Client Name: _____ Client #: _____

Children's Department Family Systems Approach

The Children's Department at the Center for Life Management works under the framework of a Family Systems Approach. This means that a child's parent(s) or guardian(s) are expected to be involved in the treatment that the child receives at our agency. We believe that the parents/guardians are the link between what has been successful in the past, what is happening right now, and what will best support your child's well-being and future.

The expectations of a Family Systems Approach include the following:

1. Therapy appointments will be provided weekly or bi-weekly depending on your family's needs. Therapy may be provided in person or through video telehealth.

2. The parent(s) or guardians(s) will bring the child to their appointment and will remain in our waiting area for the duration of the appointment. This will allow the therapist or medical provider to have you be a part of the session when appropriate and required.

3. Parent(s) or guardian(s) will be part of the therapy sessions at the beginning or end of each session, or both, depending on the client's needs. This will allow a review of the goals, treatment planning, homework assignment and progress.

4. Parent(s) or guardian(s) may be asked to participate in family therapy with their child or to meet with the therapist without the child during treatment at Center for Life Management.

Your participation is vitally important because you know your child best and we value you as an equal partner, along with your child and their treatment providers, to best meet the needs of your family.

We welcome your feedback and support as we work to improve our service delivery.

Parent/Guardian Signature_____ Date_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*** All sections on authorization form must be completed in order to be valid***

Client Name: _____ **DOB:** _____ **Case #:** _____

I hereby authorize Center for Life Management (CLM) to ☐ **Obtain from** ☐ **Disclose to** ☐ **or Exchange my protected health information including psychiatric/mental health information with:**

Name: _____ ☐ Check if PCP

Address: _____ ☐ Request Records

Phone: _____ Fax: _____ ☐ Send Records

Information to be released / obtained / exchanged (check all that apply):

**please note information to be disclosed is limited to the minimum necessary for the purpose stated below.*

☐ Intake / Assessment ☐ Psychiatric Evaluation / MD Consults ☐ Treatment / Service Plan ☐ Labs

☐ Progress Notes ☐ Complete Record ☐ Other (specify) _____

Dates of treatment: _____ to _____ or ☐ Check here for all dates of treatment

- *I understand that I may inspect or obtain a copy of the protected health information described by this authorization.*
- *I understand that I may revoke this authorization at any time by notifying CLM in writing. However, revocation does not cover information that was received or disclosed prior to CLM receiving revocation.*
- *I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.*
- *I understand that Center for Life Management (CLM) shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.*
- *For cases where parents share joint custody; at the discretion of CLM, records released to one parent with joint custody may be disclosed to the other parent without specific request.*

I AUTHORIZE CLM TO RELEASE / OBTAIN THE FOLLOWING INFORMATION:

PLEASE INITIAL AS APPROPRIATE

_____ **Alcohol and/or Drug Treatment Information** (I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.)

_____ ***PLEASE NOTE:** When client is 12 yrs or older and seeking substance abuse treatment independently, client's initials only are needed.

_____ **HIV Related Information** (I understand that I have the right to refuse release.)

The purpose of the release is(Specify): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

To receiving provider: This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. 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 42 C.F. R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ON THE CONCLUSION OF YOUR TREATMENT.

Center for Life Management (CLM) - Medical Records Department
10 Tsienneto Road, Derry, NH 03038 - Phone: (603) 434-1577 - Fax: (603) 965-0227

CENTER FOR LIFE MANAGEMENT CLIENT RIGHTS STATEMENT

As a client of Center for Life Management, you have rights that will be respected and maintained. Your most important right is the right to know what your rights are and the right to complain when you believe that your rights have been violated. No client shall be deprived of any legal right to which all citizens are entitled solely by reason of their admission to the mental health services system. Some of these rights are outlined below. If you would like a complete copy of the State regulation that governs these rights, please ask a staff member for a copy of He-M 309: Rights of Persons Receiving Mental Health Services in the Community.

