HILL ALCOHOL AND DRUG TREATMENT
ADOLESCENT INFORMATION SHEET

Mother's Name: _____ **Contact #:** _____
Lives with? Y □ N □ **Release Signed? Y □ N □** **Alternate #:** _____

Father's Name: _____ **Contact #:** _____
Lives with? Y □ N □ **Release Signed? Y □ N □** **Alternate #:** _____

Stepmother's Name: _____ **Contact #:** _____
Lives with? Y □ N □ **Release Signed? Y □ N □** **Alternate #:** _____

Stepfather's Name: _____ **Contact #:** _____
Lives with? Y □ N □ **Release Signed? Y □ N □** **Alternate #:** _____

Siblings: **Name:** _____ **Age:** _____
Name: _____ **Age:** _____
Name: _____ **Age:** _____
Name: _____ **Age:** _____

Primary Custodial Parent: _____

Address: _____ **City:** _____ **Zip:** _____

School Name: _____ **Grade Level:** _____

Address: _____ **Phone#:** _____

Expelled? Y □ N □ **Duration?** _____

Probation? Y □ N □ **Beginning?** _____ **Ending?** _____

P/O Name: _____ **Contact#:** _____

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YOUNG PERSON (Age 13-17)
ASSESSMENT

Patient Name: _____

PRENATAL

1. Did Mother use prescription drugs or illicit substances during pregnancy or while breast feeding? Y □ N □
If yes, describe: _____
2. Did Mother abuse alcohol during pregnancy? Y □ N □
3. Was there any trauma to Mother during pregnancy? Y □ N □
If yes, describe: _____
4. Were there any complications during pregnancy? Y □ N □
If yes, describe: _____
5. Were there any medical complications at birth? Y □ N □
If yes, describe: _____
6. What was the child's birth weight? _____
7. Was the child full-term? Y □ N □
If not, birth was at how many months gestation? _____
8. What was the health of the child at the time of birth? (Apgar score if you know it? _____
9. Did the Mother suffer depression during pregnancy? Y □ N □
If yes, took Antidepressant Medication? Y □ N □
10. Was there any significant trauma or medical issues within the first year (including severe, prolonged fever)? Y □ N □
If yes, please describe: _____

EARLY CHILDHOOD DEVELOPMENT

11. List anything that was delayed or unusual in patient's early development: _____
_____

Check if Within Normal Limits

Sat up	□	Spoke First Word	□
Pulled up	□	Spoke in Sentences	□
Walked	□	Toilet Training	□
Off Bottle	□	Fed Self	□
Used Cup	□	Acclimated/Transitioned to School	□

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ACADEMIC DEVELOPMENT

12. Age child began to read: _____
13. Age child began to write: _____
14. Did child enjoy grade school? Y □ N □
15. What learning problems were evidenced in Grade School? _____

_____

16. What type of grades did child receive in Grade School? _____,
    Middle school? _____ , High School? _____
17. Did child enjoy Grade School? Y □ N □
    Middle School? Y □ N □
    High School? Y □ N □
18. Academic areas of achievement? _____
19. Academic areas of difficulty? _____
20. Was or is child in special programming at school? Y □ N □
    If yes, what? _____

SOCIAL DEVELOPMENT

21. Age started school: _____
22. Did child follow rules and norms in Grade Schoo? Y □ N □
    If no, give examples: _____
23. Was there evidence of separation anxiety as a young child? Y □ N □
    In Grade School? Y □ N □
24. As a 5 year old, who did patient feel safest with? _____

PSYCHOLOGICAL DEVELOPMENT

25. Was patient diagnosed with psychological disorders? Y □ N □
    If yes: ____ age _____Diagnosis _____ Treatment Method
26. List major trauma event(s) in childhood:

_____Age: _____
_____Age: _____
_____Age: _____

GENERAL

27. Are Immunizations up to date? Y □ N □
28. Is patient enrolled in school? Y □ N □

A copy of immunization record is not required when children or adolescents are enrolled in school settings where verification of immunization is legally required

If patient is not enrolled in school a copy of immunization record is required.

29. Does patient have any identified speech, hearing or visual functioning issues? Y □ N □

**A copy of the most recent physical is not required when children or adolescents are enrolled in school settings where

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30. School Attending? _____ Grade Level: _____
31. Current GPA: _____ Highest GPA in last two years: _____
32. Favorite Subject: _____
33. Extra-Curricular Activities (Sports, music, drama, etc.): _____
34. What do you like to do in your spare time? _____
35. Where do you spend most of your free time? _____
36. Current school related problems: Y □ N □

    ____ Excessive Absenteeism ____ Failing Classes
    ____ Poor Attitude ____ Bored
    ____ Being influenced negatively by peer group
    ____ Expulsion/Suspension
    If so, what for? _____
37. Do you currently have a boyfriend or girlfriend: Y □ N □
38. What person in your life do you feel the most bonded with? _____
39. Have you ever run away? Y □ N □

