RECOVERY TECHNOLOGY L.L.C.

_____

Consent for Participation In Mental Health Program

Client Name: _____ Case Number: _____

As a consumer of Recovery Technology LLC, I agree/authorize:

1. Recovery Technology LLC to release non-identifying information to LifeWays and to the Michigan Department of Community Health in accordance with Section 748 Public Act 258 of 1974 and Rule 330.1748.
2. To participate or to permit participating in the following serves offered by Recovery Technology LLC.
    a. Outpatient treatment services through Recovery Technology LLC
        - ○ i. Yes
        - ○ ii. No

    I understand that consent may be withdrawn and participation discontinued at any time without penalty. The above service including their purposes, risks, benefits to be reasonably expected, any appropriate alternative and any further questions I had were explained to my satisfaction by _____ *on* _____.

3. Additionally, I certify that I received a copy and explanation of " A Summary of Recipient Rights" and "Consumer Code of Conduct" prior to receiving services.
4. I understand that I may be tested without consent for HBV/HIV at no cost, per Michigan compiled laws 333.5133 and that I have been offered HBV.HIV information.
5. I have provided:
    a. An advanced directive that shall be filed in my medical record:
        - ○ i. Yes
        - ○ ii. No

Recovery Technology LLC will recognize a properly executed Durable Power of Attorney for Health but is without authority to provide legal advice or services for consumers seeking to execute an advanced directive. Recovery Technology LLC will administer first aid and call for an ambulance in the event of a medical emergency despite the existence of an advanced directive. A copy of the advance directive will be provided to the medical/surgical facility as necessary.

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Note: A new consent form must be obtained if: a) the Individual Plan of Service is changed to include additional programs or interim circumstances substantially affecting the risks, benefits or other consequences reasonable expected; b) legally competent minor reaches his/her 18th birthday; orc0 change of guardianship status.

*Witness is responsible to, in good faith, assure that, if the consumer signs, he was competent to give informed consent (R330:7003) (R300:6012) (a)-(c) Michigan Department of Community Health Emergency Rules, or if the witness does not feel the consumer is competent, please refer to (R330.6011 (3)-(4)). Upon request the consumer may receive a copy of this agreement.

Treatment Agreement

Client Name_____ **Case Number**_____

Client's Responsibilities to achieve outcomes:

☐ I was asked if I had any special considerations in order to be successful with my treatment such as cultural, spiritual, physical needs, handicap accessibility, age, gender, sexual orientation, socioeconomic status, language, etc.

☐ I agree to allow Recovery Technology to contact me 30 days following discharge to check on my progress.

☐ I understand that early withdrawal from services could be detrimental to my treatment and it is necessary to attend and participate in services on a regular basis.

☐ I am aware that if I am unhappy or have concerns with any portion of my treatment, I may share those concerns through the informal complaint Resolution Process with:

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Staff Signature/Credentials_____ Date_____

Supervisor Signature/Credentials_____ Date_____

Other Signature_____ Date_____

Other Signature_____ Date_____

RECOVERY TECHNOLOGY L.L.C.

Assignment of Benefits

I _____ hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plan to: **RECOVERY TECHNOLOGY LLC**

I also understand that **I am financially responsible for all charges whether or not paid by said insurances**. This includes deductibles, co-payments, and any charges incurred for services received but not covered by my insurance. I am responsible for finding the exact amount of my payment from my insurance company and paying the amount.

_____ _____
Signature Date

I hereby authorize RECOVERY TECHNOLOGY LLC to release all information necessary to secure payment of said benefits. This allows RECOVERY TECHNOLOGY LLC to bill my insurance company and for the insurance company to send payment/rejection back.

_____ _____
Signature Date

Insurance Information – (Copy of Medicaid or other insurance card required)

Primary Insurance	_____	Secondary Insurance	_____
Policy Group #	_____	Policy Group #	_____
Policy Holder	_____	Policy Holder	_____
Policy Holder's DOB	_____	Policy Holder's DOB	_____
Policy Holder's SSN #	_____	Policy Holder's SSN #	_____
Relationship to Policy Holder	_____	Relationship to Policy Holder	_____

_____ _____
Signature Date

_____ _____
Witness Signature Date

Tele-mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with, _____, as part of my treatment. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care required.
6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to reschedule.
7) I understand that my clinician/staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my clinician/staff. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of clinician/staff Date:

Recovery Technology Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and

conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As social workers licensed in this state and as a members of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Recipients Rights Officer.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Recipient Rights Officer at (517) 796-4520

We will not retaliate against you for filing a complaint.

