SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Notice of Privacy Practices Acknowledgement
And
Receipt of Client Orientation

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:
Current Address:	
Current Phone Number:	
Additional Phone Numbers:	
Current Email Address:	

I understand that, under the Health Insurance Portability Act of 1998 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand SPSI's Notice of Privacy Practices, which provide a more complete description of the uses and disclosures of my health information. I understand that SPSI has the right to change its Notice of Privacy Practices from time to time and that I may contact SPSI at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that SPSI restrict how my private information is used or disclosed to carry out treatment, billing/payment or health care operations. I also understand that SPSI is not required to agree to my requested restrictions, but if SPSI does agree then SPSI is bound to abide by such restrictions.

Signatures Attesting to Notice of Privacy Practice Acknowledgement:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

INTENTIONALLY LEFT BLANK

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Financial Responsibility and Service Agreement

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

Financial Policy: All insurance policies, third party insurance administrator and court order payment documents are contracts and / or orders between you and the party listed on those documents. SPSI will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, usual and customary charges etc. other than to supply information as necessary. You are ultimately responsible for the timely payment of your account. Timely payment is within 30 days of the service rendered date.

Authorization to Bill Insurance: I hereby certify and attest that I have sought evaluation, treatment, or medical advice from SPSI. I authorize the medical staff, clinical provider and administrative personnel to release my, or my minor child's medical information to the insurance company(ies) named below for the purpose of determining and receiving benefits for medical billings.

I understand and acknowledge that the SPSI medical provider, clinical provider and/or administrative staff will submit my claim to the insurance company(ies) named below. I further understand that I will be held responsible for any amount of my medical bill that is not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, coinsurance, and uncovered charges I incur through using services at SPSI.

Insurance Waivers: I understand that insurance payers may waive copay or coinsurance from time to time. I further understand that SPSI will consider these waivers as part of the ongoing calculation of the client balance due to SPSI. SPSI will update the SPSI billing system when the insurance payer sends payment to SPSI.

Health Savings Accounts (HSA) & Employee Assistance Programs (EAP): I understand that if I have a third-party payer such as an HSA or EAP it will be reviewed by SPSI for consideration as a claim's payer, but there is no guarantee it can be approved for use as a SPSI claims payer. I understand that SPSI can take credit card payments which are linked to my HSA credit account. I understand that SPSI will not bill HSA third party administrators, unless I have received confirmation from SPSI directly. Lastly, I understand that I am responsible to work with my respective HSA, or EAP payer as necessary.

Adult Children on their Parent(s)/Guardian Insurance Plans: I understand that I am responsible for my insurance deductibles, fees, copayments, coinsurances, and uncovered charges incurred while using services at SPSI. I understand that I cannot assign my financial responsibility to my parent or guardian without their written consent.

Insurance One:

Name of Insurance as Written on Insurance Card	Insured ID on Card
Insured Group Number on Card	Provider Contact Telephone Number on Card
Subscriber Name	Subscriber DOB
Subscriber Relation to You	Subscriber Sex

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Insurance Two:

Name of Insurance as Written on Insurance Card	Insured ID on Card
Insured Group Number on Card	Provider Contact Telephone Number on Card
Subscriber Name	Subscriber DOB
Subscriber Relation to You	Subscriber Sex

I understand that any portion of my medical bills that are not covered by insurance will be billed to me at the address I have provided. If I do not receive a bill, I understand I may request one by contacting SPSI. I understand it is my responsibility to inform SPSI when my address changes or my insurance policy changes. Non-compliance or defaulting on payments may result in denial of service and/or legal claim against me for non-payment.

Signatures Attesting to My Financial Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW Psychological SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Coordination of Care

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:
Primary Care Printed Name	
Primary Care Address	
Primary Care Telephone Number	
Primary Care Fax Number	

I O do / O do not authorize SPSI, my behavioral health care provider and my primary care physician (identified and named above) to exchange information regarding my mental health/substance abuse treatment, medical health, psychiatric and therapy records for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, psychiatric care or substance abuse care and/or treatment (as protected under 42 CFR Part) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to SPSI. I further understand that it is my responsibility to notify this provider if I choose to change my primary care physician.

