Thank you for your referral for the Ellis Human Development Institute.

To make a Montgomery County Department of Jobs and Family Services- Children Services Division referral, please complete the attached MCDJFS Intake Packet and send to:

Ellis Human Development Institute  
9 N. Edwin C. Moses Blvd.  
Dayton, OH 45402

Or Fax to 937-775-4311

Referrals to the Ellis Institute must contain the following information in order to meet regulatory requirements and initiate a diagnostic assessment. If you have any questions about the enclosed information, please call 937-775-4300 and our clinical staff will be happy to assist with the referral process.

After we have the completed information, we will contact the foster parent, prospective adoptive parent, or the caseworker to schedule an intake appointment. Please identify who we should contact:

- Foster Parent  
- Prospective Adoptive Parent  
- MCDJFS Caseworker  
- Other:_________

**Intake Packet Checklist**—Please complete all of the following forms in their entirety and send them to the address listed above:

- A copy of the current Custody Order or a statement on agency letterhead stating that your agency currently has custody of the child. The Custody Order *must be received* before the appointment can be scheduled.

- A release of information for the foster parent(s) and/or prospective adoptive parent unless it is requested that they not be a part of the assessment or treatment process.

- Any additional releases for other persons, agencies, or schools should be included.  
  *Note:* A release of information is not necessary between Ellis Human Development Institute and your organization if you have custody of the child. Release forms can be copied.

- MDCJFS-CSD Intake Referral Information Form

- Parent Background Form: please complete all 9 pages

- Health History Questionnaire: please complete all 4 pages through the top of page 4 (signature of person completing this questionnaire)

- Previous evaluations which are currently available (e.g., school ETR/IEP, Diagnostic Assessment from counselor or psychiatrist, evaluations conducted by MCDJFS, Child Study Inventory)

- Childhood Trust Survey: to be completed by an adult who is aware of the child's trauma history

- A signed copy of the Consent for Treatment and Client Orientation Checklist, giving permission to Ellis to provide services. Please initial and sign as indicated on the form.

- Disclosure Statement: Please enter the child’s name at the top and sign the form at the bottom. Once the case is assigned to a clinician, we will fax you a copy of the form with the clinician’s name and supervisor’s name for your records.

*Note:* A copy of the Ellis Human Development Institute’s Note of Privacy Practices is also included with this packet for your review. There is also a link to our Notice of Privacy Practices on our website.
Authorization for Release of Protected Health Information

Client Name: ___________________________ Client #: __________________ Birth Date: ________________
Social Security #: ______________________ Name of Provider: ________________________________

I hereby grant my permission for release, review, and exchange of the following information relating to my care between the parties named here. This release is intended to cover all services provided by the Ellis Human Development Institute.

I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties. List limitations, if any: ________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________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Referral Date: __________ Person Completing form: __________________________ Phone: __________

Caseworker Name: ______________________________________ Caseworker Phone: __________

May we leave a message? □ Yes □ N

Child’s Name: (Last, First, MI): ______________________________________

DOB: ______ Gender: __________ Preferred spoken language: ______________________

Social Security #: __________________________ Medicaid # (12 digits): ________________

Caretaker Name: __________________________________ Caretaker Phone: __________

Caretaker Address: ____________________________________________

Current Medications: ____________________________________________

Lethality/Safety Issues: __________________________________________

School/Grade/Special Education Placement: _________________________

Counseling History: _____________________________________________

Previous Assessments: __________________________________________

Relevant Social History Including Placement History, Number of Disruptions, and Family History:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Recommendations/Request/Reasons for Referral: ____________________________
________________________________________________________________
________________________________________________________________
Please answer all of the following questions as honestly as possible with a BLUE or BLACK INK PEN.

CLIENT NAME: ___________________ NUMBER: ____________ DATE: ____________

DATE OF BIRTH: ________________ SEX: M __ F ___

FORM COMPLETED BY: ____________________________

RELATIONSHIP TO CHILD: ___________________________________________________________________
(Please indicate if child is adopted)

Why are you referring your child for services at this time: _______________________________________

Who referred you to us: _____________________________________________________________________

MEDICAL HISTORY

1. The child’s present state of health is: ___Good ___Fair ___ Poor

2. Does she/he currently have any medical problem(s)? ___No ___Yes
   If you answered “yes,” please indicate the nature of the problem(s): ___________________________
   _____________________________________________________________________________________

3. When was she/he last treated by a physician? Date: ________________
   Please indicate where: ___Private ___Physician ___Clinic
   Name of Physician or Clinic: _____________________________________________________________
   Address: _____________________________________________________________________________

4. When did she/he receive his/her last physical? Date: ________________
   Name of Physician or Clinic: ___________________________________________________________
   Address: _____________________________________________________________________________

