Client ID#: _____

Treatment Participation and Payment Policy

Our mission is to support your health and well-being by providing high-quality mental health care in a respectful and compassionate environment. This document is designed to help you understand participation in services at Center for Life Management (CLM). Please read it carefully, and let us know if you have any questions before signing.

Informed Consent to Treat

By signing this agreement, you consent to receive mental health treatment and related support services provided by CLM staff. You will receive ongoing assessment and evaluation of your mental health needs and services will be recommended to you based your assessed medical necessity. You understand that:

- Services may include assessments, individual and group therapy, case management, community support, medication management, crisis support, and other clinically appropriate interventions.
- Treatment is voluntary, and you may withdraw from services at any time unless court ordered to care.
- The risks and benefits of treatment will be explained to you by your provider, and you are encouraged to ask questions to support informed decision-making.
- You have the right to participate actively in developing your treatment plan.

Shared Parenting or Guardianship Responsibilities

CLM recognizes that children and dependent adults may have more than one parent or guardian who shares responsibility for their care. By signing this agreement, the consenting parent or guardian acknowledges and agrees that:

- Consent to treatment provided by one legal parent or guardian is considered valid and sufficient for CLM to initiate and continue services.
- The parent or guardian providing consent has the responsibility to inform and communicate with all other legal parents/guardians that fact that they have consented to the treatment of their child/ward at CLM and also regarding treatment decisions and progress.
- It is the responsibility of the consenting parent/guardian to inform CLM of an objection to treatment by another parent/guardian who has legal authority to consent for treatment.
- Legal paperwork indicating court orders may be requested to initiate or continue care.
- CLM will not mediate disagreements between parents or guardians regarding treatment decisions. If disputes arise, CLM may request documentation (e.g., custody agreements or court orders) to guide clinical and administrative actions.
- It remains the responsibility of all legal parents/guardians to coordinate with one another regarding the care of the client.

Telehealth Services

CLM offers telehealth as an option for service delivery. By signing, you consent to receive care through secure video or telephone platforms when appropriate. You understand that:

- Telehealth may not be appropriate for all situations, and in-person appointments may sometimes be required.
- Confidentiality protections apply in telehealth just as they do in-person for both the client and provider.
- You are responsible for ensuring you have access to a private space and reliable technology during telehealth sessions.
- Services rendered over telephone may be billable.

Attendance and Cancellation

- **24-Hour Notice:** We require at least 24 hours' notice for appointment cancellations.
- **Excused Cancellations:** Last-minute rescheduling may be permitted in cases of unforeseen illness, psychiatric crisis, or family emergency.
- **No-Show Appointments:** Repeated missed appointments without notice may result in fees being charged to your account and/or impact your ability to remain in services.
- **Appointment Confirmations:** By providing your preferred contact information, you consent to receive appointment confirmations and reminders via text, phone call, and/or email. You may update or withdraw this consent at any time by notifying our office.

Financial Responsibility and Payment

CLM is committed to helping you access care and maintain financial transparency. Please review the following:

- **Insurance Coverage:** We will bill your insurance directly. However, insurance may not cover the full cost of services. You are responsible for any remaining balance, including co-pays, deductibles, or services not covered. Individuals who may otherwise qualify for NH Medicaid and refuse to apply will be responsible for the full cost of services.
- **Updated Insurance Information:** You are responsible for providing current and accurate insurance information. Failure to update this information may result in denied claims for which you will be billed directly.
- **Outstanding Balances:** Per New Hampshire He-M regulations, failure to pay for services or apply for insurance which could cover your services may result in case closure.
- **Payment Arrangements:** If you are unable to pay in full, you may work with CLM's Finance Department to establish a payment plan.
- **Additional Fees:** You may incur fees for missed appointments (no-shows), crisis care, or other services not covered by insurance.
- **Acute Care Fees:** Additional charges may apply if services are rendered by CLM's Acute Care Services during a psychiatric crisis.
- Should you or your child/ward stop receiving services from CLM, payment is expected for sessions that have already been provided prior to the end of treatment.

Authorization to Release Information for Payment Purposes

By signing this agreement, you authorize CLM to release necessary medical and billing information to your insurance company, third-party payer, or other authorized agencies for the purpose of processing claims related to your treatment and payment.

