



**ADOLESCENT
RESIDENTIAL
TREATMENT
INTAKE PACKET**

*The Fred and Clara Eckert
Foundation for Children*

Eckert 



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**ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS
FOR INFORMED CONSENT
Adolescent Residential Treatment**

Eckert understands the right of each client to be fully informed about treatment, and provides clients with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse services, and their right to withdraw consent within time frames delineated in the consent. Eckert has an obligation to review with each client - in writing and verbally - the rights and responsibilities of both Providers and clients. Providers shall have clients attest to their understanding of the parameters covered by the Informed Consent. Please initial behind each document, indicating that you have received the specific documents and information detailed below and were given the opportunity to ask questions about each of them.

Document / Information	Parent(s)/Guardian(s) Initials	Youth Initials
*Guidelines for Eckert (Rev. 09/2023)		
*Roommate and Co-Ed Rules (Rev. 09/2023)		
*Personal Boundaries / No touching (Rev. 09/2023)		
*No Bullying and Threatening (Rev. 09/2023)		
Notice of Confidentiality and Release of Information Procedures and Rights 42 C.F.R. Part 2 Regulations		
*Risks and reasonable alternatives (Rev. 09/2023)		
*Service Recipient Rights (Rev. 09/2023)		
*Emergency Procedures (Rev. 09/2023)		
*Grievance Procedures (Rev. 09/2023)		
Fees, Billing, Payment		
Waiver of Liability of Valuables		
Runaway Notice Parent Agreement (Rev. 09/2023)		
Releases of Information		

*These items can be found in the Adolescent Handbook.

Youth signature: _____ Date: _____

Parent signature: _____ Date: _____

Parent signature: _____ Date: _____

Eckert Youth Homes

Signed: _____

Print Name: _____, Title _____

Youth Physical Screen – Required Prior to Admission

All information reported in this document must be true and reflect the youth's health history. Purposefully withholding information will hinder Eckert's ability to treat the youth and may result in an administrative discharge.

Completed by:	Date:
Eckert staff reviewed for completion:	Date:

1. Does the youth have any current or past physical health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
2. Does the youth have any physical disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
3. Does the youth have any history of head injuries or been assessed for a Traumatic Brain Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
4. Is the youth up to date on immunizations? Immunization Records Requested by Eckert <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:

5. Does the youth have any allergies? Include food, insects, etc.

Yes No Unknown

If yes, please explain:

6. Does the allergy require an Epi-pen? **[Epi-pen must be presented to Eckert at admit]**

Yes No Unknown

If yes, please explain:

Primary Care Doctor	Telephone Number	Services Received	
Address	City	State	ZIP Code
Last Contact with this Provider:			

Mental Health Provider	Telephone Number	Services Received	
Address	City	State	ZIP Code
Last Contact with this Provider:			

Other Health Provider	Telephone Number	Services Received	
Address	City	State	ZIP Code
Last Contact with this Provider:			

Youth Behavior Screen – Required Prior to Admission

All information reported in this document must be true and reflect the youth’s behavior history.
 Purposefully withholding information will hinder Eckert’s ability to treat the youth and may
 result in an administrative discharge.

Completed by:	Date:
Eckert staff reviewed for completion:	Date:

1. Does the youth have any history of destructiveness (include fire-setting)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
2. Does the youth have any history of aggressiveness? Please include fighting, threats, or similar behavior. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
3. Does the youth have any history sexual offending, inappropriate sexual activity, STDs, or pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
4. Does the youth have difficulty in relationships with peers/classmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:

5. Does the youth have difficulty in relationship with adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
6. Does the youth have difficulty in relationships with authority/teachers/counselors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
7. Does the youth have a history of harm to self (cutting, burning, etc.) Include suicide attempt history and/or any hospitalizations. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
8. Does the youth have history of danger/violence to others (include animals) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
9. Does the youth have any abnormal eating and/or sleeping habits? (eating and sleeping disorder) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
10. Has the youth ever been administratively discharged from any residential treatment facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:

11. Does the youth have any mental illness history or any learning disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
12. Does the youth present a runaway risk or have a history of running away or going AWOL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
14. Does the youth have any legal history? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain:
15. Describe any current or previous involvement with social services or CPS.
16. Please describe family member's mental health history. Include parents/siblings/extended biological family:
17. Please describe family member's alcohol/drug usage. Include parents/siblings/extended biological family:



**Eckert Adolescent Residential Addiction Treatment Facility
Behavior Expectations and Administrative Discharge Agreement**

Mission: "Eckert provides quality services which encourage the spiritual, education, behavioral, emotional and physical development of children and their families".

The below text outlines behavior and boundaries that we expect residents to follow while in our program. Our goal is that everyone has a positive treatment experience, in a safe environment that fosters growth, resiliency and recovery. We have outlined a guide of what is expected by both parents/guardians and youth. Please read below, initial where prompted and sign acknowledgement of receipt.

I acknowledge the following rules:

_____ To be respectful and courteous of all residents and staff (No foul, aggressive, insulting language).

_____ To be present and on time for all meals.

_____ To stay with the group on all outings.

_____ To communicate to staff where I am, both inside and outside the house.

_____ To not bring any contraband (see handbook) onto Eckert property.

_____ To always stay on Eckert property unless on an approved outing with an approved staff.

_____ To clean my room, make my bed, and complete my daily chores.

_____ To read the Resident Handbook and follow the guidelines, boundaries, and expectations of Eckert.

_____ To respect the property of Eckert, Eckert staff and peers while in treatment.

_____ Lack of participation, not completing tasks assigned by any staff and disregard for Eckert boundaries and expectations can hinder treatment progress and increase my time at Eckert.

_____ Eckert reserves the right to administratively discharge me for circumstances or incidents that put my safety or the safety of others at risk. Examples include but are not limited to threats, physical aggression, tampering with doors, alarms and/or cameras, contraband, AWOL, physical contact with other residents or staff, etc.