5. Do you have a family physician: ___No ___Yes
   Name of Physician: _________________________________________________________________
   Address: ____________________________________________________________________________

6. Please check any of the following which have been a problem for your child:
   _____ Sleep problems _____ Problems w/ motor coordination
7. Does this child have any allergies?  ___ No  ___ Yes  
If “yes,” please name the drug(s), food(s), or other substance(s) to which she/he is allergic:

---

**EARLY DEVELOPMENT**

1. Did the mother have any difficulties with the pregnancy, labor, or delivery of this child?  ___ No  ___ Don’t Know  ___ Yes  
If ‘Yes’, please specify: _____________________________________________

---

2. What was the child’s weight at birth:  ____ lbs.  ____ oz.

---

3. Did the child have any problems at birth?  ___ No  ___ Don’t Know  ___ Yes  
If ‘Yes’, please specify: _____________________________________________

---

4. Was this child’s rate of development normal during the first 18 months?  
___ No  ___ Don’t Know  ___ Yes  
If ‘Yes’, please specify: _____________________________________________

---

5. Please check the appropriate age at which your child performed the following:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Under 6 Months</th>
<th>Between 6 Mths-1 Year</th>
<th>Between 1 &amp; 1½ Years</th>
<th>Over 1½ Years</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawled</td>
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<tr>
<td>Walked</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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5. Check any of the following which describe how you felt about having this child:
   ___ Happy       ___ Unprepared       ___ Unhappy
   ___ Nervous     ___ Life disrupted   ___ Financially burdened
   ___ Excited     ___ Fulfilled
   ___ Other, please specify: ____________________________

   ___________________________________________________

6. Which of the following best describes this child as an infant?
   ___ Fun           ___ Sickly         ___ Fussy
   ___ Overactive    ___ Quiet          ___ Irritating

   Summary
   (please do not write in this space)

   ___________________________________________________

   ___________________________________________________

   ___________________________________________________

   ___________________________________________________

   ___________________________________________________

   ___________________________________________________

   ___________________________________________________

SOCIAL AND FAMILY HISTORY

1. What grade is this child in now?

2. How many different schools has this child attended?

3. What kind of grades does she/he make in school?
   ___ Excellent       ___ Good          ___ Fair        ___ Poor        ___ Failing

4. Has this child ever repeated a grade? ___ No     ___ Yes
   If ‘Yes’, please specify: ____________________________

   ___________________________________________________

5. Has this child ever had specialized testing at school?
   ___ No     ___ Yes
   If ‘Yes’, please specify: ____________________________

   ___________________________________________________

6. How would you describe the child’s school attendance? ___ Good     ___ Fair    ___ Poor

7. Does this child have problems in school? ___ No     ___ Yes
   If ‘Yes’, please specify: ____________________________

   ___________________________________________________
8. How well does this child get along with other children?
   ___ Very well  ___ Not very well
   ___ Satisfactory  ___ Very poorly

9. Does this child participate in school activities? ___ No  ___ Yes, some  ___ Yes, many

10. Choose those characteristics which describe your child’s attitude toward authority figures (teachers, parents, etc.)
    ___ Assertive  ___ Cooperative
    ___ Defiant  ___ Excessive demands for attention
    ___ Fearful  ___ Overly anxious to please
    ___ Respectful  ___ Shy
    ___ Submissive  ___ Uncooperative

11. Are most of this child’s close friends: ___ Same age  ___ Older  ___ Younger

12. Are most the child’s close friends: ___ Same age  ___ Opposite sex  ___ Both sexes

13. What does this child do well?
    ___________________________________________________________
    ___________________________________________________________

14. Does this child have interests or hobbies she/he enjoys? ___ No  ___ Yes
    If ‘Yes’, please specify: _______________________________________
    ___________________________________________________________

15. Does this child have a strong fear about any of the following?
    ___ Being left alone  ___ Being in crowds
    ___ The dark  ___ Strangers
    ___ Any animals or insects  ___ Bodily harm
    ___ Thunder or lightning  ___ Death
    ___ Closed in places  ___ Riding in a car
    ___ High places  ___ No known fears
    ___ Other, please specify: ______________________________________

16. Check any of the following which apply to your child:
    ___ Lonely  ___ Obedient  ___ Clumsy
    ___ Destructive of
        property
    ___ Dependable  ___ Sleep-walking
    ___ Fire setting  ___ Artistic for age
    ___ Friendly  ___ Acts young
    ___ Cruel to animals  ___ Acts old for age
    ___ Energetic
    ___ Shy
    ___ Overactive