Client/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Behavior Health Provider Information (to be completed by provider)

Treating Provider:_____ Address: Saginaw Psychological Services Inc.
2100 Hemmeter Rd. Saginaw, MI 48603

DSM V Diagnosis Code and Name: _____

Treatment Modalities:

Psychotherapy-O Individual O Group O Family Frequency of Visits:_____

Notes:_____

Medication Management By:_____
(Physician's name, phone, fax number)

Medications prescribed for behavioral health

Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____
Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____
Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____

If authorization is given, a copy of this form should be sent to the PCP: Date

Sent_____ Sent by:_____ Method: O Fax O Mailed

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

INTENTIONALLY LEFT BLANK

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Release Medical Records Information

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

I authorize SPSI to release and/or obtain medical and/or mental health information contained in my records as specified below and to provide access to or provide such photocopies as may be requested of the person or organization and to the extent and nature listed below, subject to the conditions listed below.

I authorize SPSI to provide information to the following Person(s)/Organization(s)

Printed Name
Address
Telephone Number
Fax Number
Covering Date of Service Range

Place a "x" next to information to provide:

	Psychological Evaluation		Treatment Summary		Medication Review(s)
	Psychiatric Evaluation		Discharge Summary		Discharge Instructions
	Lab Work Results		Clinical Psychotherapy Note(s)		
	Other (specify)				

Identified information should be disclosed:

	Verbally		Hard Copy

Place a "x" next to purpose of disclosure:

	Employer Request		Vocational Rehabilitation		Attorney Inquiry
	Insurance Claim		Social Security		Disability Certification
	Continuation of Care		Consultation		Insurance Application
	Social Service		Worker's Comp		
	Other (specify)				

Place a "x" to authorize disclosure of records/information/notes related to:

	HIV/AIDS		Substance Abuse

I authorize SPSI to obtain information from the following Person(s)/Organization(s)

Printed Name
Address
Telephone Number
Fax Number
Covering Date of Service Range

Place a "x" next to information to provide:

	Psychological Evaluation		Treatment Summary		Medication Review(s)
	Psychiatric Evaluation		Discharge Summary		Discharge Instructions
	Lab Work Results		Clinical Psychotherapy Note(s)		
	Other (specify)				

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

I authorize SPSI to obtain information from the following Person(s)/Organization(s) ***Continued***

Identified information should be disclosed:		Verbally		Hard Copy

Place a "x" next to purpose of disclosure:

	Employer Request		Vocational Rehabilitation		Attorney Inquiry
	Insurance Claim		Social Security		Disability Certification
	Continuation of Care		Consultation		Insurance Application
	Social Service		Worker's Comp		
	Other (specify)				

Place a "x" to authorize disclosure of records/information/notes related to:

	HIV/AIDS		Substance Abuse

I understand that my records are protected by Federal and State Confidentiality Laws, and cannot be further disclosed without my written authorization, unless release is required by other State or Federal regulations. I understand that there is a possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand that I may inspect or copy any information released under this authorization.

I understand this authorization will expire upon termination of services, or one year from the date of signature. I further understand that, per the Privacy Notice, I may revoke this authorization at any time by notifying Saginaw Psychological Services, Inc in writing, but that previously disclosed information would be subject to may revocation request.

Signatures Attesting to My Consent to Release of Information:

Client/Guardian Signature Date

Witness Signature Date

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Treatment

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

The following is to be read, completed and signed by the client or the client's parent/guardian. If guardian, please provide a copy of the court paperwork (true copy, copy) for our records, legally stating guardian award.

I agree to attend psychotherapy and/or case management on an individual, family or group as determined with a therapist or examiner. I have the Client Handbook, which includes the SPSI Code of Ethics and my Rights. Questions which arose were answered satisfactorily.

The following pertains only to client seeking SPSI services. I have read, reviewed, and understand the "know your rights" booklet for substance abuse clients. Any questions I may have had, have been answered satisfactorily.

Signatures Attesting to Consent to Provide Treatment:

Client/Guardian Signature	Date
Witness Signature	Date

The following pertains only to:

- Community Mental Health Clients
  - Includes but not limited to: SCCMHA; BABHA; MSHN, TBHS
- Medicaid Clients

I have received a copy of the following supplemental booklets and/or pamphlets. Question which arose were answered satisfactorily.

- Notice of Privacy Practice – containing "Your Rights" booklet information.
- Community Mental Health specific brochures and handbooks
  - Includes but not limited to: SCCMHA; BABHA; MSHN, TBHS
- Person Centered planning brochure

Signatures Attesting to Receipt of the Above Documents:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

INTENTIONALLY LEFT BLANK

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to TeleMedicine Services

TeleMedicine involves the use of electronic communication to enable health care and mental health providers at locations different from their consumers to engage in therapeutic services or share medical information for the purpose of maintaining and improving care. The information may be used for diagnosis, therapy, follow up and/or education. While our best efforts are made to safeguard privacy and confidentiality, there is inherent risk in this modality.

