___In Case of Emergency

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(Legal papers must accompany in the case of guardianship)

Witness Signature: _____ Date: _____

LIVINGSTON COUNTY CATHOLIC CHARITIES
HELPING LIVES GROW

LIVINGSTON COUNTY CATHOLIC CHARITIES
CLIENT DEMOGRAPHIC DATA
(TO BE FILLED OUT AT INTAKE)

PLEASE FILL OUT ALL SECTIONS OF THIS SURVEY. THIS INFORMATION IS USED STRICTLY FOR FULLFILLING AGENCY CONTRACTUAL REPORTING REQUIREMENTS AND **WILL NOT** BE PLACED IN YOUR RECORD.☐

PROGRAM:
☐ COUNSELING ☐ SUBSTANCE ABUSE COUNSELING ☐ ROSC

GENDER: ZIP CODE: _____
☐ MALE ☐ FEMALE ☐ OTHER

ETHNICITY:
☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN ☐HISPANIC ☐WHITE ☐NATIVE AMERICAN
☐PACIFIC ISLANDER/ASIAN ☐OTHER

AGE:
☐ 0-4 ☐ 5-12 ☐13-17 ☐ 18-34 ☐35-59 ☐60+ ☐ UNKNOWN

EDUCATION:
☐ NO COMPLETION OF HS ☐HS/GED ☐SOME COLLEGE ☐4 YR DEGREE ☐ MASTERS

MARITAL STATUS:
☐ SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

HOUSEHOLD INCOME:
☐0-13,690 ☐ 13,691-20,535 ☐ 20,536-27,380 ☐27,381-41,070
☐ 41,071-54,760 ☐54,761-82,140 ☐ 82,141-UP

RELIGION:
☐CATHOLIC ☐ EPISCOPAL ☐ JEWISH ☐ PRESBYTERIAN ☐ METHODIST ☐ BAPTIST
☐ LUTHERAN ☐ NONE ☐ OTHER CHRISTIAN ☐ OTHER

REFERRAL STATUS:
☐ INSURANCE ☐ FAMILY ☐FRIEND ☐ CMH ☐ DHS ☐ SCHOOL ☐ COURT ☐ DOCTOR
☐ CHURCH ☐ADVERTISING ☐SELF ☐ FORMER CLIENT