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<table>
<thead>
<tr>
<th>Rigid/compulsive</th>
<th>Feelings easily hurt</th>
<th>Impulsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent</td>
<td>Easily influenced</td>
<td>Clinging</td>
</tr>
<tr>
<td>Daydreaming</td>
<td>Sleep problem</td>
<td>Stubborn</td>
</tr>
<tr>
<td>Messy</td>
<td>Sense of humor</td>
<td>Lazy</td>
</tr>
<tr>
<td>Bed wetting</td>
<td>Nail-biting</td>
<td>Tells lies</td>
</tr>
<tr>
<td>Irresponsible</td>
<td>Self-confident</td>
<td>Considerate</td>
</tr>
<tr>
<td>Cries easily</td>
<td>Fights constantly</td>
<td>Steals</td>
</tr>
<tr>
<td>Loving</td>
<td>Likes to be alone</td>
<td>Jealous</td>
</tr>
<tr>
<td>Often sad</td>
<td>Unsure of self</td>
<td>Nightmares</td>
</tr>
<tr>
<td>Nervous</td>
<td>Temper tantrums</td>
<td>Short attention</td>
</tr>
<tr>
<td>Independent</td>
<td>Many physical complaints</td>
<td>span</td>
</tr>
</tbody>
</table>

17. Has your child ever had previous treatment for any of the above?  __No  __Yes
Whom did she/he see? ____________________________________________________________

Address: ______________________________________________________________________

18. Did anything happen that affected the family shortly before your child's behavior problem occurred?

__Death – Specify: ____________________________________________________________

__Job change – Specify: _______________________________________________________

__Divorce/Separation – Specify: ________________________________________________

__Birth/Adoption – Specify: ____________________________________________________

__Other – Specify: _____________________________________________________________

__No

21. Check all persons with whom this child has lived most of her/his life and indicate how well s/he gets along with these people.

<table>
<thead>
<tr>
<th></th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
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<tbody>
<tr>
<td>Natural Mother</td>
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<td>Natural Father</td>
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<tr>
<td>Stepmother</td>
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<tr>
<td>Stepfather</td>
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<tr>
<td>Adoptive parents</td>
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<td>Foster parents</td>
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<td>Brothers (list)</td>
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<tr>
<td>Sisters (list)</td>
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<td>Other relative(s) (who?)</td>
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<td>Institution (where?)</td>
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</tbody>
</table>

22. Whom does child live with now?

23. In your family, who likes your child best?

24. In your family, who likes her/him least?

25. Does your child remind you of anyone else (yourself, spouse, a relative)?
   No    Yes
   If ‘Yes’, please specify: ____________________________
   ____________________________
   ____________________________

26. Does another child in this family have a serious medical or emotional problem?
   No    Yes
   If ‘Yes’, please specify child and condition: ____________________________
   ____________________________
   ____________________________
27. Does your family regularly engage in family activities? ___No    ___Yes
   Please describe: ____________________________________________________________
   ________________________________

28. Have you had trouble with the police? ___No    ___Yes
   If ‘Yes’, please specify: ____________________________________________________
   ________________________________

29. Has your child had trouble with the police? ___No    ___Yes
   If ‘Yes’, please specify: ____________________________________________________
   ________________________________

30. Please complete the following:
   Child’s   Child’s   Step-Parent,
   Mother   Father   if applicable

   Age (present)   _____   _____   ______

   Age when first married to
   First spouse     _____   _____   ______

   Total number of marriages
   _____   _____   ______

   Number of children by previous
   Marriage         _____   _____   ______

   Years of schooling
   _____   _____   ______

   Occupation       _____   _____   ______

31. How often do you attend religious services? ________________________________

32. Check any of the following which describe your relationship with your current
   spouse:
   _____Stormy       _____Indifferent       _____Unrewarding
   _____Disappointing _____Harmonious       _____Impossible
   _____Happy        _____Mistake          _____Understanding
   _____Devoted      _____Wholesome        _____Hopeless
   _____Insecure     _____Average          _____Secure

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33.1 In general, would you say life in your present family is:
   ______ Excellent    ______ Good    ______ Fair    ______ Poor    ______ Bad

34. How do you get along with your other child(ren)?
   ______ Very well    ______ Fairly well    ______ Not very well    ______ Very poorly

35. How well does your spouse or partner get along with your other child(ren)?
   ______ Very well    ______ Fairly well    ______ Not very well    ______ Very poorly

36. How do you usually punish your child(ren)?
   ______ Spanking
   ______ Withholding privileges
   ______ Privileges
   ______ Assigning work duties
   ______ Spanking and withholding
   ______ Other, specify

37. How does your spouse/partner usually punish your child(ren)?
   ______ Spanking
   ______ Withholding privileges
   ______ Privileges
   ______ Assigning work duties
   ______ Spanking and withholding
   ______ Other, specify

38. Is getting away from your child(ren) - (having time for yourself) a problem for you?
   ______ No    ______ Yes

39. Do you feel your life is being disrupted by this child? ______ No  ______ Yes

40. Do you or others feel you or your spouse/partner have a problem with use of drugs or alcohol?
    ______ No

    ______ Yes, I do with

    ______ Yes, my spouse does with

41. Do you and your spouse disagree frequently about this child?
    ______ No  ______ Yes

42. Was your home life a happy one?  ______ No  ______ Yes

43. Were you raised by your natural parents?  ______ Yes  ______ No
    Specify by whom:

44. How were you usually punished as a child?
    ______ Spanking
    ______ Withholding privileges
    ______ Privileges
    ______ Assigning work duties
    ______ Spanking and withholding
    ______ Other, specify

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45. Carefully read the following list, then check up to five (5) traits that were stressed in your home during your childhood.