RECOVERY TECHNOLOGY L.L.C.

_____

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name_____ Case #_____Date_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Recovery Technology's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Recipient Rights Officer Andra Antczak at (517) 796-4520.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Personal Representative: _____ Date: _____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

☐ Client/Patient Refuses to Acknowledge Receipt

Signature of Staff Person: _____ Date: _____

RECOVERY TECHNOLOGY L.L.C.

Consent for Release of Confidential Information

Client Name_____ Case #_____Date_____

DOB: _____ I do authorize and request:

Recovery Technology LLC
1200 N West Avenue, Suite 400
Jackson, MI 49202
Phone 517-780-3336 Fax 517-796-4561

To verbally and or in writing communicate with:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____ Relationship: _____

To disclose the following information:

- ☐ Diagnosis
- ☐ Psychological Testing
- ☐ Treatment History
- ☐ Vocational Assessment
- ☐ Current/Past Medications
- ☐ Lab Results/Drug Screens
- ☐ Hospitalization Information
- ☐ Psychiatric Evaluation
- ☐ Psychosocial History
- ☐ History/Status Legal Issues
- ☐ Employment Information
- ☐ History/Physical Exam
- ☐ Medical Information
- ☐ Discharge Summary
- ☐ School/Records/Behaviors
- ☐ Insurance Information
- ☐ Treatment Progress Notes
- ☐ OT/PT/Speech Information
- ☐ Eligibility Determination
- ☐ Return to Work/School
- ☐ Substance Abuse History
- ☐ Other: _____

To determine:

☐ Need and type of treatment ☐ Coordination of Services ☐ Other: _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 25 CFR Parts 160 & 164; and the Mental Health Code, Section 330.1748 of the Public Act, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I understand that information contained in the medical record may include mental health treatment, alcohol or drug abuse treatment, Human Immunodeficiency Virus or AIDS, or a serious communicable or sexually transmitted disease.

I hereby authorize the release of my substance abuse records. Client Initial: _____

I understand that I may revoke this consent, verbally or in writing at any time except to the extent that action has been taken, its reliance on it, and that in any event this consent shall expire one year from the date of the signature or sixty days after the date of my discharge from Recovery Technology LLC services unless specified below.

I understand that revoking this authorization prior to completion of court ordered treatment might affect my association with the court.

Verbal Revocation Client Initial: _____ Date: _____
Written Revocation Client Initial: _____ Date: _____
Event/Condition presented to revoke consent: _____

I understand that authorizing the disclosure of health information is voluntary and that I may refuse to sign his authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

RECOVERY TECHNOLOGY L.L.C.

Consent for Release of Confidential Information

Client Name_____ Case #_____Date_____

DOB: _____ I do authorize and request:

Recovery Technology LLC
1200 N West Avenue, Suite 400
Jackson, MI 49202
Phone 517-780-3336 Fax 517-796-4561

To verbally and or in writing communicate with:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____ Relationship: _____

To disclose the following information:

- ☐ Diagnosis
- ☐ Psychological Testing
- ☐ Treatment History
- ☐ Vocational Assessment
- ☐ Current/Past Medications
- ☐ Lab Results/Drug Screens
- ☐ Hospitalization Information
- ☐ Psychiatric Evaluation
- ☐ Psychosocial History
- ☐ History/Status Legal Issues
- ☐ Employment Information
- ☐ History/Physical Exam
- ☐ Medical Information
- ☐ Discharge Summary
- ☐ School/Records/Behaviors
- ☐ Insurance Information
- ☐ Treatment Progress Notes
- ☐ OT/PT/Speech Information
- ☐ Eligibility Determination
- ☐ Return to Work/School
- ☐ Substance Abuse History
- ☐ Other: _____

To determine:

☐ Need and type of treatment ☐ Coordination of Services ☐ Other: _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 25 CFR Parts 160 & 164; and the Mental Health Code, Section 330.1748 of the Public Act, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I understand that information contained in the medical record may include mental health treatment, alcohol or drug abuse treatment, Human Immunodeficiency Virus or AIDS, or a serious communicable or sexually transmitted disease.