PARENTS/GUARDIANS

_____ I acknowledge and agree that if my youth is administratively discharged, I will come and get them or make other arrangements for pick up within 24 hours of receiving notice of discharge. Eckert commits to notifying necessary parties of behaviors as they arise that may result in discharge to minimize unexpectedness as much as possible.

_____ I acknowledge that, in emergency situations, administrative discharges may not have prior notice.

_____ I acknowledge and agree that I am responsible for unexpected expenses related to misconduct. This includes damage to property, theft, expenses incurred from Youth Assessment Center hold, if necessary.

Parent/Guardian Signature _____ Date: _____

Youth Signature _____ Date: _____

Staff Signature _____ Date: _____

Education Information – Required Prior to Admission

All youth are required to spend a minimum of 5 hours per week on academic development. Per Eckert Policy, Eckert must fully integrate the adolescent’s education program into their clinical programming by:

- providing access to educational instruction with treatment,
- including assistance in obtaining General Education Degree (GED), if applicable,
- working with the educational system to address the adolescent’s school related situation,
- and developing a plan to assist adolescent to successfully transition back into the community educational system.
- In the event youth are misusing the Chromebook it will be removed from them. Misuse refers to the youth using the Chromebook for something other than school related activities.

Completed by:	Date:
Eckert staff reviewed for completion:	Date:

1. Please describe the youth’s current academic/education involvement:	
2. Name of current or most recent school, and dates of most recent attendance:	
3. School contact person name and contact information:	
4. Present Grade Level:	
5. Last Grade Completed:	
6. If received GED, date received:	
7. Describe school attendance history: punctuality, approximate number of excused and unexcused absences, etc.)	
8. Please list the youth’s educational strengths, interests, and achievements:	

9. Please list youth's educational barriers: history of learning/perceptual problems, sensory deficits, dyslexia, etc.	
10. Has the youth received any special education services? If yes, please explain:	
11. History of school performance – Average grades	
12. Has the school been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Please provide any other contact information for youth's education/academic/career development. For example, independent living coordinator, etc.	
14. Does the youth have a school Chromebook available to bring to Eckert? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Please provide youth's school login and password, if applicable.	
Login:	
Password:	

I am aware that participating in educational/academic tutoring is a requirement of Eckert's Residential Addiction Treatment Program.

Youth Signature: _____ Date: _____

Adolescent Addiction Treatment - Family Session Informed Consent

The safety of the youth at Eckert is a top priority. Family sessions are encouraged, and can be cancelled or rescheduled due to:

- Threats to or from the youth
- Physical safety of the youth

Benefits of Family sessions

Eckert provides weekly family sessions. Family sessions include education for the resident and family, addressing the needs of the youth and family regarding recovery environment, and addressing service needs in or near the community the youth is returning to.

Confidentiality

As a general rule, information you share in therapy sessions is confidential, unless you give consent to disclose certain information. However, there are exceptions to this rule that are important to understand prior to starting with the therapy process. In some situations, it is required by law or professional guidelines that information discussed in sessions has to be disclosed. Some of those situations are described below. Most involve your protection and the protection of others from the potential to be harmed.

- If you report having a plan to harm yourself, based on the evaluation of that plan, confidentiality can be broken in order to protect you from harming yourself
- If you report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person you intend to harm
- If you are involved in activities that could cause harm to yourself or someone else, even if you do not *intend* to harm yourself or someone else, based on the evaluation of that behavior, confidentiality can be broken
- If you report that you are being abused - physically, emotionally, or sexually – or that you have been abused in the past, the law requires that this be reported to the appropriate Department of Social Services
- If you are involved in a court case and a request is made for information about your therapy, information will be disclosed with your written consent unless the court *orders* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you
- All treatment team is bound by confidentiality; however, information may be shared with Eckert treatment team to provide the top-quality outcome of treatment for the youth

Please sign below to indicate that you understand and agree to the above, and consent to family sessions. You are encouraged to keep a copy of this form and refer to it from time to time during treatment.

Youth Printed Name: _____ Signature: _____ Date: _____

Family Printed Name: _____ Signature: _____ Date: _____

Family Printed Name: _____ Signature: _____ Date: _____

Eckert Staff Printed Name: _____ Signature: _____ Date: _____

Email address for sessions: _____

Eckert Adolescent Addiction Treatment Approval to Schedule Appointments

Upon admission to the Eckert, the youth will be referred to Eckert staff RN to have an initial health screen completed within 24 hours of admission identify the need for immediate medical care and assess for communicable disease and potential for withdrawal symptoms. In situations where the resident is unable to receive an initial health screening by a qualified medical practitioner within 24 hours, Eckert will document exceptional circumstances.

The purpose of the examination is to identify and assess medical, developmental, and mental health conditions that require treatment, additional evaluation, and/or referrals to other healthcare professionals or specialists.

In the event of a medical or psychiatric emergency for the youth, Eckert staff will seek necessary medical care as the Informed Consent states. Eckert staff will attempt to reach the parent(s)/guardian(s), and/or emergency contacts identified at intake.

Any laboratory, radiological, or other results that are obtained from these appointments can be released to Eckert RN. RN will attempt to reach the youth's guardian once received.

Eckert staff will make efforts to contact parents/guardians to get approval to schedule medical appointments. If the parent/guardian is not responsive, Eckert has permission to schedule and attend medical appointments at the discretion of Eckert RN.

_____ I have read the New Medication Payment Procedure.

Custodian/Parent Signature Date

Youth Signature Date

Eckert Staff Signature Date

Eckert Addiction Treatment - Parent Approved Medications at Intake

Resident Name: _____

Prescribed Medications	Prescribed By	Date Prescribed

Food and Medication Allergies	Severity of Symptoms

Non-Prescribed Medications (Over the Counter – OTC)

I, _____, give my permission for _____, to take as needed, per label instructions, any of the medicines below that I have checked.