- Personal appearance
- Warmth and affection
- Power and position
- Aggressiveness
- Social obligations
- Cleanliness
- Independence
- Generosity
- Quietness
- Fun
- Religion
- Initiative
- Manners
- Thrift
- Honesty
- Ambition
- Education
- Morality
- Pride
- Work
- Survival
- Obedience
- Security
- Other, specify

46. Please state here any additional information you feel may be important (include how you think this child could be helped, i.e., counseling with parents and/or teacher, psychological testing, medication, individual therapy, etc.):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
**HEALTH HISTORY QUESTIONNAIRE**

This form should be completed as fully as possible by client but reviewed by medical or clinical staff. Clients should notify staff if they need any assistance in completing this form.

<table>
<thead>
<tr>
<th>Client Name (First, Ml, Last)</th>
<th>Client No.</th>
<th>Age</th>
</tr>
</thead>
</table>

Has the client had any of the following health problems?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Now</th>
<th>Past</th>
<th>Never</th>
<th>Treatment Received and Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
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<td>Arthritis</td>
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<td>Asthma</td>
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<tr>
<td>Bleeding Disorder</td>
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<tr>
<td>Blood Pressure (high or low)</td>
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<tr>
<td>Bone/Joint Problems</td>
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<tr>
<td>Cancer</td>
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<td>Cirrhosis/Liver Disease</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy/Seizures</td>
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<tr>
<td>Eye Disease/Blindness</td>
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<tr>
<td>Fibromyalgia/Muscle Pain</td>
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<td>Glaucoma</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Head Injury/Brain Tumor</td>
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<tr>
<td>Hearing Problems/Deafness</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Hepatitis/Jaundice</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Lung Disease</td>
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<tr>
<td>Menstrual Pain</td>
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<tr>
<td>Oral Health/Dental</td>
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<tr>
<td>Stomach/Bowel Problems</td>
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<tr>
<td>Stroke</td>
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<td>Thyroid</td>
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<td>Tuberculosis</td>
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<tr>
<td>AIDS/HIV</td>
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<tr>
<td>Sexual Transmitted Disease</td>
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<tr>
<td>Learning Problems</td>
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<tr>
<td>Speech Problems</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Bipolar Disorder</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Eating Disorder</td>
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<tr>
<td>Hyperactivity/ADD</td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Sexual Problems</td>
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<tr>
<td>Sleep Disorder</td>
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<tr>
<td>Suicide Attempts/Thoughts</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

Please note family history of any of the above conditions and client's relationship to that family member.
<table>
<thead>
<tr>
<th>Client Name (First, Mi, Last)</th>
<th>Client No.</th>
</tr>
</thead>
</table>

**Has client had medical hospitalizations/surgical procedures in the last 3 years?**
- [ ] Yes
- [ ] No

If yes, complete information below.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City</th>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
</table>

**Allergies/Drug Sensitivities**
- [ ] None
- [ ] Food (specify):
- [ ] Medicine (specify):
- [ ] Other (specify):

**Pregnancy History (if applicable)**
- [ ] Not Applicable

**Currently pregnant?** If yes, expected delivery date.
- [ ] No
- [ ] Yes

**Receiving pre-natal healthcare?** If yes, indicate provider.
- [ ] No
- [ ] Yes

**Last Menstrual Period Date**

**Any significant pregnancy history?** If yes, explain.
- [ ] No
- [ ] Yes

**Last Physical Examination**

<table>
<thead>
<tr>
<th>By Whom</th>
<th>Date</th>
<th>Phone No. (if known)</th>
</tr>
</thead>
</table>