PERSONAL RIGHTS

- to not be discriminated against
- to be treated with dignity and respect
- to be free from abuse, neglect, and exploitation
- to confidentiality: some exceptions are outlined below
- to complain about a violation of rights

SOME EXCEPTIONS TO CONFIDENTIALITY

- to secure payment
- when reporting abuse, neglect or exploitation of disabled adults or of children to the Division of Behavioral Health
- in cases of an Involuntary Emergency Admission or Guardianship proceedings
- when you are a danger to yourself or others
- to family members or other person who lives with the client or provides direct care to the client (under certain circumstances)

TREATMENT RIGHTS

- to adequate and humane treatment
- to make decisions about your services
- to treatment based on generally accepted clinical and professional standards
- to a mutually agreed upon treatment plan
- to services in the least restrictive setting
- to be informed of all significant risks, benefits, side affects, and alternative treatment and services
- to be fully informed of your diagnosis and prognosis
- to seek changes in services or treatment
- to refuse medication and treatment (except in Involuntary Emergency Admissions)
- to consultation and second opinions
- to have someone with you at treatment meetings where informed decision-making is required
- to freedom from restraint and seclusion except for personal safety
- to receive adequate written notice prior to suspension or termination of treatment with explanations as to the reason, and for the right to appeal the action
- to an explanation of the purpose of the Individual Service Planning (ISP) treatment planning process including goals, objectives, timelines, reviews, and crisis plans

FOR THOSE ELIGIBLE FOR STATE SUPPORTED SERVICES

- to choose either of the following methods by which my ISP is developed
  - through a formal client centered conference that is a meeting at a mutually convenient time and place with the psychiatrist and other involved persons approved by me, such as family members, CLM staff, representatives of other agencies providing services to me such as vocational rehabilitation, friends, an attorney, legal representative, a peer advocate and/or others with relevant knowledge or expertise
  - through a less formal method that shall include one or more one-on-one or small group meetings with the psychiatrist and/or others by phone, in person and/or through other effective means.
- to have ten days to make a decision after receiving the written explanation regarding the method to develop the ISP
- to consult with family, friends, therapists, advocates and others before making the decision regarding the method to develop my ISP

These treatment rights do not require CLM to provide services or administer treatment that it considers unreasonable, unnecessary and/or against the clinical judgment of its professional staff. To assure a safe environment for all persons I understand that no firearms or other weapons are allowed on CLM premises except by law enforcement personnel, in the line of duty.

If you feel that your rights have been violated, we urge you to contact us at any of the CLM sites or offices. You may do so by phone or in writing. Address your concerns to The Client Rights Investigator at Center for Life Management, 10 Tsienneto Road, Derry, NH 03038 or call 434-1577.

Client Signature Date

☐ I understand that checking this box constitutes a legal signature.

Parent/Guardian/DPOA Date

☐ I understand that checking this box constitutes a legal signature.

WHITE COPY TO CLIENT AND YELLOW COPY FOR RECORD

Individual Service Plan (ISP)

Signature Form

Client's#:_____

☐ I have participated in the Individual Service Plan (ISP) process for my child. My child's clinician/case manager has explained to me the significance of the plan and I understand that the plan will be modified periodically during my participation in treatment services at Center for Life Management (CLM). I have been given a copy of the plan for my records.

☐ I have received a copy of the CLM's Client Rights Statement.

Signature of Client _____ Date_____

Signature of Legal Guardian_____ Date_____

CLM Center for Life Management™

Name:_____ ID Number:_____ Date:_____

Parent/Guardian:_____ Parent/Guardian: _____

Parent/Guardian:_____ Parent/Guardian: _____

HEALTH HISTORY

Children's Services

Please check if the child/adolescent being seen has ever experienced problems related to the areas indicated.