Client Information

Last Name:	First Name:
Today's Date:	Date of Birth:

I am providing my consent to engage in TeleMedicine with SPSI as a part of psychological services. I understand that TeleMedicine psychotherapy may include: mental health evaluation, assessment, consultation, treatment planning and therapy. TeleMedicine will occur primarily through interactive audio, video and telephone.

By signing this form, I understand and consent to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to TeleMedicine; this means that no information obtained in the use of TeleMedicine which identifies me will be disclosed to researchers or other entities without my expressed written consent.
2. I understand that the limits of confidentiality that apply to treatment also apply to TeleMedicine; these include a mandated reporting of child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law.
3. I understand that I have the right to withhold or withdraw my consent to the use of TeleMedicine in the course of my care at any time without affecting my right to future care or treatment.
4. I understand that TeleMedicine may involve electronic communication of my protected health information (PHI) to other medical practitioners who may be located in other areas.
5. I understand that it is my duty to inform my treatment provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that security protocols can fail. Meaning privacy and confidentiality of protected health information cannot be guaranteed with the use of TeleMedicine.
7. I understand that in rare cases, information transmitted may be insufficient to allow for appropriate medical decisions (e.g., poor resolution or sound quality).
8. I understand that delays of treatment may occur due to deficiencies of equipment.
9. I understand that if my provider deems the service, he/she is providing to be inappropriate through TeleMedicine, he/she may require the remainder of said services to be carried out in person.
10. I understand that I may expect the anticipated benefits from the use of TeleMedicine in my care, but that no results can be guaranteed or assured.
11. I acknowledge that I have been made aware of the above information regarding TeleMedicine and have reached out to SPSI to answer any questions or concerns I have. I hereby give my informed consent for the use of TeleMedicine with SPSI.

Signatures Attesting to My Informed TeleMedicine Consent for Services:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

INTENTIONALLY LEFT BLANK

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Consent to Discharge Agreement

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

Discharge Policy: Under certain circumstances, clients may be discharged for cause from treatment or participation in services at Saginaw Psychological Services Inc. Conditions that may precipitate involuntary discharge are as follows:

- Acts of violence against either staff or other clients of the agency.
- Threats of violence against either staff or other clients of the agency.
- Failure to maintain scheduled appointments.
- Failure to remain in regular contact with SPSI for more than thirty (30) days.
- Failure to work toward treatment plan objectives.
- Failure to adhere to these SPSI agreements and policies
    - Financial Responsibility
    - Coordination of Care
    - TeleMedicine Services

Client discharge decisions are made by the SPSI clinical program director in consultation with your primary clinician. Acts or threats of violence may result in immediate discharge by the clinical staff present at the time of such act.

I understand that in the instance of involuntary discharge, I have the right to appeal the discharge to the clinical program director and recipient rights personnel.

If I am being considered for involuntary discharge, I will be notified of this in writing. In cases of acts or threats of violence, written discharge is not provided, rather a verbal discharge at the time of the incident is provided.

I have reviewed and understand the criteria for discharge described above.

Signatures Attesting to My Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

INTENTIONALLY LEFT BLANK

SAGINAW
Psychological
SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Drug and/or Alcohol Testing Consent Form

I hereby agree, upon a request made under the drug/alcohol testing policy of SPSI, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if at any time I refuse to submit a sample for drug or alcohol testing, under policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to termination. I further authorize and give full permission to have SPSI send any specimen collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to SPSI and/or to the PIHP.

I understand that only duly authorized SPSI employees and MSHN will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make treatment decisions.

I will hold harmless SPSI, MSHN, and any testing laboratory that SPSI might use, meaning that I will not sue or hold responsible such parties for any alleged harm that might result from such testing, even if SPSI or laboratory makes an error in the administration, analysis, of the test or the reporting of the results. I will further hold harmless SPSI. MSHN, and any testing laboratory that SPSI might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as release or use of information is within the scope of this policy and the procedures explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have questions about the test or the policy, they will be answered.

I understand that SPSI and MSHN will require a drug screen and/or alcohol test under this policy on a random basis, while I am involved in treatment with SPSI and MSHN, and I agree to submit to any such test.