**Has client had any of the following symptoms in the past 60 days? Please check.**

- [ ] Ankle Swelling
- [ ] Bed-wetting
- [ ] Blood in Stool
- [ ] Breathing Difficulty
- [ ] Chest Pain
- [ ] Confusion
- [ ] Consciousness Loss
- [ ] Constipation
- [ ] Coughing
- [ ] Cramps
- [ ] Diarrhea
- [ ] Dizziness
- [ ] Falling
- [ ] Gait Unsteadiness
- [ ] Hair Change
- [ ] Hearing Loss
- [ ] Light-headedness
- [ ] Memory Problems
- [ ] Mole/Wart Changes
- [ ] Muscle Weakness
- [ ] Nervousness
- [ ] Nosebleeds
- [ ] Numbness
- [ ] Panic Attacks
- [ ] Penile Discharge
- [ ] Pulse Irregularity
- [ ] Seizures
- [ ] Shakiness
- [ ] Sleep Problems
- [ ] Sweats (night)
- [ ] Tingling in Arms & Legs
- [ ] Tremor
- [ ] Urination Difficulty
- [ ] Vaginal Discharge
- [ ] Vision Changes
- [ ] Vomiting
- [ ] Other: __________

**Immunizations**

**Immunizations (Child or MR/DD only) - Has client had or been immunized for the following diseases? Please check.**

- [ ] Chicken Pox
- [ ] Diphtheria
- [ ] German Measles
- [ ] Hepatitis B
- [ ] Measles
- [ ] Mumps
- [ ] Polio
- [ ] Small Pox
- [ ] Tetanus
- [ ] Other: __________

**Immunizations Within the Past Year**

**Height/Weight**

**Height**
- [ ] No
- [ ] Yes

If reporting for a child, has height changed in the past year?
- [ ] No
- [ ] Yes

If yes, by how much (+ or -)?

**Weight**
- [ ] No
- [ ] Yes

Has client’s weight changed in the past year?
- [ ] No
- [ ] Yes

If yes, by how much (+ or -)?
Nutritional Screening (please check)

- No Problem
- Eating: More, Less, Not Eating
- Drinking: More, Less, Takes Liquids Only
- Appetite: Increased, Decreased

- Nausea
- Vomiting
- Trouble Chewing or Swallowing

Special Diet: Other

Pain Screening

- Does pain currently interfere with your activities? Yes
- If yes, how much does it interfere? Not at All, Mildly, Moderately, Severely, Extremely

Please indicate the source of the pain.

Substance Use History/Current Use (please check appropriate columns)

<table>
<thead>
<tr>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Wine</td>
<td></td>
<td></td>
<td></td>
<td>Sleep Medication</td>
<td></td>
<td></td>
<td></td>
<td>Cocaine/Crack</td>
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<tr>
<td>Marijuana</td>
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<td></td>
<td>Tranquilizers</td>
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<td></td>
<td></td>
<td>Heroin</td>
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<td>Hashish</td>
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<td></td>
<td>Hallucinogens</td>
<td></td>
<td></td>
<td></td>
<td>Pain Medication</td>
<td></td>
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<tr>
<td>Stimulants</td>
<td></td>
<td></td>
<td></td>
<td>Inhalants</td>
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<td></td>
<td></td>
<td>Other</td>
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</tbody>
</table>

- Caffeine use? Yes
- How much per week (cups, bottles)?

- Tobacco use? Yes
- How much per week (packs, etc.)

- Are you currently prescribed medications?
  - Yes, No
  - If yes, complete information below.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Prescribing Physician</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Please describe your use of complementary health approaches (i.e. massage, chiropractic, homeopathic remedies, acupuncture, herbs, probiotics, etc.):
<table>
<thead>
<tr>
<th>Comments, Recommendations, or Referrals by Medical Reviewer</th>
<th>☐ No Referral Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Referral(s) Needed and Specify Action(s)</td>
<td></td>
</tr>
<tr>
<td>☐ Primary Care Physician:</td>
<td></td>
</tr>
<tr>
<td>☐ Healthcare Agency:</td>
<td></td>
</tr>
<tr>
<td>☐ Specialty Care:</td>
<td></td>
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<tr>
<td>☐ Other, specify:</td>
<td></td>
</tr>
<tr>
<td>Recommendations shared with client? If yes, client's response.</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Provider signature</td>
<td></td>
</tr>
<tr>
<td>Supervisor Signature</td>
<td></td>
</tr>
<tr>
<td>If no, how will recommendations be shared with client?</td>
<td></td>
</tr>
<tr>
<td>Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
The Childhood Trust Events Survey
Children and Adolescents: Caregiver Form
Version 2.0; 10/10/2006

It is important for us to understand what may have happened to your child. The questions below describe some kinds of upsetting experiences. Since we give these questions to everyone, we list a lot of possible events that may have happened at any time in your child’s life. If one or more of these experiences has happened at some time in your child’s life, please circle Y for Yes. If not, circle N for No. If you are unsure, circle DK for Don’t Know. Thank you for completing this survey.