1. GENERAL	**YES**	**NO**
Weight Change		
Fever		
Sweats		
Fatigue		
2. EYES		
Glaucoma		
Cataracts		
Wears Glasses		
Blurred or Double Vision		
3. EARS, NOSE, THROAT		
Wears Hearing Aid		
Hearing Loss with No Aid		
Dizziness		
Pain		
4. RESPIRATORY		
Shortness of Breath		
Trouble Breathing		
Asthma		
Bronchitis		
Chronic Cough		
5. CARDIOVASCULAR		
Heart Attack		
Chest Pain/Angina		
Heart Murmur		
Rapid Heart Beat		
High Blood Pressure		
Congenital Heart Condition		
6. GASTROINTESTIONAL		
Ulcers		
Stomach Pain		
Diarrhea		
Constipation		
Gastro-esophageal Reflux		
Nausea		
7. ENDOCRINE SYSTEM		
Diabetes		
Hypo/Hyper Thyroid		

8. URINARY SYSTEMS	**YES**	**NO**
Urinary Tract/Bladder Infections		
Incontinence		
Trouble Urinating		
Kidney Problems		
9. REPRODUCTIVE		
PMS		
10. SKIN		
Rashes		
Dry Skin		
Jaundice		
Melanoma		
11. NEUROLOGIC		
Stroke		
Seizures		
Head Injury		
Tingling		
Numbness		
12. MUSCLES/JOINTS		
Arthritis		
Weakness		
Frequent Falls/Unsteady		
13. BLOOD/LYMPHATIC		
Bruising/Bleeding Easily		
Anemia		
Swollen Lymph Nodes		
14. PSYCHIATRIC		
Sleep Disturbance		
Feeling Anxious		
Feeling Depressed		
Suicidal		
Substance Abuse		
15. SMOKING STATUS		
Smokes?		
If so, how much per day	_____	
16. ALCOHOL USE		
Consumes alcohol?		
If so, how much/how often?	_____	

OTHER MEDICAL CONDITIONS/ADDITIONAL COMMENTS:

Please complete the back of form as well.

Revised 1/5/2022

(Form continues on the reverse side)

ALLERGIES:

CURRENT MEDICATIONS:	CURRENT MEDICATIONS		
NAME	DOSE	FREQUENCY	REASON FOR TAKING

HOSPITALIZATIONS:

DATE(S)	PLACE	REASON

MEDICAL PROVIDERS	NAME	CONTACT INFO	REASON FOR SEEING	DATE LAST SEEN
PEDIATRICIAN				
SPECIALIST				
SPECIALIST				
SPECIALIST				

FAMILY PSYCHIATRIC/SUBSTANCE USE HISTORY:

FAMILY MEMBER	CONDITION/PROBLEM	FAMILY MEMBER	CONDITION/PROBLEM

FAMIILY GENERAL MEDICAL HISTORY:

	FAMILY MEMBER	FAMILY MEMBER	FAMILY MEMBER
DIABETES		OTHER	
CANCER/TUMOR		OTHER	
HEART DISEASE		OTHER	
SEIZURE		OTHER	

Revised 1/5/2022

DEVELOPMENTAL HISTORY:

Name of Parent _____ Date of Birth_____
Occupation_____ Martial Status_____
Custodial/decision making status _____

Name of Parent _____ Date of Birth_____
Occupation_____ Martial Status_____
Custodial/decision making status _____

Name of Parent _____ Date of Birth_____
Occupation_____ Martial Status_____
Custodial/decision making status _____

Name of Parent _____ Date of Birth_____
Occupation_____ Martial Status_____
Custodial/decision making status _____

Siblings:	Name	Age	Education
1			
2			
3			
4			

Others Living with Family:

	Name	Age	Education
1			
2			
3			
4			

How many times has the child moved? _____

Pregnancy and Birth:

During this pregnancy did the mother experience any unusual illnesses, conditions or accident such as German Measles, RH incompatibility, false labor etc.? If so, please describe:

Was the mother taking any drugs during pregnancy? If yes, please list:

Length of Pregnancy:_____ Duration of Labor:_____ Birth Weight:_____

Were there any problems with delivery such as breech birth, Caesarian section etc.? If so, please describe:

Was the pregnancy planned? Yes ☐ No ☐

Feeding:

Were there any feeding problems? If yes, please describe:

Developmental:

At what age did the following occur? Walking _____ Talking_____ Dressed and undressed self_____

Does she/he fall or lose balance easily?