    When? _____ Where did you go? _____
    How long were you gone? _____
    Would you do it again? ____Y ____N
40. What types of dangerous activities do you participate in? (like riding in a car with someone under the influence) _____
41. What are your areas of weakness? _____
42. What are your areas of strength? _____

_____	_____	_____
Patient Signature	Parent Signature	Date

_____	_____
Reviewed by Assessor – Signature	Date
_____	_____
Reviewed by Counselor – Signature	Date

HILL ALCOHOL AND DRUG TREATMENT
ADOLESCENT INFORMATION SHEET

FOR OFFICE USE ONLY

AGREEMENT AND RELEASE FROM LIABILITY

I/we the parent/guardian of, _____
Print Patient's name

_____ Understand Hill Alcohol and Drug Treatment is not responsible for my child if he/she does not arrive at or remain during the entire scheduled treatment session.

_____ Understand that it is my responsibility to ensure that my child arrives at the treatment session and is properly checked in for each session.

_____ Understand that there is a break between the educational segment or treatment sessions and the group segment of treatment sessions during which no employee of Hill Alcohol and Drug Treatment is directly monitoring or otherwise supervising the activities of my adolescent.

_____ Understand that during the educational segments and treatment sessions and the group segment of treatment the Adolescent and Adult clients are in a mixed group setting.

_____ _____
Print Parent/Guardian's Name Date

_____
Parent/Guardian's Signature

_____ _____
Print Parent/Guardian's Name Date

_____
Parent/Guardian's Signature

_____ _____
Staff Signature Date

HILL ALCOHOL AND DRUG TREATMENT
ADOLESCENT INFORMATION SHEET

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PARENT/GUARDIAN CONTRACT

I/We as parents of _____ agree and commit to the following:
Print Patient's name

_____ I/ we as parent/guardians or at least one parent /guardian will present and participate in the Family Group Sessions every Monday Night throughout Primary Phase (8 weeks) of our child's treatment.

_____ It is detrimental to the goal of my/our child's early sobriety to have alcohol and/or other illicit substances in the home or to have these substances used by us, as parents/guardians and role models.

_____ Chemical dependency is an illness that impacts the family. As such, I/we agree to attend Al-Anon, meetings as recommended by Hill Alcohol and Drug Treatment Program as a support to our personal growth.

_____ To provide transportation to and from Hill Alcohol and Drug Treatment programs facility during the Primary Phase of treatment, as well as during the AfterCare phase of treatment.

_____ To provide transportation to and from 12-Step Meeting as recommended by the Treatment Plan.

_____ _____
Print Parent/Guardian's Name Date

_____
Parent/Guardian's Signature

_____ _____
Print Parent/Guardian's Name Date

_____
Parent/Guardian's Signature

_____ _____
Staff Signature Date

Substance Use History Form

Client Name: _____
Date: _____
Clinician: _____

Substance	Quantity / Typical Amount	Frequency & Duration of Use	Date of Last Use	Current Withdrawal Symptoms

Additional Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Hill Alcohol and Drug Treatment – Reported Medications Sheet

Patient Name: _____DOB: _____ Admission Date: _____

Medication Name (Brand/Generic)	Dosage	How do you take this med? (Oral, cream, etc.)	Prescriber / Pharmacy	Notes / Reason

Patient Signature: _____ Date: _____

Rume Health Consent

DOB: MRN: Patient Name:

Date: **Time:**

Consent to Telemedicine

I hereby consent to the use of telemedicine by Rume Health and contracted medical groups including "Elevated Health" and "Rume Medical Group". I understand that telemedicine involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine.

Patient Choice

I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future treatment. Access to Information. I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics in the state, such as my primary care physician or therapist.

Confidentiality

I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations that identifies me will be disclosed to third parties without my consent. Potential Risks. I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. I understand that telemedicine is an alternative to in-person treatment and my Elevated Health/Rume Medical Group provider may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here. Benefits. I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed.

Statement of Financial Responsibility

Thank you for choosing Rume Health as your provider. We are committed to providing you with the best possible care. Your clear understanding of our practices' financial policy is important to

our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment and responsibility. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, money order, Visa, MasterCard, or Discover. While filing insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. Rume Health will file claims to insurances provided (primary & secondary) during registration. Your insurance is a contract between you and/or your employer, and the insurance company, we are not party to that contract. In order for us to file a claim on your behalf, you must present a CURRENT copy of your insurance card(s) at each visit and communicate any changes in your personal information. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance compay. Some common examples of non covered services are labs, radiology, pharmacy, dental supplies and/or labs, contact lenses, mental health, and chiropractic, etc. Rejection of your claim does not relieve you of your financial responsibility to Rume Health "Elevated Recovery / Rume Medical Group Inc."