1. Was your child ever in a really bad accident, such as a serious car accident? Y N DK
2. Was your child ever in a disaster such as a tornado, hurricane, fire, big earthquake, or flood? Y N DK
3. Was your child ever so badly hurt or sick that he/she had to have painful or frightening medical treatment? Y N DK
4. Has your child ever been threatened or harassed by a bully (someone outside of his/her family)? Y N DK
5. Has your child ever repeatedly had a parent swear at him/her, insult him/her, or had hurtful things said to him/her such as “You are no good,” “You will be sent away because you are bad,” or “I wish you were never born”? Y N DK
6. Was your child ever completely separated from his/her parent(s) for a long time, such as going to a foster home, the parent living far apart from him/her, or never seeing the parent again? Y N DK
7. Has your child ever had a family member who was put in jail or prison or taken away by the police? Y N DK
8. Has your child ever had a time in his/her life when he/she did not have the right care, such as not having enough to eat, being left in charge of younger brothers or sisters for long periods of time, or being left with an adult who used drugs? Y N DK
9. Has your child ever had a time in his/her life when he/she was living in a car, living in a homeless shelter, living in a battered women’s shelter, or living on the street? Y N DK
10. Has your child ever had someone living in his/her home who abused alcohol or used street drugs? Y N DK
11. Has your child ever seen someone in the home try to hurt or kill himself/herself, such as cutting himself/herself or taking too many pills or drugs?

Page 1 subtotal  ___  ___  ___
12. Has your child ever had a family member who was depressed or mentally ill for a long time?  Y  N  DK

13. Has your child ever had a family member or someone else very close to him/her die unexpectedly?  Y  N  DK

14. Has someone in your child’s home ever been physically violent toward him/her, such as whipping, kicking, or hitting hard enough to leave marks?  Y  N  DK

15. Has an adult ever said they were going to hurt your child really badly or kill him/her, or acted like they were going to hurt your child very badly or kill him/her, even if this person didn’t actually do it?  Y  N  DK

16. Has your child ever seen or heard family members act like they were going to kill or hurt each other badly, even if they didn’t actually do it?  Y  N  DK

17. Has your child ever seen or heard a family member being hit, punched, kicked very hard, or killed?  Y  N  DK

18. Has your child ever seen someone in his/her neighborhood be beaten up, shot at or killed?  Y  N  DK

19. Has someone ever robbed or tried to rob (jump) your child or your child’s family with a weapon?  Y  N  DK

20. Has someone ever kidnapped your child or has someone close to your child ever been kidnapped?  Y  N  DK

21. Has your child ever been badly hurt by an animal, such as attacked by a dog?  Y  N  DK

22. Has your child ever had a pet or animal that was hurt or killed on purpose by someone he/she knew?  Y  N  DK

23. Has your child ever seen a friend killed?  Y  N  DK

24. Has someone ever touched your child’s private sexual body parts when he/she did not want them to?  Y  N  DK

25. Has someone ever made your child touch another person’s private sexual body parts?  Y  N  DK

26. Has an adult ever tied your child up, gagged him/her, blindfolded him/her, or locked him/her in a closet or a dark scary place?  Y  N  DK

If more than one event happened AND still seems to bother your child, put a star next to the one that you believe bothers him/her the most.

Trauma Treatment Training Center
The Childhood Trust & The Mayerson Center for Safe and Healthy Children
Cincinnati Children’s Hospital Medical Center
3333 Burnet Ave, MLC 3006 Cincinnati, Ohio 45229-3039

This survey is a public domain document and may be freely reproduced and distributed without copyright restrictions. Please do not alter the item wording or content or the response format and then distribute the modified version under the original name. If you feel you must make any modifications of this survey, please rename it so that others will not be confused. For more information about this scale, please contact Erica Pearl, Psy.D. Email: erica.pearl@cchmc.org.
Client Orientation to Services Checklist & Consent to Treat—MCDJFS-CSD

I acknowledge that I have received and understand the Ellis Human Development Institute (EHDI) orientation information that consists of:

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Orientation Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consent to Treat</strong></td>
<td></td>
</tr>
<tr>
<td>I agree and hereby give consent for the Ellis Institute to provide services to me and/or my child under the conditions identified in the paragraphs below. In addition, I acknowledge that any psychological tests used will not be released to me, that test data may be collected and processed through the publisher’s electronic scoring system, and that the publisher of psychological testing materials may gain access to the test data scored and my electronic protected health information.</td>
<td></td>
</tr>
<tr>
<td><strong>Client Signature:</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Video Taping** |
| I understand that most services provided as part of the contact between the Ellis Human Development Institute and the Montgomery County Department of Job and Family Services will not be audio or video recorded. However, if the evaluation includes the Marschak Interaction Method (MIM), a structured observation of the parent-child relationship, the MIM will be video-recorded for supervision and scoring purposes. The MIM video recording is not part of the client’s record and, as such, will not be released to the client/guardian. **Please sign below:** |
| * I consent to video/audio recording for the MIM: |
| * I decline video/audio recording for the MIM: |