I hereby authorize the release of my substance abuse records. Client Initial: _____

I understand that I may revoke this consent, verbally or in writing at any time except to the extent that action has been taken, its reliance on it, and that in any event this consent shall expire one year from the date of the signature or sixty days after the date of my discharge from Recovery Technology LLC services unless specified below.

I understand that revoking this authorization prior to completion of court ordered treatment might affect my association with the court.

Verbal Revocation Client Initial: _____ Date: _____
Written Revocation Client Initial: _____ Date: _____
Event/Condition presented to revoke consent: _____

I understand that authorizing the disclosure of health information is voluntary and that I may refuse to sign his authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

RECOVERY TECHNOLOGY L.L.C.

Consent for Release of Confidential Information

Client Name_____ Case #_____Date_____

DOB: _____ I do authorize and request:

Recovery Technology LLC
1200 N West Avenue, Suite 400
Jackson, MI 49202
Phone 517-780-3336 Fax 517-796-4561

To verbally and or in writing communicate with:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____ Relationship: _____

To disclose the following information:

- ☐ Diagnosis
- ☐ Psychological Testing
- ☐ Treatment History
- ☐ Vocational Assessment
- ☐ Current/Past Medications
- ☐ Lab Results/Drug Screens
- ☐ Hospitalization Information
- ☐ Psychiatric Evaluation
- ☐ Psychosocial History
- ☐ History/Status Legal Issues
- ☐ Employment Information
- ☐ History/Physical Exam
- ☐ Medical Information
- ☐ Discharge Summary
- ☐ School/Records/Behaviors
- ☐ Insurance Information
- ☐ Treatment Progress Notes
- ☐ OT/PT/Speech Information
- ☐ Eligibility Determination
- ☐ Return to Work/School
- ☐ Substance Abuse History
- ☐ Other: _____

To determine:

☐ Need and type of treatment ☐ Coordination of Services ☐ Other: _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 25 CFR Parts 160 & 164; and the Mental Health Code, Section 330.1748 of the Public Act, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I understand that information contained in the medical record may include mental health treatment, alcohol or drug abuse treatment, Human Immunodeficiency Virus or AIDS, or a serious communicable or sexually transmitted disease.

I hereby authorize the release of my substance abuse records. Client Initial: _____

I understand that I may revoke this consent, verbally or in writing at any time except to the extent that action has been taken, its reliance on it, and that in any event this consent shall expire one year from the date of the signature or sixty days after the date of my discharge from Recovery Technology LLC services unless specified below.

I understand that revoking this authorization prior to completion of court ordered treatment might affect my association with the court.

Verbal Revocation Client Initial: _____ Date: _____
Written Revocation Client Initial: _____ Date: _____
Event/Condition presented to revoke consent: _____

I understand that authorizing the disclosure of health information is voluntary and that I may refuse to sign his authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

RECOVERY TECHNOLOGY L.L.C.

Mutual Consent for Release of Confidential Information

Client Name_____ Case #_____Date_____

DOB: _____ I do authorize and request:

Recovery Technology LLC
1200 N West Avenue, Suite 400
Jackson, MI 49202
Phone 517-780-3336 Fax 517-796-4561

To verbally and or in writing communicate with:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____ Relationship: _____

To disclose the following information:

- ☐ Diagnosis
- ☐ Psychological Testing
- ☐ Treatment History
- ☐ Vocational Assessment
- ☐ Current/Past Medications
- ☐ Lab Results/Drug Screens
- ☐ Hospitalization Information
- ☐ Psychiatric Evaluation
- ☐ Psychosocial History
- ☐ History/Status Legal Issues
- ☐ Employment Information
- ☐ History/Physical Exam
- ☐ Medical Information
- ☐ Discharge Summary
- ☐ School/Records/Behaviors
- ☐ Insurance Information
- ☐ Treatment Progress Notes
- ☐ OT/PT/Speech Information
- ☐ Eligibility Determination
- ☐ Return to Work/School
- ☐ Substance Abuse History
- ☐ Other: _____

To determine:

☐ Need and type of treatment ☐ Coordination of Services ☐ Other: _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 25 CFR Parts 160 & 164; and the Mental Health Code, Section 330.1748 of the Public Act, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I understand that information contained in the medical record may include mental health treatment, alcohol or drug abuse treatment, Human Immunodeficiency Virus or AIDS, or a serious communicable or sexually transmitted disease.