Acknowledgment and Agreement

By signing below, you acknowledge that you have read and understood this Participation, Service Agreement, and Payment Policy. You agree to comply with these terms, ask questions when clarification is needed, and work collaboratively with CLM to support your treatment and financial responsibilities.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Client ID#: _____

Client Rights Statement

At Center for Life Management (CLM), we are committed to providing care in an atmosphere of dignity, respect, and partnership. As a client, you have important rights related to your personal well-being, your treatment, and the confidentiality of your information.

Personal Rights

As a client of CLM, you have the right to:

- Be treated with dignity, respect, and compassion at all times.
- Receive services in an environment free from discrimination based on age, race, ethnicity, culture, national origin, religion, sex, sexual orientation, gender identity or expression, disability, or socioeconomic status.
- Be safe from abuse, neglect, exploitation, or mistreatment.
- Request reasonable accommodations if you have a disability or specific needs.
- File a complaint or grievance without fear of retaliation, and to have your concerns heard and addressed fairly.

Treatment Rights

As part of your care at CLM, you have the right to:

- Participate actively in developing your treatment plan and making decisions about your care.
- Be informed of the potential risks, benefits, and alternatives to treatment.
- Decline or withdraw from services at any time, within the limits of the law and professional standards.
- Receive services in the least restrictive setting that is clinically appropriate.
- Request a second opinion or referral to another provider if desired.
- Be informed in clear language about your diagnosis, treatment, and progress during periodic review of your services.

Confidentiality and Exceptions

CLM respects your right to privacy. Information shared in treatment is kept confidential except in the following circumstances, as required or permitted by law. In these situations, only the necessary information will be shared, and whenever possible, you will be informed.:

- If there is suspected abuse or neglect of a child, elder, or vulnerable adult.
- If you present a serious risk of harm to yourself or others.
- If your records are requested by court order or as otherwise required by law.
- In cases of involuntary emergency admission or guardianship proceedings.
- To family members or other persons who reside in the same home if a psychiatric crisis occurs.
- For purposes of billing, payment, and health care operations.

Confidentiality in Practice and Recording of Sessions

To protect the privacy of both clients and staff:

- CLM does *not* permit recording of sessions (audio, video, or other methods) by clients or staff unless there is prior, explicit, written consent from all parties involved. This may include recording sessions for AI-assisted clinical documentation.
- This protocol protects your right to confidentiality as well as the confidentiality and privacy of CLM staff.
- Both clients and staff have the right to expect that what is shared in treatment, subject to the exceptions as outlined above, remains private and respectful.

Questions or Concerns

If you have questions about your rights or concerns about your care, you are encouraged to:

- Speak directly with your provider.
- Contact CLM's Compliance Officer.
- File a grievance following CLM's Compliance policy, available upon request.

Acknowledgment of Receipt
I have received and reviewed a copy of the Client Rights Statement from Center for Life Management.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Client ID#: _____

Children's Services – Family Systems Approach

The Children's Department at the Center for Life Management (CLM) 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) may be part of the therapy sessions at the beginning or end of each session, or both, depending on the client's needs. This allows 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.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Client ID#: _____

CLM Center for Life Management

Notice of Confidentiality for Alcohol and Drug Treatment Information

Federal law provides special confidentiality protections for your alcohol and drug treatment records for people aged 12 and older. These protections are stricter than standard health privacy rules. The purpose of this notice is to help you understand your rights and the limits of disclosure of your treatment information.

Special Protections Under 42 CFR Part 2

- Records that identify you as receiving alcohol or drug treatment services are protected by federal law (42 CFR Part 2)
- These records generally cannot be shared with anyone outside of Center for Life Management (CLM) without your written consent
- This protection is stronger than the general health information privacy protections under HIPAA

When Information May Be Shared With Your Consent

- To coordinate your care among members of your treatment team
- With your insurance company, if you authorize it
- Any other person or agency you specifically authorize in writing

When Information May Be Shared Without Your Consent

Federal law allows disclosure of alcohol and drug treatment information without your consent in limited circumstances, including:

- Medical emergencies (to protect your health or safety)
- Mandated reporting of child abuse or neglect
- Crimes committed on CLM premises or against CLM staff
- Court orders that meet strict federal requirements
- Internal program operations (for quality assurance, billing, or compliance purposes as permitted by law)

Additional Consents May Be Required

Because of these special protections, you may be asked to sign extra consent forms if your alcohol and drug treatment information needs to be shared for purposes such as:

- Coordinating with outside medical providers
- Communicating with schools, courts, or community agencies
- Billing and insurance coverage

Acknowledgement of Notice

I have read (or had explained to me) this notice regarding the confidentiality of alcohol and drug treatment information. I understand that these records are specially protected under HIPAA and 42 CFR Part 2, and that my written consent is generally required before information about my treatment may be shared.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Client ID#: _____

Client Code of Conduct

At Center for Life Management (CLM), we are committed to providing a safe, supportive, and respectful environment for all individuals receiving services. To ensure that everyone has the best experience, we ask that all clients adhere to the following Code of Conduct. This document outlines the behavior and responsibilities expected during your time in our care.