Printed Name of Client: _____

Signature of Client_____ Date: _____

Signature of Representative: _____ Date: _____

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as “substance use disorder” throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☐ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 3: What Information You Want to Share

Choose one option:

☐ Share **all** my behavioral health and substance use disorder records. This does not include "psychotherapy notes."

☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)

  Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed above in Section 1.

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdrawal	Print Name	Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.

Additional Identifiers (Optional)

Medicaid Last 4 of the Social Security Number

Form Copy (Optional, Choose One Option)

☐ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Communicable Disease Risk Assessment

Instructions to interviewer: The intent of this interview is to help you and your client determine if your client is at risk for a significant communicable disease. The questions cited below focus on important risk factors and symptoms related to HIV infection, Hepatitis B, Tuberculosis, and Sexually Transmitted Diseases. If your client responds "yes" to any of these questions, immediately refer him/her for medical evaluation and follow up on the results. If your client responds "no" to every question, recommend a medical evaluation and the recommended screenings as outlined on the previous pages, although this can be accomplished sometime later during the course of substance abuse treatment. Medical evaluations may be obtained through local health departments and through private medical providers.

PART 1

Individuals who report a history of substance abuse are at a greater risk for developing certain serious communicable diseases. Please answer the follow questions to determine if you may need further health screening.

	Yes	No
A. The following questions relate to HIV (the virus that causes AIDS), Hepatitis and Sexually Transmitted Diseases (STD's): 1. Have you ever had unprotected sex or engaged in sexual behaviors (oral, anal, or genital) with a person whose HIV, Hepatitis or Sexually Transmitted Disease (STD) status is unknown to you? (For example, sex while drunk or high with a person you do not know very well.)		
2. Have you ever engaged in sexual behavior with anyone who has: Injected drugs?		
Traded sex for drugs?		
Many sexual partners?		
HIV / AIDS?		
Hepatitis?		
STD's?		
3. Have you ever shared needles or injecting "works" with other individuals?		
4. Have you experienced other forms of blood-to-blood or body fluid contact (for example, blood transfusions, hemophilia treatments, employment in medical field), and have concerns about your risk for HIV, Hepatitis, or STD's?		
B. Individuals who abuse substances are also at risk for contracting Tuberculosis (TB). Please answer the following questions to determine if you may need health screening for TB: 1. Have you recently lived in a substance abuse treatment facility, homeless shelter, drug house, jail, mental hospital or in other close quarters with people you did not know well?		
2. Have you recently had close contact with someone diagnosed with or being treated for TB?		

3. Have you had a nagging cough for more than three weeks along with any of the following symptoms: a. Weight loss?		
b. Fever for 3 days or longer?		
c. Night sweats?		
d. Coughing up blood?		

I understand that if I answered "Yes" to any of the above questions, I may be at risk for HIV, Hepatitis, STD's, or TB. I have been given information on how HIV, Hepatitis, STD's and TB are transmitted and how substance abuse can put me at risk for contracting these diseases. I have been told about ways to decrease the risk for getting these diseases or giving them to others.

Client Signature: _____ Date: _____

PART 2 To be completed by CDR or Treatment Program.

1. This individual is a high risk candidate for (check all that apply):

   ____ HIV ____ STD's ____ Hepatitis ____ TB

2. If at risk, a referral ***must*** be indicated (check all that apply):

   ____ Health Department ____ Private Physician (name): _____

   ____ Wellness Network ____ Other (specify): _____

CDR or Treatment Staff Signature: _____ Date: _____

PART 3 To be completed by the program only when risk assessment has been forwarded by the CDR.

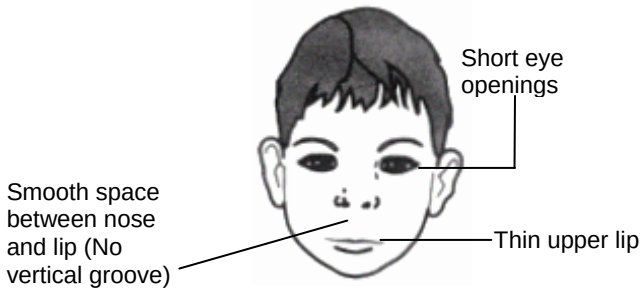
Name of Treatment Agency: Saginaw Psychological Services, Inc.

I have reviewed and updated where necessary this Communicable Disease Risk Assessment with the client, and have dated and initialed any additions or deletions to this information. I have reviewed with this client all referrals based on the results of this Risk Assessment.