I hereby authorize the release of my substance abuse records. Client Initial: _____

I understand that I may revoke this consent, verbally or in writing at any time except to the extent that action has been taken, its reliance on it, and that in any event this consent shall expire one year from the date of the signature or sixty days after the date of my discharge from Recovery Technology LLC services unless specified below.

I understand that revoking this authorization prior to completion of court ordered treatment might affect my association with the court.

Verbal Revocation Client Initial: _____ Date: _____
Written Revocation Client Initial: _____ Date: _____
Event/Condition presented to revoke consent: _____

I understand that authorizing the disclosure of health information is voluntary and that I may refuse to sign his authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

RECOVERY TECHNOLOGY L.L.C.

Primary Physician Coordination of Care Form

Doctor: _____ Date: _____

Address: _____

City/State/Zip: _____

Re: _____ DOB _____

Dear Dr. _____

This is to inform you that the above-named patient has had the following change in treatment:

☐ Hospitalization ☐ Crisis Home Placement ☐ Other: _____

Receiving the following services:

☐ Outpatient Mental Health Therapy
☐ Substance Abuse Therapy
☐ Assertive Community Treatment
☐ Integrated Dual Disorder Treatment
☐ Dialectical Behavior Therapy
☐ Case Management

Request information from you:

☐ Most current lab results
☐ Diagnosis that you are treating
☐ Most recent physical exam results
☐ Immunization Records
☐ Medications being prescribed by you
☐ Other: _____

The Patient's Diagnosis is: _____

_____

_____

_____

☐ THIS PERSON QUALIFIES AS A MEDICALLY INDIGENT INDIVIDUAL AS DEFINED IN SECTION 106 OF THE SOCIAL WELFARE ACT." MCL § 333.26263(K)

THE SOCIAL WELFARE ACT DEFINES A "MEDICALLY INDIGENT INDIVIDUAL" AS "[A]N INDIVIDUAL RECEIVING FAMILY INDEPENDENCE PROGRAM BENEFITS OR AN INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME . . ."

MICHIGAN'S MEDICAL RECORDS ACCESS ACT, PROVIDES THAT "A HEALTH CARE PROVIDER, HEALTH FACILITY, OR MEDICAL RECORDS COMPANY SHALL WAIVE ALL FEES FOR A MEDICALLY INDIGENT INDIVIDUAL." MCL § 333.26269(E)(3).

The patient has signed a release allowing further contact between us. Please feel free to contact me for any questions or coordination of care.

Clinician: _____ Phone Number: _____
(please print)

Clinician Signature/Credentials: _____

RECOVERY TECHNOLOGY L.L.C.

Service Orientation Checklist

Client Name: _____ Case #: _____

Please check all that apply:

I have chosen the following service(s):

- ☐ Individual Therapy
- ☐ Case Management
- ☐ Anger Management
- ☐ Dialectical Behavior Therapy
- ☐ Assertive Community Treatment
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Psychiatric
- ☐ Other

- ☐ I have been educated on the service I have chosen and had a chance to ask questions.
- ☐ I have been informed that the Internal Recipient Rights Advisor for Recovery Technology is Andra Antczak at 796-4520.
- ☐ I was trained on the emergency preparedness plan (fire, tornados, bomb threats, assaults with weapons, aggressive behaviors and how to use the fire extinguishers and emergency exits.)
- ☐ Self-determination was explained to me and I was given the choice to participate or not.
- ☐ Quality Improvement was explained to me and I was invited to be a member of the Advisory Board Committee (ABC).
- ☐ Clinician discussed with me the importance of keeping appointments and participating in services scheduled. **I understand that if I miss 3 appointments I may be discharged from the service.**
- ☐ Treatment is court ordered and the requirements for follow-up and discharge have been explained to me.

_____ _____ _____ _____

Client Signature Date Witness Date

_____ _____

Guardian Signature Date

Informal Complaint Process

Date: _____

Client Name: _____ Case #: _____

If you have any questions or concerns regarding your services at Recovery Technology, please call one of the following phone numbers for assistance. If you are unhappy with the outcome of your informal complaint, please contact a member of Recover Technology's management team or if referred by LifeWays, you may contact LifeWays Customer Service.