| **Initial Here** |
| **Training Clinic** |
| I understand that Ellis Institute is a training, service and research center and services are provided by doctoral level students who are under the supervision of licensed psychologists. |
| • If you are asked to participate in a research project, you will also be asked to sign a separate consent. Participation in research is always voluntary. Not participating in a research project does not affect your services. |

| **Initial Here** |
| **Receipt of HIPAA Privacy Policy** |
| I acknowledge that I have received the Ellis Institute’s HIPAA Privacy Policy, which was attached to this packet, entitled: **Notice of Privacy Practices.** The HIPAA policy is also located on the EHDI website. |

| **Initial Here** |
| **Client Services Handbook** |
| I acknowledge that I have access to a copy of the Ellis Institute’s Client Service Pamphlet, which includes the following information: |
| • Client Rights & Responsibilities |
| • Grievance Procedures |
| • Therapy and Treatment Planning Processes (Includes Satisfaction Surveys, quality of care & outcome achievement) |
| • Assessment of Needs |
| • Risks & Benefits of Treatment |
| • Client Code of Ethics |
| • Attendance & Cancellation Guidelines. |
| • Program Rules (Includes Involuntary Termination) |
| • No use of Seclusion and Restraint, no smoking, illicit or licit drugs or weapons brought into the facility. |
| • Confidentiality and Exceptions to Confidentiality |
| • Motivational incentives when appropriate (bus tokens, food, gift cards.) |

Fire Exit Locations and Evacuations will be communicated to clients by staff.

**Legal Rule with Minors**

➢ Disclosed to minor that parent and/or guardian has a right to access minor’s records.

I was given the opportunity to ask questions. I understand I can have these booklets read to me if I am unable to read them.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
<tr>
<td>EHDI Provider Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

Rev: 8/24/17
DISCLOSURE STATEMENT

Client Name:_________________________ Client ID#:_________________________

The staff of Duke E. Ellis Human Development Institute includes licensed psychologists, psychology fellows, psychology residents, psychology postdoctoral trainees, psychology interns, and psychology trainees with a range of training and experience. Services provided by the Psychology staff include individual, family, couples and group psychotherapy, psychological testing and assessment, psychoeducation and consultation services. If your mental health provider is a psychology trainee, a psychology intern or a psychology fellow or resident, he or she will be supervised by a licensed psychologist. The supervisor has ultimate professional responsibility for your care, and as such, all supervisees are required to discuss your treatment, including the content of your sessions and psychological testing results, with the supervisor. You have the right to know the status of the provider working with you, to know the identity of his or her supervisor and to meet with that supervisor if you so desire.

Supervisee assigned to your case is:_________________________ Phone:_________________________

His/her supervisor is:_________________________ Phone:_________________________

As you enter treatment, a client record or file is opened which includes information about your history, service plan, medications, progress and any testing results or correspondence which may be generated. This information is shared only with those involved in your treatment or with other staff within Duke E. Ellis Human Development Institute who may be consulted about your case. You must provide written consent before this information is shared with anyone outside of Duke E. Ellis Human Development Institute; however, Duke E. Ellis Human Development Institute may release information without your consent if the law requires that we do so. This might occur (a) if a court order is received; (b) if there is an emergency or a situation which threatens your life or the life of another; or (c) it is suspected that child or elder abuse and/or neglect has occurred, or abuse of MR/DD "vulnerable" adult. Knowledge/belief of domestic violence/abuse will be noted in the client records. (Other information regarding disclosure of information is outlined in the Client Services Handbook.)

The frequency of appointments will be determined by the mental health provider with input from the client. Appointments will be scheduled by the mental health provider or office staff, unless other arrangements are made. If illness or an emergency prevents you from keeping a scheduled appointment, please contact Duke E. Ellis Human Development Institute as soon as possible. Cost of services and billing will be consistent with Duke E. Ellis Human Development Institute's policies.

Supervisors do not typically provide back-up coverage for supervisees (i.e. psychology fellows, psychology postdoctoral trainees, psychology residents, psychology interns, and psychology trainees). In the event that a supervisee is temporarily or permanently unable to speak to or meet with clients on their caseload, backup coverage will be arranged in accordance with the policy in place at Duke E. Ellis Human Development Institute.

Mental health services are generally provided at:

Duke E. Ellis Human Development Institute
Wright State University
9 N. Edwin C. Moses Boulevard
Dayton, OH 45402

At times, services may be delivered in another location.

For emergency services at a time when Duke E. Ellis Human Development Institute is closed, you may contact Crisis Care (937-224-4646) or go to the nearest emergency room.

I understand and agree to the above conditions. I understand that my signature indicates my consent to treatment by a supervisee at Duke E. Ellis Human Development Institute.