---

1. Respect and Dignity

- Treat all staff, fellow clients, and visitors with courtesy, respect, and dignity at all times.
- Avoid any forms of discrimination, harassment, or aggression, including but not limited to racial, cultural, religious, gender, or sexual harassment.

2. Safety and Well-being

- Refrain from any violent, threatening, or harmful behavior that may jeopardize the safety of others or yourself.
- Comply with the CLM's policies regarding the use of substances, including alcohol, recreational drugs, and any unauthorized medications as outlined in CLM's Treatment Participation and Payment Agreement.
- CLM maintains a NO WEAPONS policy while on CLM property, inside CLM buildings, or when with staff in the community.
- Follow any recommendations or instructions from providers regarding treatment plans, medications, or service sessions.

3. Confidentiality and Privacy

- Respect the confidentiality and privacy of all individuals receiving services, as well as that of staff.
- Do not disclose any personal or sensitive information about other clients without their consent.
- Abide by policies and guidelines, including restrictions on personal electronic devices and recording. Recording of sessions and phone calls is not permitted by staff or client without written consent.

4. Attendance and Punctuality

- Attend scheduled sessions, appointments, or group meetings as required, arriving on time. If you are unable to attend, please notify front office staff at least 24 hours in advance.
- If you are late or miss a session, please contact the front office to reschedule.

5. Property and Facilities

- Respect the property and resources provided by the facility. This includes personal property as well as facility-owned items and spaces.
- Do not damage, deface, or remove any property from the premises.
- Maintain a clean and orderly environment, disposing of trash properly and informing CLM staff when there is a cleanliness or safety issue that requires attention.

6. Substance Use and Medication Adherence

- Adhere to CLM's policy regarding medication use, including taking prescribed medications as directed by your healthcare provider as outlined in CLM's Participation Agreement.
- Bringing illegal substances or alcohol onto the premises is prohibited.

- Smoking, vaping or using any illegal substances during sessions, including telehealth, is prohibited.
- If you are prescribed medication outside of CLM, please notify staff of any changes in your medication regimen. Please notify staff of any concerns you have about side effects or interactions.
- To promote safe and coordinated care, you are encouraged to share information about medications prescribed through Center for Life Management with their other healthcare providers, as appropriate.

7. Collaboration with Staff

- Engage actively and openly in your treatment process, and communicate openly with your healthcare providers, therapists, and support staff.
- Follow the agreed-upon treatment plan, and ask questions or raise concerns if you do not understand any part of your treatment.
- Inform staff of any changes in your personal, physical, or mental health that may impact your treatment.

8. Disruptive Behavior

- Refrain from disruptive or inappropriate behavior during sessions or within the facility, including loud outbursts, offensive language, or any form of verbal or physical aggression.
- If you experience any emotional distress, please inform a staff member immediately so that they can provide appropriate support.
- Behavior that disrupts the therapeutic process or threatens the comfort and safety of others may result in a review of your services and possible discharge.

9. Rights and Responsibilities

- You have the right to be informed of your treatment plan, to provide consent for treatment, and to refuse any treatment within the limits of the law.
- You have the responsibility to participate in your treatment to the best of your ability, to inform staff of any difficulties you experience, and to respect the rights of others receiving care.

10. Violations and Consequences

- Clients who fail to adhere to the Code of Conduct may face consequences, including verbal or written warnings, suspension of services, or termination of care.
- Any behavior that is deemed illegal, harmful, or violent may result in immediate removal from the facility and possible legal action.

By signing below, you acknowledge that you have read, understood, and agree to abide by the Client Code of Conduct during your time at the Center for Life Management.

Client Signature: _____

Printed Name: _____

Date: _____

We believe that by maintaining this Code of Conduct, we can ensure a positive and safe experience for all clients. Your cooperation is greatly appreciated, and we look forward to supporting you on your journey toward better mental health.

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:**

Primary Care Physician

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

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:			
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
DIABETES		OTHER	
CANCER/TUMOR		OTHER	
HEART DISEASE		OTHER	
SEIZURE		OTHER	

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: _____