For Recovery Technology:

Clinician's Name:_____	Phone: _____
Recovery Technology Receptionist	517-780-3336
Recovery Technology CEO/Management	517-780-3336
Recovery Technology Recipient Rights Advisor	517-796-4520

If referred by LifeWays:

LifeWays Customer Service	517-780-3332

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Communication and Message Consent Form

Client Name: _____ Case #: _____ Date: _____

We, at RECOVERY TECHNOLOGY LLC, are committed to safeguarding the privacy and confidentiality of your records including the personal information that you provide us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time, it may be necessary or desirable to contact patients by phone **or text**. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

- ☐ I **DO NOT** want to have detailed messages left with another person who could answer my phone.
- ☐ I **DO NOT** want to have detailed messages left on my voicemail.
- ☐ I **DO NOT** want to be texted with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls at my place of employment.

TEXT MESSAGING INFORMATION

How we will use text messaging: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your text messages may be forwarded to another RECOVERY TECHNOLOGY LLC staff member as necessary for appropriate handling. We will not disclose your text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

Risk of using text messages: The use of text messages has a few risks that you should consider. These risks include, but are not limited to, the following:

- Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress a text and send the information to an undesired recipient.
- Employers and on-line services have a right to inspect texts sent through their company systems.
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of text messages:

RECOVERY TECHNOLOGY, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions (by signing below):

- **IN A MEDICAL EMERGENCY, DO NOT USE TEXTING, CALL 911.**
- If you have an urgent problem during regular business hours, please call your case manager or outpatient therapist, or 517-780-3336. Urgent messages or needs should be relayed to us by using regular telephone communication.
- You should speak with your case manager or therapist to discuss complex and/or sensitive situations rather than using text messages regarding such situations.

- Text messages may be filed electronically into your medical record.
- Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of text messages for communication of sensitive medical information. **Clinical staff are not responsible for the content of messages.**
- RECOVERY TECHNOLOGY, LLC is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with staff if warranted.

I UNDERSTAND THAT STANDARD CELL PHONE RATES AND TEXT MESSAGING RATES WILL APPLY TO ANY MESSAGE RECEIVED FROM RECOVERY TECHNOLOGY. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. MY REVOCATION OF CONSENT WILL NOT AFFECT MY ABILITY TO OBTAIN FUTURE HEALTH CARE NOR WILL IT CAUSE THE LOSS OF ANY BENEFITS TO WHICH I AM OTHERWISE ENTITLED.

THIS CONSENT DOES NOT EXPIRE UNLESS SPECIFICALLY REVOKED BY THE CLIENT/GUARDIAN.

Client/Guardian Signature: _____

Date

Witness Signature: _____

Date

○ Initial ○ Quarterly ○ Annual ○ Discharge

Consumer Name:	
Consumer ID:	Date:

Daily Living Activities (©DLA-20): Adult Mental Health

Instructions: Using the scale below, rate how often or how well the consumer independently performed or managed each of the 20 Activities of Daily Living (ADLs) in the community during the last 30 days.

If the consumer's level of functioning varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (e.g., "no jobs available"). Strengths are scored >=5 in an activity and indicate functioning "within normal limits" (WNL) for that activity. Enter N/A only if the activity was not assessed & do not exceed 5 N/A DLAs.

1	2	3	4	5 (WNL)	6 (WNL)	7 (WNL)
None of the time; extremely severe impairment of problems in functioning; pervasive level of continuous paid supports needed	A little of the time; severe impairment or problems in functioning; extensive level of continuous paid supports needed	Occasionally; moderately severe impairment or problems in functioning; moderate level of continuous paid supports needed	Some of the time; moderate impairment or problems in functioning; low level of continuous paid supports needed	A good bit of the time; mild impairment or problems in functioning; moderate level of intermittent paid supports needed	Most of the time; very mild impairment or problems in functioning; low level of intermittent paid supports needed	All of the time; independently managed DLA in community; no impairment or problem in functioning requiring paid supports