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnosis are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Medicare and Medi-Cal

We gladly accept Medicare patients and will bill our services at the allowed rates. Medicare regulations require that you sign an Advanced Beneficiary Notice (ABN) at every visit where your procedure may not be covered. This form helps to explain which services Medicare may not cover and may be your responsibility. Non-Covered services include, but are not limited to, Chiropractic and Vision.

Co-Payments

Your insurance company requires us to collect copayments at the time of service. Waiver of copayments may constitute a fraud under state and federal law. If you do not have your co-payment, your appointment may be rescheduled. Medical Records. All Rume Health patients may request a copy of their medical records via email. This can be done at no charge to the patient and received electronically within 30 (thirty) business days.

Uses and Disclosure of Health Information

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

REVIEW IT CAREFULLY. This notice is effective as of April 15, 2023.

USES AND DISCLOSURE OF HEALTH INFORMATION

Rume Health is committed to protecting the privacy of the personal and health information we collect or create as part of providing health care services to our clients, known as "Protected Health Information" or "PHI". PHI typically includes your name, address, date of birth, billing arrangements, care, and other information that relates to your health, health care provided to you, or payment for health care provided to you. PHI DOES NOT include information that is de-identified or cannot be linked to you. This notice of Health Information Privacy Practices (the "Notice") describes Rume Health's duties with respect to the privacy of PHI, Rume Health's use of and disclosure of PHI, client rights and contact information for comments, questions, and complaints.

Rume Health's PRIVACY PROCEDURES AND LEGAL OBLIGATIONS

Rume Health obtains most of its PHI directly from you, through care applications, assessments, and direct questions. We may collect additional personal information depending upon the nature of your needs and consent to make additional referrals and inquiries. We may also obtain PHI from community health care agencies, other governmental agencies, or health care providers as we set up your service arrangements. Rume Health is required by law to provide you with this notice and to abide by the terms of the Notice currently in effect. Rume Health reserves the right to amend this Notice at any time to reflect changes in our privacy practices. Any such changes will be applicable to and effective for all PHI that we maintain including PHI we created or received prior to the effective date of the revised notice. Any revised notice will be mailed to you or provided upon request. Rume Health is erquired by law to maintain the privacy of PHI. Rume Health will comply with federal law and will not comply with any state law that further limits or restricts the uses and disclosures discussed below. In order to comply with these state and federal laws, Rume Health has adopted policies and procedures that require its employees to obtain, maintain, use and disclose PHI in a manner that protects client privacy.

USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as outlined below, Rume Health will not use or disclose your PHI without your written authorization. The authorization form is available from Rume Health. You have the right to revoke your authorization at any time, except to the extent that Rume Medical Group Inc has taken action in reliance on the authorization. The law permits Rume Health to use and disclose your PHI for the following reasons without your authorization: For Your Treatment. We may disclose your PHI to physicians, psychologists, nurses and other authorized healthcare professionals who need your PHI in order to conduct an examination, prescribe medication or otherwise provide health care services to you.

To Obtain Payment: We may use or disclose your PHI to insurance companies, government agencies or health plans to assist us in getting paid for our services. For example, we may

release information such as dates of treatment ro an insurance company in order to obtain treatment.

For Our Health Care Operations: We may use or disclose your PHI in the course of activities necessary to support our health care operations such as performing quality checks on your employee services. We may also disclose PHI to other persons not in Rume Health's workforce or to companies who help us perform our health services (referred to as "Business Associates") we require these business associates to appropriately protect the priacy of your information.

As Permitted or Required By The Law: In some cases we are required by law to disclose PHI. Such disclosures may be required by statute, regulation court order, or government agency, we reasonably believe an individual to be a victim of abuse, neglect or domestic violence: for judicial and administrative proceedings and enforcement purposes.

For Public Health Activities:

We may disclose your PHI for public health purposes such as reporting communicable disease results to public health departments as required by law or when required for law enforcement purposes. By signing below, I acknowledge my understanding and agreement with the above statements

Release of Medical Records Authorization for Use and Disclosure of Health Information

I Andy Esparva authorize Rume Health to disclose of medical records to

Name of Facility

and any referring providers needed for my medical care.

FOR: ALL DATES OF TREATMENT OR FROM one year of the day signed for

PURPOSE: FOR ONGOING MEDICAL CARE/TREATMENT AT THE REQUEST OF THE INDIVIDUAL YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

1. I understand that if I sign this authorization, I will be provided with a copy of this authorization.

2. I understand that I am under no obligation to sign this form and that Rume Health, Inc providers may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding health plan enrollment or eligibility, or the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

3. I understand that I have the right to withdraw this authorization at any time providing a written statement of withdrawal to Rume Health. I am aware that my withdrawal will not be effective until received by Rume Health, Inc and will not be effective regarding the uses and/or disclosures of my health information that Rume Health has made prior to receipt of my withdrawal statement.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

THIS AUTHORIZATION IS VALID FOR ONE YEAR (12 MONTHS) FROM DATE OF SIGNATURE

☐ Client Refuses to Sign

Creator / Last Editor Name - Erin Hill