- | | | |
|---|---|--|
| <input type="checkbox"/> Acetaminophen (Tylenol)
<input type="checkbox"/> Advil (Ibuprofen)
<input type="checkbox"/> Airborne
<input type="checkbox"/> Alka Seltzer Plus
<input type="checkbox"/> Allegra
<input type="checkbox"/> Anbesol

<input type="checkbox"/> Anti-Itch Spray
<input type="checkbox"/> Asper cream
<input type="checkbox"/> Aspirin
<input type="checkbox"/> Azo (urinary pain relief)
<input type="checkbox"/> Benadryl
<input type="checkbox"/> Burn relief spray/gel
<input type="checkbox"/> Calamine Lotion
<input type="checkbox"/> Cetirizine | <input type="checkbox"/> Chapstick
<input type="checkbox"/> Chloraseptic (spray/lozenges)
<input type="checkbox"/> Claritin (Loratadine)
<input type="checkbox"/> Colace
<input type="checkbox"/> Cortisone Cream
<input type="checkbox"/> Cough Drops

<input type="checkbox"/> Cough Syrup
<input type="checkbox"/> Dramamine
<input type="checkbox"/> Dulcolax
<input type="checkbox"/> Earache Drops
<input type="checkbox"/> Emergency C (cold medicine)
<input type="checkbox"/> Excedrin
<input type="checkbox"/> Excedrin Migraine
<input type="checkbox"/> Eye Drops | <input type="checkbox"/> Gas-X
<input type="checkbox"/> Icy Hot
<input type="checkbox"/> Imodium AM
<input type="checkbox"/> Lactaid
<input type="checkbox"/> Lotrimin (anti-fungal crème)
<input type="checkbox"/> Melatonin
<input type="checkbox"/> Midol
<input type="checkbox"/> MiraLAX
<input type="checkbox"/> Pepto Bismol
<input type="checkbox"/> Stye Lubricant
<input type="checkbox"/> Theraflu
<input type="checkbox"/> Triple Antibiotic Ointment
<input type="checkbox"/> Tums
<input type="checkbox"/> Tylenol Cold and Flu |
|---|---|--|

Youth's Signature

Date _____

Parent(s)/Guardian(s) Signature

Date _____

Eckert Staff Signature

Date _____

Resident Approved Phone List

Name of resident: _____

Name	Relationship	Authorized Information	Phone Number	Email Address	Date Added to List and method of permission

RESTRICTED CONTACT LIST (IF APPLICABLE)

1. _____ 2. _____

Youth's signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Eckert Personnel

Signed: _____ Print Name: _____ Title _____ Date: _____

Consent form for Rapid Covid-19 Antigen Test

Facility: Eckert Youth Foundation

Youth Name:

Youth Birthdate:

Parent/Guardian Name(s):

Please carefully read the following informed consent:

Please carefully read the following notice and sign the authorization to test for COVID-19.

1. I understand that the COVID-19 testing will be conducted by Eckert staff.
2. I understand that the ability to receive testing is limited to the availability of test supplies.
3. I understand the entity performing the test is not acting as a medical provider. Testing does not replace treatment by a medical provider. I give Eckert RN consent to make medical appointments as deemed necessary for youth who are symptomatic. I agree to allow Eckert staff to take youth to the ER as deemed necessary for any emergent care if youth's condition worsens. I understand that discharge from treatment facility is possible dependent on youth's condition, clinical advice, or parent request.
4. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
5. I understand it is my responsibility to inform youth's health care provider of a positive test result, and that a copy will not be sent to youth's health care provider for me.
6. I understand that the antigen test result will be available in 15-30 minutes.
7. I understand and acknowledge that a positive antigen test result is an indication that the youth need to self-isolate to avoid infecting others until a negative test result is obtained and symptoms have cleared.
8. Youth will be informed of the test purpose, procedures, and potential risks and benefits. Youth will have the opportunity to ask questions before proceeding with a COVID-19 test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without authorization to Eckert Staff.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19 ♦

I agree to authorize my child to undergo COVID-19 testing.

Parent/Guardian Signature:

Date:

Witness:

Resident Liability for Damages Agreement

Responsibility for Damages. At check-in, the Resident must complete a “Room Inspection Report” with an Intake Team Member, listing all damage to and deficiencies in the Room and its furnishings, fixtures, and equipment. At all times during the resident’s stay at Eckert, the Resident must maintain the Room and its furnishings, fixtures and equipment to the same standard and condition as exists at the time possession of the Room is given to the Resident (or if the Maintenance Technician repairs any damage or deficiency noted in the Room Inspection Report, to the same standard and condition as exists after repairing that damage or deficiency), subject to typical wear and tear. The Resident and any other person sharing a Room with the Resident are jointly and individually liable for any damage to or deficiency in the Room and its furnishings, fixtures, and equipment, other than damage and deficiencies noted in the Room Inspection Report which are not repaired by the Maintenance Technician. The Resident must give prompt written notice of any accidents, damage or malfunctions of any kind to the Room or its furnishings, fixtures and equipment.

Liability of Resident. The Resident is liable for any damage to the building structure, fittings, fixtures, finishes, furniture, and equipment comprising the Resident’s Room, except only if such damage is caused by the proven negligence of Eckert Youth Homes or the Maintenance Technician. The Resident is liable for any damage to the building structure, fittings, finishes, furniture, and equipment beyond the confines of the Resident’s Room should the damage arise from the negligence or willful act of the Resident. Eckert Youth Homes itself does not assume any responsibility for personal property that is lost, stolen, forgotten, or damaged from any cause. The Resident is strongly encouraged to obtain insurance to cover the above liabilities. Residence does not purchase such protection for personal property. The Resident must keep all personal property and valuables locked up that they have brought with them for treatment.

Damages to Common Areas. Residents are responsible for taking all actions associated with good citizenship, including reporting information about damage and vandalism, and those allegedly responsible for causing the damage. The Resident may be held financially responsible for damage to any part of the Residence (interior/exterior common areas) if the resident is found to be directly or indirectly involved in said damage. Common areas include and are not limited to the hallways, living/dining rooms, laundry rooms, stairwells, the exterior of Room doors, parking lots and any other public areas of the Residence. All charges for damage to common areas in residence will be invoiced for the costs incurred.