Treatment Staff Signature: _____ Date of review: _____

Michigan Department of Community Health
Fetal Alcohol Spectrum Disorders Program
FETAL ALCOHOL SYNDROME PRE-SCREEN

Fetal Alcohol Syndrome (FAS) is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This form is not intended to take the place of a diagnostic evaluation.



FACIAL FEATURES

Last Name:	First Name:	Sex: ☐ Male ☐ Female
Address:		Race:
City, State, ZIP code:		Birthdate:
Parent/Caregiver Name(s):		Home Phone:
Child is: ☐ Biological ☐ Foster ☐ Adopted ☐ Other		Work Phone/Cell:

*If **2 or more** of the identifiers listed below are noted, the individual should be referred for a full FAS Diagnostic Evaluation.*

IDENTIFIERS	CHECK OR EXPLAIN IF A CONCERN EXISTS
1. Height and weight seem small for age	
2. Facial features (see diagram above)	
3. Size of head seems small for age	
4. Behavioral concerns: (any one of these qualifies as an identifier) • Sleeping/eating problem • Mental retardation or IQ below familial expectations • Attention problem/impulsive/restless • Learning disability • Speech and/or language delays • Problem with reasoning and judgment • Acts younger than children the same age	
5. Maternal alcohol use during pregnancy	

Any previous diagnosis:_____

Screener:_____ Agency:_____

FAS Diagnostic Centers in Michigan (to schedule a full FAS Diagnostic Evaluation):

Ann Arbor: 734-936-9777 Grand Rapids: 616-391-2319 Marquette: 906-225-4777

Detroit: 313-993-3891 Kalamazoo: 269-387-7073

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
_____	_____	_____	_____	_____

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	○	○
2. Did you try to control or cut down on your drug use but were unable to do it?	○	○
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4. Did you have a strong desire or urge to use drugs?	○	○
5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6. Did you continue using drugs even when it led to social or interpersonal problems?	○	○
7. Did you spend less time at work, school, or with friends because of your drug use?	○	○
8. Did you use drugs that put you or others in physical danger?	○	○
9. Did you continue using drugs even when it was causing you physical or psychological problems?	○	○
10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
10b. Did using the same amount of a drug lead to it having less of an effect as it did before?	○	○
11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○
11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

○ None
○ Alcohol
○ Cannaboids – Marijuana *(weed)*
○ Cannaboids – Hashish *(hash)*
○ Synthetic Marijuana *(K2/Spice)*
○ Natural Opioids – Heroin *(smack)*
○ Synthetic Opioids – Fentanyl/Iso
○ Stimulants – Powder Cocaine *(coke)*
○ Stimulants – Crack Cocaine *(rock)*
○ Stimulants – Amphetamines *(speed)*
○ Stimulants – Methamphetamine *(meth)*
○ Synthetic Cathinones *(Bath Salts)*
○ Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
○ Dissociative Drugs – Ketamine/PCP *(Special K)*
○ Hallucinogens – LSD/Mushrooms *(acid)*
○ Inhalants – Solvents *(paint thinner)*
○ Prescription Medications – Depressants
○ Prescription Medications – Stimulants
○ Prescription Medications – Opioid Pain Relievers
○ Other (specify) _____

Client ID#	Today's Date	Facility ID#	Zip Code	Administration

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana *(weed)*	○	○	○	○	○
c. Cannaboids – Hashish *(hash)*	○	○	○	○	○
d. Synthetic Marijuana *(K2/Spice)*	○	○	○	○	○
e. Natural Opioids – Heroin *(smack)*	○	○	○	○	○
f. Synthetic Opioids – Fentanyl/Iso	○	○	○	○	○
g. Stimulants – Powder cocaine *(coke)*	○	○	○	○	○
h. Stimulants – Crack Cocaine *(rock)*	○	○	○	○	○
i. Stimulants – Amphetamines *(speed)*	○	○	○	○	○
j. Stimulants – Methamphetamine *(meth)*	○	○	○	○	○
k. Synthetic Cathinones *(Bath Salts)*	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms *(acid)*	○	○	○	○	○
o. Inhalants – Solvents *(paint thinner)*	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. Other (specify)_____	○	○	○	○	○

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

○ *Never* ○ *1 time* ○ *2 times* ○ *3 times* ○ *4 or more times*

15. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

○ *Never* ○ *Only a few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

17. How important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*