Describe the child's temperament:

Does the child have difficulty with strangers or separating from parents?

Have there been any developmental problems or concerns? If yes, please explain:

Trauma: Has the child ever experienced any of the following? If so, please provide detail if known.

Physical Abuse
Sexual Abuse
Emotional/Verbal Abuse
Neglect
Bullying
Witness to Domestic Violence
Natural/Environmental Catastrophe
Other Possible Trauma

Medical History:

Describe accidents or operations the child has had: _____

Have there been any medical problems other than normal childhood illnesses? If yes, please describe:

_____

Were any of these illnesses followed by noticeable changes in the child's general behavior or speech? If yes, please describe:

_____

Have the child's eyes been examined? _____ Results: _____

Have the child's ears been examined? _____ Results: _____

Address: _____

Has the mother been hospitalized for anything other than childbirth? If yes, when? _____

What for? _____

How Long? _____ What was the child's reaction? _____

Education History:

School attending _____ Grade: _____ Teacher: _____

What are the child's usual grades in the following subjects? Math _____ Reading _____ Spelling _____

Grades failed? _____ Grades Skipped? _____

Did the child attend Nursery School? _____ Kindergarten? _____

Is the child frequently absent from school? If yes, please explain:

_____

Daily Behavior:

Does the child have nightmares? _____ Does she/he sleep well? _____

Does the child have fears? _____ If yes, please describe: _____

Does the child eat well? _____ If no, please describe: _____

Does the child tend to play alone or with other children? _____

How does the child get along with other children? _____

How does the child get along with other adults? _____

Is it difficult to discipline the child? If yes, please describe _____

_____

Would you describe the child as basically happy or unhappy? _____

Does the child have difficulty in concentration? _____

What are the child's favorite play activities? _____

Are there additional comments regarding the child's behavior? _____

Describe the child's relationship with:

Parent _____

Parent _____

Parent _____

Parent _____

Siblings _____

Has the child had a neurological examination prior to this time? _____ Where? _____

Has the child had a psychological examination prior to this time? _____ Where? _____

Additional Information:

If there is additional information which you feel will help us to better understand the child and his/her current problems, please describe (use reverse side of page if necessary):

_____

_____

_____

COMMENTS OF REVIEWER:

Reviewed by: _____ Date: _____

NOTICE REGARDING THE CONFIDENTIALITY OF ALCOHOL AND DRUG TREATMENT INFORMATION

Client Name: _____ Client #: _____

As a patient receiving substance use disorder (SUD) treatment services at Center for Life Management, the records and information concerning your SUD treatment are subject to heightened privacy protections under a federal law known as "Part 2." *See* 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2.

Under Part 2, we may not disclose records or information about your SUD treatment, including acknowledging your current or past presence at our practice, **unless**:

1. You or your personal representative consent to disclosure in writing;
2. The disclosure is allowed by a court order;
3. The disclosure is made to medical personnel to respond to a medical emergency you are experiencing and you lack capacity to consent to disclosure;
4. The disclosure is made to authorities to report suspected child abuse/neglect or inability to care for self as required by law;
5. The disclosure is made for qualifying research, audit, or program evaluation purposes;
6. The disclosure is made in connection with a suspected crime committed on our premises or a crime against any person who works for us or about any threat to commit such a crime;
7. The disclosure is made to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the Health Insurance Portability and Accountability Act and/or related laws or regulations; or
8. The disclosure is made to a public health authority and involves information relating to the cause of your death.

Other than as stated above or as allowed by applicable law, we will not use or disclose your SUD treatment records or information without your written consent. Violation of Part 2 is a crime and suspected violations may be reported to the U.S. Attorney's Office for the District of New Hampshire at (603) 225-1552 or usanh.webmail@usdoj.gov.

_____ _____ _____

Signature of Client or Guardian | Print Name | Date