I acknowledge that I will be held responsible and billed for any damage that may result from my stay at Eckert Youth Homes.

Resident Name

Parent/Guardian/Stakeholder

Date

Date

Fred and Clara Eckert Foundation for Children
Waiver of Liability of Valuables

Youth Name: _____

Youth are responsible for the care of their own personal property and are encouraged not to bring items of value to Eckert. Items such as money, jewelry, expensive clothing, electronic equipment, cell phones, and the like are tempting targets for theft and extortion. Eckert staff may confiscate such items and return them to the youth's Parent(s)/Guardian(s). Eckert and/or is not responsible for their safe-keeping and will not be liable for loss or damage to personal valuables.

I have read and understand the above.

Youth Signature: _____

Print Name: _____

Date: _____

Parent(s)/Guardian(s) Signature: _____

Print Name: _____

Date: _____

Eckert Staff Signature: _____

Print Name: _____

Date: _____

Eckert Adolescent Addiction Treatment - Recreational Activities Release

Eckert believes in providing recreational opportunities for residents, so they can experience safe and fun activities while in our care. The following is a list of safe and healthy, staff-monitored*, off-campus activities for our residents during scheduled times**.

Residents who are not approved for off-campus activities will be offered access to on-campus recreational resources. Please check which of the following activities you release your youth to participate in:

- WILLISTON ARC/OTHER RECREATIONAL CENTERS): Residents may participate in staff-monitored sports activities such as basketball, football, soccer, volleyball, tennis, racquetball, exercise machines, weightlifting, indoor golfing simulator, swimming (swim certification required).
- BOWLING: Staff-monitored with exclusive lanes for residents.
- TRAMPOLINE PARK, ON- OR OFF-CAMPUS INFLATABLE BOUNCE HOUSES, ARCADE GAMES, LASER TAG: Ratio of staff to residents sufficient to monitor all participants at all times. In most activities, staff participate with residents.
- GO-CARTS (SEASONAL): Residents drive safe, speed-governed Go-carts on a tire-lined, paved track. Staff-monitored for limited social interaction. Residents are able to wait in Eckert transportation until their turn on the track.
- MOVIES AT LOCAL THEATRES: Staff-monitored seating for all participants.
- HIKING IN COMMUNITY AND REGIONAL PARKS (SEASONAL)
- FIELD TRIPS TO AREA ATTRACTIONS (SOME ARE SEASONAL): May include, but are not limited to, field trips to area farms for livestock care, local animal shelters, fruit or berry-picking areas, museums, area historic sites, etc.
- FISHING IN AREA LAKES AND RIVERS (SEASONAL): If a resident's age requires a license, parents will need to purchase one from the ND State Game & Fish Department, or in some cases, a guest license may be issued.
- CURLING, ICE SKATING, SLEDDING, HOCKEY & OTHER WINTER SPORTS (SEASONAL) – Residents will be with an instructor and staff for private lessons/games.
- BOATING & WATER SPORTS (SEASONAL - PLEASE SEE SEPARATE DESCRIPTION & RELEASE FORM)
 - SWIM CERTIFICATION (REQUIRED FOR WATER SPORTS ONLY): Participation in water sports require each participant to obtain a Swimming Skills Certification by completing a basic swimming skills test conducted by an Eckert staff member or a certified lifeguard.

I, _____, (print parent/legal guardian's name here) represent that I am the parent/legal guardian of _____ (print resident's name here) and hereby consent to Youth's participation in the off-campus activities initialed above. I understand these activities require Youth to be in public venues. I understand and acknowledge that the activities indicated above may be dangerous and may involve the risk that the Youth will sustain serious injury, temporary or permanent disability, death, and/or property damage. I understand that while the activities may be supervised by Eckert, such supervision will not and cannot prevent all potential incidents or injuries. I further agree that Eckert makes no representation as to the condition of the facilities, property, or the safety of any structures or equipment that may be used in the activities. I, for the Youth, accept and the Youth shall use the facilities, premises, and equipment in its "AS IS" condition. I acknowledge and agree that I am not relying upon any representation or statement by Eckert or Eckert's employees, agents, or representatives

regarding this agreement or the facilities, premises, and equipment, except to the extent such representations are expressly set forth in this agreement. I voluntarily and freely assume all risks and dangers that may occur pursuant to youth's participation in activities described above, including the risk of injury, death, or property damage.

I hereby agree, on behalf of myself, the Youth, our heirs, and our personal representatives, to fully and forever discharge and release Eckert and its affiliates, and their respective partners, agents, operators, managers, employees, and representatives ("Released Parties") from any and all claims I or Youth may have or hereinafter have for any injury, temporary or permanent disability, death, damages, liabilities, expenses and/or causes of action, now known or hereinafter known in any jurisdiction in the world, attributable or relating in any manner to Youth's participation in the activities indicated above, whether caused by the negligence of Eckert or any of the Released Parties or by any other reason. I acknowledge and agree that this Release and Waiver of Liability is intended to be, and is, a complete release of any responsibility of the Released Parties for any and all personal injuries, temporary or permanent disability, death, and/or property damage sustained by Youth while participating in the activities. This release of the Released Parties does not apply to the gross negligence or intentionally harmful conduct of a particular Released Party as required by North Dakota law.

Custodian/Parent Signature Date

Youth Signature Date

Eckert Staff Signature Date

*There is a minimum requirement of two staff members for all off-campus activities, regardless of the size of group. For larger groups where two vehicles are needed for transport, a minimum of two staff members for each vehicle is required when the passengers are coed and number four or more.

**There are community activities which are part of each resident's program, including, but not limited to, art classes, woodworking, self-defense, and yoga. These are not included on the "free time" list, because they are not elective and are considered part of the resident's weekly programming.