_____________________________ ____________________________
Client or Parent/Guardian Date

_____________________________ ____________________________
Supervisee Date

_____________________________ ____________________________
Supervisor Date
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information. Wright State University and Ellis Human Development Institute ("Ellis Institute") are committed to protecting the privacy of client personal and health information. Applicable Federal and State laws require us to maintain the privacy of our clients' personal and health information. This Notice explains Ellis Institute’s privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal or protected health information ("PHI") is referred to as "health information" and includes information regarding your health care and treatment with identifiable factors such as your name, age, address, income or other financial information. We will follow the privacy practices described in this Notice while it is in effect.

How We Protect Your Health Information. We protect your health information by:

- Treating all of your health information that we collect as confidential.
- Stating confidentiality policies and practices in our staff handbooks, as well as disciplinary measures for privacy violations.
- Restricting access to your health information only to those clinical staff that needs to know your health information in order to provide our services to you.
- Only disclosing your health information that is necessary for an outside service company to perform its function on Ellis Institute’s behalf; such companies have by contract agreed to protect and maintain the confidentiality of your health information.
- Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations. Ellis Institute may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operations purposes, as long as you have given your consent to receive evaluation or treatment services from Ellis Institute. To help clarify these terms, here are some definitions:

- "Treatment, Payment, and Health Care Operations"
  Treatment is when a clinician provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a clinician consults with another health care provider, such as your family physician.  
  Payment is when a clinician obtains reimbursement for your healthcare. Examples of payment are when Ellis Institute discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.  
  Health Care Operations are activities that relate to the performance and operation of Ellis Institute. Examples of health care operations are quality assessment and improvement activities, business- related matters such as audits and administrative services, case management and care coordination, conducting training and educational programs or accreditation activities.
- "Use" applies only to activities within Ellis Institute such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of Ellis Institute, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization. Ellis Institute may use or disclose PHI for purposes outside treatment, payment, or healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Ellis Institute is asked for information for purposes outside of treatment, payment or healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist or practitioner has made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

Ellis Institute will obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice
- Psychotherapy notes

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Ellis Institute has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage; law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization. Ellis Institute may use or disclose PHI without your consent or authorization in the following circumstances:

- Abuse. If we have reason to believe that a minor child, elderly person, disabled person, or otherwise vulnerable person has been abused, abandoned, or neglected, we must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
- Health Oversight Activities. If there is an investigation involving a clinician that you have filed a formal complaint against, Ellis Institute may be required to disclose protected health information regarding your case.
- Judicial and Administrative Proceedings as Required. If you are involved in a court proceeding and a court subpoenaed information about the professional services provided you and/or the records thereof, we may be compelled to provide the information. Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order Ellis Institute to disclose personal health or treatment information. Ellis Institute will not release information without your written authorization, or that of your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party (e.g. Law enforcement agency or Social Security) or where the evaluation is court ordered.
- Serious Threat to Health or Safety. If you communicate to Ellis Institute personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s) including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death.

Revised 3.8.17
to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

- **Worker’s Compensation.** Ellis Institute may disclose protected health information regarding you as authorized by, and to the extent necessary, to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- **National Security.** We may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

- **Research.** Under certain limited circumstances, we may use and disclose health information for research purposes. All research projects, however, are subject to an institutional review board.

Sometimes the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state’s confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

**Patient’s Rights and Psychologist’s Duties: Patient’s Rights:**

- **Rights to Request Restrictions.** You have the right to request additional restrictions on certain uses and disclosures of protected health information. Ellis Institute may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at Ellis Institute. On your request, Ellis Institute will send your bills to another address.)

- **Right to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of your Ellis Institute health records. A reasonable fee may be charged for copying or, if necessary, redacting the record. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

- **Right to Amend.** You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

- **Right to an Accounting.** You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- **Electronic vs. Paper Copy.** If you received this notice electronically (e.g., accessing a website), you have the right to obtain a paper copy of the notice from Ellis Institute upon request.

- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

- **Right to Be Notified If There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

**Ellis Institute Duties:**

- Ellis Institute is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices.

- Wright State University and Ellis Institute reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, Ellis Institute is required to abide by the terms currently in effect.

**Other Restrictions.** Ellis Institute must also conform to Federal regulations (42 CFR, Part 2) regarding the release of alcohol/drug treatment records and confidentiality standards related to such treatment.

- In addition, couples and families seeking conjoint treatment sign a supplemental consent indicating they understand that the record of treatment services provided will not be released without authorization from all affected present. If one individual insists on his or her right to review and copy the record, the record will be redacted to protect the release of information about others when a private record is released to an individual.

**Changes to this Notice.** Wright State University and Ellis Institute reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may request a copy of the Notice at any time.

**Questions and Complaints.** For questions regarding this Notice or our privacy practices, please contact Ellis Institute.

If you are concerned that your privacy rights may have been violated, you may contact the Ellis Institute Privacy Officer listed below to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services whose address will be provided upon request.

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

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