ACTIVITIES	Examples of scoring strengths as WNL behaviors (Scores 5-7) Dates:	Eval	R2	R3	R4	R5
1. Health Practices	Takes care of health issues, manages moods, infections; takes medication as prescribed; follows up on medical appointments.					
2. Housing Stability, Maintenance	Maintains stable housing; organizes possessions, cleans, abides by rules and contributes to maintenance if living with others					
3. Communication	Listens to people, expresses opinions/feelings; makes wishes know effectively.					
4. Safety	Safely moves about community – adequate vision, hearing, makes safe decisions. Safely uses small appliances, ovens/burners, matches, knives, razors, other tools.					
5. Managing Time	Follows regular schedule for bedtime, wake-up, meal times, rarely tardy or absent for work, day programs, appointments, scheduled activities.					
6. Managing Money	Manages money wisely (independent source of funds); controls spending habits.					
7. Nutrition	Eats at least 2 basically nutritious meals daily.					
8. Problem Solving	Resolves basic problems of daily living, asks questions for clarity and setting expectations.					
9. Family Relationships	Gets along with family, positive relationships as parent, sibling, child, significant other family member.					
10. Alcohol/Drug Use	Avoids abuse or abstains from alcohol/drugs, cigarettes; understands signs and symptoms of abuse or dependency; avoids misuse or combining alcohol, drugs, medication.					
11. Leisure	Relaxes with a variety of activities; attends/participates in sports or performing arts events; reads newspapers, magazines, books; recreational games with others; involved arts/crafts; goes to movies.					
12. Community Resources	Uses other community services, self-help groups, telephone, public transportation, religious organizations, shopping.					
13. Social Network	Gets along with friends, neighbors, coworkers, other peers.					
14. Sexuality	Appropriate behavior toward others; comfortable with gender, respects privacy and rights of others, practices safe sex or abstains.					
15. Productivity	Independently working, volunteering, homemaking, or learning skills for financial self-support.					
16. Coping Skills	Knows about nature of disability/illness, probable limitations, and symptoms of relapse; behaviors that cause relapse or make situation/condition worse; options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.					
17. Behavior Norms	Complies with community norms, probation/parole, court requirements, if applicable; controls dangerous, violent, aggressive, bizarre, or nuisance behaviors; respects rights of others.					
18. Personal Hygiene	Cares for personal cleanliness, such as bathing, brushing teeth.					
19. Grooming	Cares for hair, hands, general appearance; shaves.					
20. Dress	Dresses self; wears clean clothes that are appropriate for weather, job, and other activities; clothing is generally neat and intact.					

Scoring Instructions: Ratings for all 20 DLAs can be added then divided in half to estimate mGAF or:
Step 1. Add scores from applicable column.
Step 2. Divide sum by number of activities actually rated. This is the average DLA score.
Step 3. To estimate GAF or mGAF, multiply the average DLA by 10. Compare to DSMIV Axis V GAF description on back and compare to calculated DLA+-3 points.
Step 4. +/- Change/Outcome Score: subtract GAF/mGAF, column R1 from most recent rating R2 to R5.

	Eval	R2	R3	R4	R5
Sum (max.140)	0	0	0	0	0
Average/ DLA	0	0	0	0	0
Est. mGAF	0	0	0	0	0
Change Score	0				

CSM ☐ ACT ☐ OPT ☐ IDDT ☐ DBT ☐ Clinician (please print): _____

Last name

Client Satisfaction Survey

Date: _____

Please specify how you are associated with RECOVERY TECHNOLOGY:

☐ Client ☐ Guardian ☐ Service Provider ☐ Other: _____

Please specify what services are being rated:

☐ CSM/Support Coordination ☐ Outpatient Therapy ☐ ACT/IDDT

☐ Physician Services ☐ Anger Management/BIP

RECOVERY TECHNOLOGY would like to thank you for giving us the opportunity to serve you. Please help us serve you better by taking a couple minutes to tell us about the services that you have received so far. We appreciate your loyalty and want to make sure we meet your expectations. Your completed survey can be returned to our office at the address listed above**.** All information provided remains confidential. Please check the appropriate response. Thank you for your time and input.

If you do not have an answer or are unsure on any statement, please select "Neutral." Thank you.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Neutral
1. I like the services that I receive(d).					
2. I was able to get the services I thought I needed.					
3. Staff helped me obtain the information I needed so that I could take charge of managing my mental health or disability.					
4. I, not staff, decided my treatment goals.					
5. Staff believed that I could grow, change and recover.					
6. Recovery Technology staff is friendly and helpful.					
7. As a direct result of the services I received, I am better able to take care of my needs.					
8. Recovery Technology's staff were sensitive to my cultural/ethnic background (ex., race, religion, language, etc.).					
9. Recovery Technology staff explained my rights to me in a clear and understandable way.					
10. The services Recovery Technology deliver assisted you in managing your life/illness?					

In what ways, do you think Recovery Technology can improve? (Please continue on the back if more space is needed.)