Eckert Adolescent Addiction Treatment - Pontoon and Water Sports Release

Eckert believes in providing recreational opportunities for residents, so they can experience safe and fun activities while in our care.

Eckert has a pontoon that is licensed and insured and carries all of the necessary equipment (life jackets, first aid kits, fire extinguishers, etc.) to promote the safety and well-being of all passengers. It is Eckert's policy that the number of passengers will never exceed the manufacturer's limits. All passengers wear life jackets at all times the boat is in motion. All staff who are responsible to drive the pontoon have participated in a ND Game and Fish Boat Certification course. Eckert also requires every resident who gets into the water (pools or lake) to be swim certified, by completing a basic swimming skills test conducted by an Eckert staff member or a certified lifeguard. Eckert also promotes normal water sports (swimming, tubing, skiing) and if allowed to participate, all participants are coached on the safety of the sport as well as wearing appropriate safety devices (life jackets).

I, _____, (print parent/legal guardian's name here) represent that I am the parent/legal guardian of _____ (print resident's name here) and hereby consent to Youth's participation in the off-campus activities initialed above. I understand these activities require Youth to be in public venues. I understand and acknowledge that the activities indicated above may be dangerous and may involve the risk that the Youth will sustain serious injury, temporary or permanent disability, death, and/or property damage. I understand that while the activities may be supervised by Eckert, such supervision will not and cannot prevent all potential incidents or injuries. I further agree that Eckert makes no representation as to the condition of the facilities, property, or the safety of any structures or equipment that may be used in the activities. I, for the Youth, accept and the Youth shall use the facilities, premises, and equipment in its "AS IS" condition. I acknowledge and agree that I am not relying upon any representation or statement by Eckert or Eckert's employees, agents, or representatives regarding this agreement or the facilities, premises, and equipment, except to the extent such representations are expressly set forth in this agreement. I voluntarily and freely assume all risks and dangers that may occur pursuant to youth's participation in activities described above, including the risk of injury, death, or property damage.

I hereby agree, on behalf of myself, the Youth, our heirs, and our personal representatives, to fully and forever discharge and release Eckert and its affiliates, and their respective partners, agents, operators, managers, employees, and representatives ("Released Parties") from any and all claims I or Youth may have or hereinafter have for any injury, temporary or permanent disability, death, damages, liabilities, expenses and/or causes of action, now known or hereinafter known in any jurisdiction in the world, attributable or relating in any manner to Youth's participation in the activities indicated above, whether caused by the negligence of Eckert or any of the Released Parties or by any other reason. I acknowledge and agree that this Release and Waiver of Liability is intended to be, and is, a complete release of any responsibility of the Released Parties for any and all personal injuries, temporary or permanent disability, death, and/or property damage sustained by Youth while participating in the activities. This release of the Released Parties does not apply to the gross negligence or intentionally harmful conduct of a particular Released Party as required by North Dakota law.

I, _____, give _____ permission
(Parent and/or Guardian) (Resident)

to participate in the activities checked below:

_____ Boating

_____ Swimming

_____ Tubing

_____ Water Skiing

Custodian/Parent Signature Date

Resident signature Date

Eckert Staff Signature Date

Eckert Resident Runaway Notice Parent Agreement

In the event that the resident runs away from the property of Eckert or the supervision of Eckert staff, I acknowledge that Eckert must initiate the following steps:

Parent/guardian and youth indicate acknowledgement by initialing the below items.

	Youth Initials	Parent/Guardian Initials
Call the police department/law enforcement		
Call the parent / guardian		

Print name(s) and number(s) of person(s) to be contacted

The below information will be given to the police department:

Parent/guardian and youth indicate acknowledgement by initialing the items that are approved.

	Youth Initials	Parent/Guardian Initials
Name of resident		
Social Security Number of resident		
Date of Birth of resident		
Picture of resident		
Identifying marks/tattoos/piercings		
Law Enforcement can post picture and info on social media		
Serious Health Condition of resident		

Youth's signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Eckert Personnel

Signed: _____ Print Name: _____

Title _____ Date: _____

Procedure/Fee Schedule Listing

FRED AND CLARA ECKERT FOUNDATION FOR CHILDREN

Charge Code and Description	Amount	Description
Fee Schedule: STANDARD		
90791-PSYCH DIAGNOSTIC EVALUATION	\$300.00	Integrated biophysical assessment, including history, mental status, and recommendations
90832-PSYTX PT&/FAMILY 30 MINUTES	\$150.00	Individual psychotherapy, 30 minutes
90834-PSYTX PT&/FAMILY 45 MINUTES	\$200.00	Individual psychotherapy, 45 minutes
90837-PSYTX PT&/FAMILY 60 MINUTES	\$250.00	Individual psychotherapy, 60 minutes
H0001-ALCOHOL AND/OR DRUG ASSESSMENT	\$200.00	Alcohol and/drug assessment
H0004-BEHAVIORAL HEALTH CNSL&TX-15 MIN	\$45.00	Per 15 Min Counseling/Treatment
H0012-ALCOHL&/RX SRVC; SUB-AC DTOX RES OP	\$250.00	Alcohol and/or drug services; sub-acute detoxification
H0015-ALCOHL&/RX SRVC; INTENSV OP; INTRVN	\$260.00	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H2034-ALC&/RX ABS HALFWAY HOUSE SRVC DIEM	\$400.00	Alcohol and/or drug abuse halfway house services, per diem
H2035-ALCOHOL &OR OTH DRUG TX PROGM-HOUR	\$100.00	Alcohol and/or other drug treatment program, per hour
H2036-ALCOHOL &OR OTH DRUG TX PROGM-DIEM	\$900.00	Alcohol and/or drug treatment program per diem: Residential Treatment Center (RTC) services are reimbursed on a uniform per-diem basis, and payment are based on the lesser of charges or the per-diem rate. The per-diem rate includes all services used in the RTC program, such as room and board, lab, all therapies and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dietitians, etc. Services by psychologists and psychiatrists inherent to the treatment program, such as group therapy, should not be billed separately
S9475-ADOL FULL DAY	\$500.00	Ambulatory setting substance abuse treatment or detox services per diem



Convenient Pay Agreement – Credit Card on File

Dear Parents and/or Guardians of Residents,

Like many of our colleagues, our Foundation has been forced to make a difficult policy decision regarding our billing practices. With the many changing environments in healthcare, 90% of our patients now have deductibles and/or co-insurances in addition to their copayments. Additionally, the need to limit contact with personal items has pressed the Foundation to adopt a Credit Card on File program to simplify billing.

Similar to hotels and car rental agencies, you will be asked for a credit card at the time you check-in.

- The information will be held securely in an encrypted system only accessible by select members of our staff by using your Eckert Youth Homes account number.
- You will automatically be emailed a receipt for the charges from our office as soon as the charge is run.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
- For balances of more than \$1,000.00, we will be happy to discuss a payment plan with you. You must contact our office as soon as your Explanation of Benefits is received to enter a payment plan. Payment plans are arranged with automatic payments charged to your card on file on mutually agreed upon dates of each month.
- The card on file is used for additional items such as co-payments, over-the-counter medications that you may want that we don't carry, prescriptions if deemed necessary and not covered under your insurance carrier, or doctor visits while in our custody.
- You may change the payment method at any time with a simple call to our office.

We appreciate your understanding.

Regards,
Eckert Youth Homes



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy) and CVV:
Cardholder Billing Address:

I, _____,
authorize Eckert Youth Homes to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Signature

Date



Patient Financial Agreement

- € All co-insurances (Medicaid and Commercial) may be collected at the time of service. Patients without secondary insurance will be charged their co-insurance percentage at the time of service. I am responsible for ALL amounts due to Eckert Youth Homes that are not paid by my insurance even if this is the entire cost of the treatment visit and all associated services billed. I also accept financial responsibility for any property damage that may occur as the result of my child's behavior while being a resident at the facility.
- € I authorize release of any medical or other information necessary to process the claim.
- € I authorize payment of my insurance benefits directly to the Fred & Clara Eckert Foundation for Children.
- € It is my responsibility to know what my insurance covers and to ask questions prior to receiving service. Insurance deductible estimates, including for Medicaid, will be verified prior to your visit. The outlined estimate is based on limited information obtained from your insurance company. In the case of some insurance carriers, they will not even provide us with an estimate. All unmet deductibles may be collected at the time of service based on your specific insurance plan information.
- € If I do not have insurance, I accept full financial responsibility for all charges incurred.
- € Payments: We allow 90 days for your insurance company to make a payment, after this time all inquiries (follow-up) on payments due from your insurance become your responsibility. All balances are due in full within 30 days of the first billing. Any balance left unpaid after 60 days without attempt at resolution will be considered delinquent and may be sent to collections.
- € Collection agency fees: I understand and agree that if I fail to pay my account bill or any monies due and owing the Fred & Clara Eckert Foundation by the scheduled due date and fail to make acceptable payment arrangements to bring my account current, the Eckert Foundation may refer my delinquent account to a third-party collection agency. I further understand and agree that I am responsible for paying the collection agency fee, which may be based on a percentage at a maximum of thirty-nine percent (39%) of my delinquent account, together with all costs, and expenses, including reasonable attorney's fees and court costs, necessary for the collection of my delinquent account. Finally, I understand and agree that my delinquent account may be reported to one or more of the national credit bureaus.

Agreement valid for one year from date signed.

X

Signature of Responsible Party

X

Date

X

Printed Name of Responsible Party

X

Relationship to Resident



1102 7TH AVE E
WILLISTON, ND 58801
701-572-7262 Phone 701-572-8783 Fax

Leah Hoffman, PhD, LMAC
Carrie Burris, MSW, LCSW

Child's Name: _____
Date of Birth: _____

NEW RESIDENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____

Mother or Legal Guardian: _____

Father or Legal Guardian: _____

DOB: _____

DOB: _____

Please check if it is ok to leave a message **Yes No**

Home Ph.: _____

Home Ph.: _____

Cell Ph.: _____

Cell Ph.: _____

Work Ph.: _____

Work Ph.: _____

Best number to reach you at: _____

Physical Address: _____

Physical Address: _____

Mailing Address: _____

Mailing Address: _____

Occupation: _____

Occupation: _____

Employer: _____

Employer: _____

Child resides with? _____

Who has custody of the child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person. _____

EMERGENCY CONTACT: _____
NAME: _____ **PHONE:** _____
RELATIONSHIP: _____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: _____

Secondary Insurance: _____

Policy Number: _____

Policy Number: _____

Group Number: _____

Group Number: _____

Claims Address: _____

Claims Address: _____

Phone Number: _____

Phone Number: _____

Insured's Name: _____

Insured's Name: _____

Insured's DOB: _____

Insured's DOB: _____

I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. _____

Initial

Financial Responsibility Agreement for Medical Expenses

As the legal guardian and/or guarantor for the youth under the care of Eckert Youth Homes, I understand and agree to the following terms regarding financial responsibility:

Legal Guardian/Guarantor initials below:

____ Notification of Medical Emergencies: Eckert Youth Homes will make every reasonable effort to notify the youth's legal guardian and/or guarantor in the event of a medical emergency involving the youth. This notification will be made as soon as possible after the emergency has been identified.

____ Authorization of Medical Services: I acknowledge that, in situations where immediate medical attention is necessary, Eckert Youth Homes may authorize medical services for the youth without prior consent from the legal guardian and/or guarantor if it is in the best interest of the youth's health and safety. This may include, but is not limited to, emergency medical treatment, hospitalization, and necessary procedures as determined by medical professionals.

____ Financial Responsibility: I agree to be fully responsible for all medical expenses incurred as a result of medical services provided to the youth while under the care of Eckert Youth Homes, regardless of whether prior consent was obtained. This includes, but is not limited to, costs related to emergency care, transportation, hospitalization, surgery, medications, and any other medical treatments deemed necessary.

____ Insurance Coverage: If the youth is covered under a health insurance plan, I agree to provide Eckert Youth Homes with current and accurate insurance information to facilitate the processing of any claims. I understand that any costs not covered by insurance will be my responsibility. If the youth does not have active insurance coverage, I understand that I am financially responsible for any medical costs that are accrued. I release Eckert Youth Homes, its staff, and affiliates from any and all financial obligations related to medical services rendered to the youth, as well as any legal fees or costs associated with the enforcement of this agreement.

By signing this statement, I acknowledge that I have read, understood, and agree to the terms outlined above regarding financial responsibility for medical services provided to the youth under the care of Eckert Youth Homes. This agreement represents the entire understanding between the parties and supersedes any prior agreements or understandings, whether written or oral, related to the subject matter herein. This agreement remains in effect for one year from the date of signing.

Guarantor's Contact Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email:

Resident Information

Full Name:

Date of Birth:

Address:

Legal Guardian/Guarantor Name: _____

Signature: _____

Date: _____

Eckert Youth Homes Representative: _____

Signature: _____

Date: _____

Acute Flaccid Myelitis
Anaplasmosis
Anthrax ♦
Arboviral infection (other)
Babesiosis
Botulism ♦
Brucellosis ♦
Campylobacteriosis
Candida auris ♦
Carbapenem-resistant organisms
• *Enterobacteriaceae* ♦
• *Pseudomonas aeruginosa* ♦
Chickenpox (varicella)
Chikungunya virus disease
Chlamydial infection
Cholera ♦
Cluster of severe or unexplained illnesses and deaths
Coccidioidomycosis
Creutzfeldt-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Dengue
Diphtheria ♦
Eastern equine encephalitis ♦
E. coli (Shiga toxin-producing) ♦
Ehrlichiosis
Foodborne/waterborne outbreaks
Giardiasis
Glanders ♦
Gonorrhea
Haemophilus influenzae (invasive) ♦
Hantavirus ♦
Hemolytic uremic syndrome
Hepatitis A ♦
Hepatitis B

Hepatitis C*
Hepatitis D
Hepatitis E
HIV/AIDS infection**
Influenza
• Pediatric deaths
• Seasonal
• **Suspect novel, PCR influenza A unsubtypeable** ♦
Jamestown Canyon virus disease
Laboratory incidents with possible release of category A agents or novel influenza virus ♦
La Crosse encephalitis
Legionellosis
Leptospirosis
Listeriosis ♦
Lyme disease
Malaria ♦
Measles (rubeola) ♦
Melioidosis ♦
Meningococcal disease (invasive) ♦
Mumps ♦
Nipah virus infections ♦
Nosocomial outbreaks
Novel severe acute respiratory illness ♦
Pertussis
Plague ♦
Poliomyelitis ♦
Powassan virus disease
Pregnancy in person infected with:
• Hepatitis B
• HIV
Q fever ♦

Rabies
• **Animal**
• **Human** ♦
Rocky Mountain spotted fever
Rubella ♦
Salmonellosis ♦
Scabies outbreaks in institutions
Shigellosis ♦
Smallpox ♦
Staphylococcus aureus
• Vancomycin-resistant and intermediate resistant (VRSA and VISA) – any site ♦
Staphylococcus enterotoxin B intoxication ♦
St. Louis encephalitis
Streptococcus pneumoniae infection (invasive) ♦
Syphilis
Tetanus
Tickborne disease (other)
Trichinosis
Tuberculosis***
• **Disease** ♦
• **Infection**
Tularemia ♦
Typhoid fever ♦
Unexplained or emerging critical illness/death
Vibriosis ♦
Viral hemorrhagic fevers ♦
Weapons of Mass Destruction suspected event ♦
Western equine encephalitis
West Nile virus
Yellow fever ♦
Zika virus

♦ Send isolate or sample to North Dakota Department of Health Division of Microbiology.

♦ This is a Select Agent when confirmed. Notify the Division of Microbiology at 701-328-6272. Report any possible lab exposures.

*Hepatitis C: All positive/reactive test results, hepatitis C genotypes, all hepatitis C nucleic acid test results (including nondetectable)

**HIV/AIDS: Any positive/reactive test results, gene sequencing and drug resistance patterns, all HIV nucleic acid test results (including nondetectable), all CD4 test results

***TB: All positive PPD & IGRA results. All results for AFB Smears, cultures and rapid methodologies performed when *M. tuberculosis* complex is suspected.

How to Report: • Secure website: www.ndhealth.gov/disease/reportcard/ • Telephone: 701-328-2378 or 800-472-2180 • Secure Fax: 701-328-0355 • Electronic laboratory reporting: www.ndhealth.gov/disease/ELR/

Other Mandatory Reportable Conditions

If highlighted red, report immediately: 701-328-2372

Report all other conditions within seven days

- Autism*
- Cancer+
- **Cluster of severe or unexplained illnesses or deaths**
- Critical congenital heart disease (CCHD)
- Fetal alcohol syndrome (FAS)
- Lead level results (all)
- Neonatal abstinence syndrome (NAS)
- Overdoses
- Suicide and suicide attempts
- Tumors of the central nervous system+
- Violent deaths^
- Visible congenital deformity

^ Homicides, legal intervention, unintentional fire-arm related injury death, deaths of unknown intent and terrorism.

How to Report:

- + Submit report to the North Dakota Cancer Registry. Call 800-280-5512 for assistance.
- * Autism report form: www.nd.gov/eforms/Doc/sfn60804.pdf
- Telephone: 701-328-2372
- Secure Fax: 701-328-2785
- Secure website: www.ndhealth.gov/disease/reportcard/
- Electronic reporting may be available. Email dohstateepi@nd.gov for more information.

North Dakota Administrative Code 33-06-01, North Dakota Century Code 23-07-01

North Dakota Century Code 23-01-41 (Autism)

North Dakota Century Code 23-41-04 and 23-41-05 (Visible congenital deformity)

THE FRED AND CLARA ECKERT FOUNDATION FOR CHILDREN

ADOLESCENT ADDICTION TREATMENT NEW MEDICATION PAYMENT PROCEDURE

Eckert's **Medical and Healthcare Services Procedures** states the below:

- Eckert provides needed health services directly or by referral.
- The custodian, parent or guardian of resident must each be informed of benefits, risks, side effects, and potential effects of psychotropic medications prescribed. When a psychotropic medication is prescribed or discontinued for a resident, the resident's medication regime must be reviewed by a psychiatrist or medical doctor as determined medically necessary by the prescribing professional.

Eckert Staff will consult with the youth's responsible party to assist in coordinating payment for the medication, if necessary. The below sequence of events is typical:

- The prescribing provider will send the prescription to a Williston Pharmacy (most often, Service Drug)
- Eckert is notified by the pharmacy and if the youth's insurance does not cover the medication, Eckert staff will contact youth's guardian to see if they will cover the amount due.
- Eckert staff will pick up the medication from the pharmacy and proceed with Medication Procedures as outlined

VISITOR NON-DISCLOSURE AGREEMENT

Eckert has a legal and ethical responsibility to safeguard the privacy of all residents and protect the confidentiality of their health information. This information is protected under 42 C.F.R. Part 2 and this Agreement restricts you from disclosing and information protected by Federal confidentiality rules. The Federal rules prohibit you from disclosure of this information and disclosure of this information is without expressly permitted written consent of the person to whom it pertains or as otherwise prohibited by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

In the course of my visit at Eckert, I may come into contact with confidential resident information even though I may not be directly involved in providing resident services. In fulfillment of this responsibility and to honor the right of Eckert residents to strict confidentiality it is required of all visitors to sign the following state of Non-Disclosure.

I understand that any resident information (including names, identities) that I come into contact with at Eckert is confidential and I will not at any time during or after my visitation at Eckert disclose any resident information to an person. I understand photography of youth is strictly forbidden without prior written approval.

Printed Name

Signature

Address

Date

Purpose of Visit

**THE FRED AND CLARA ECKERT FOUNDATION FOR CHILDREN
ADOLESCENT ADDICTION TREATMENT**

**NOTICE OF CONFIDENTIALITY AND RELEASE OF INFORMATION
PROCEDURES AND RIGHTS**

In the substance abuse field, confidentiality is governed by federal law (42 U.S.C. § 290dd-2) and regulations (42 CFR Part 2) that outline under what limited circumstances information about the client's treatment may be disclosed with and without the client's consent. Generally, a substance use disorder program is not permitted to disclose any information about the participants unless one of the following apply:

1. The patient provides written consent
2. The disclosure is allowed by a proper court order
3. The disclosure is made to medical providers in a medical emergency
4. The disclosure is made to qualified personnel for research, audit, or program evaluation
5. The patient commits or threatens to commit a crime on Eckert premises or against Eckert personnel
6. The disclosure is made under state law to appropriate state or local authorities to initially report suspected child abuse or neglect
7. Federal law or regulations allow the disclosure.

42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Under 42 CFR Part 2 and applicable North Dakota law, for individuals under 14 years of age, any written consent for disclosure of information must be given by both the minor and their parent, guardian, or other individual authorized under state law to act in the minor's behalf. For individuals 14 years of age or older, the necessary consent for disclosure may be given only by the minor patient. Eckert will not make disclosure to the individual's parent, guardian, or other individual authorized under state law to act on the minor's behalf without consent from the minor unless Eckert's program director determines that the minor lacks capacity to make a rational decision on whether to consent to disclosure and the minor's situation poses a threat to life or safety that disclosure may reduce.

Releases of Information:

Releases of Information are secured in written form for any referrals or recommendations, as well as for any information requested from other parties that is necessary and appropriate for the client's assessment or treatment plan.

Releases of information meet standards of current laws and guidelines and clearly identifies:

- The full name and date of birth of the patient.

- The name of the entity permitted to make the disclosure (Eckert Youth Homes).
- How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.
- The name of the individual/entity to whom a disclosure is to be made.
- The purpose of the disclosure. In accordance with § 2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.
- A statement that the consent is subject to revocation at any time except to the extent that Eckert has already acted in reliance on it.
- The date, event, or condition upon which the consent will expire if not revoked before.
- The signature of the patient and, when required for a minor under the age of 14, the signature of an individual authorized to give consent.
- The date on which the consent is signed.

Eckert’s copy of the Release of Information will be placed in the client’s file.

A note reflecting the Release of Information will be documented in the clients Electronic Health Record and must include a statement that a copy of the Release of Information was offered to the client or client’s legal representative.

Violations:

Violations of federal law and regulations concerning the confidentiality of substance use disorder information by a covered program is a crime. In accordance with federal regulations, suspected violations may be reported to one offices of the United States Attorney for the District of North Dakota at:

Quentin N. Burdick United States Courthouse
 U.S. Attorney's Office
 655 First Avenue North, Suite 250
 Fargo, ND 58102-4932
 Phone: (701) 297-7400
 Fax: (701) 297-7405
 TTY Phone: (701) 297-7444

William L. Guy Federal Building
 U.S. Attorney's Office
 220 East Rosser Ave, Room 372
 Bismarck, ND 58502-0699
 Phone: (701) 530-2420
 Fax: (701) 530-2421
 TTY Phone: (701) 530-2441

Or to the Substance Abuse and Mental Health Services Administration (SAMHSA) at:

Substance Abuse and Mental Health Services Administration
 5600 Fishers Lane
 Rockville, MD 20857
 Phone: 877-SAMHSA-7 (726-4727)
 TTY Phone: 800-487-4889

This notice is given pursuant to the Federal Regulations and state law. The relevant laws can be found at 42 United States Code § 290dd-2, 42 Code of Federal Regulations Part 2, and North Dakota Century Code sections 50-06-15 and 14-10-17