North Central Ohio Rehabilitation Center

Parent Contract of Participation

I, _____ parent or guardian (circle one) of _____, understand that as of my child being placed in the North Central Ohio Rehabilitation Center, I will do the following:

1. I understand that I must participate in any family therapy sessions, team meetings, activities, along with everyone else in the immediate family, as deemed necessary by the treatment team.

2. I understand that I am responsible to pay child support as ordered by the Court, to be determined by the Ohio Revised Code.

3. If a support order is in place, I agree that the portion determined to be for this child shall now go to the Department of Youth Services of the State of Ohio.

4. I understand that I am responsible for any medical, dental, damages, clothing expenses, and pharmacy expenses incurred by my child while in the NCORC.

I understand that by signing this agreement, it becomes an order of the Court. I understand that if I fail to comply with any of the above stipulations, that I can be held in contempt of Court which may result in a fine or incarceration.

_____ _____

Parent/Guardian Signature Date

North Central Ohio Rehabilitation Center

RIGHT TO TREAT FORM

I, _____ (youth) have been informed and acknowledge that the program description/rules and regulations have been discussed, explained and outlined to me and my parent(s) or guardians.

I agree to be completely honest during all treatment/evaluation sessions and assume full responsibility for my behavior. I understand that being honest includes not giving false information as well as leaving out important information. I understand the importance of principles of honesty and will make every effort to apply them to my daily life.

I understand that during my Assessment/Evaluation in the North Central Ohio Rehabilitation Center, I will be observed, evaluated and assessed by rehabilitation personnel and/or their designee.

_____ _____

Youth Signature Date

_____ _____

Parent/guardian signature Date

_____ _____

Witness Date

North Central Ohio Rehabilitation Center

Initial Medical Screening

Youth Name: _____ Completed by Parent / Guardian: _____Date: _____

CONFIDENTIAL INFORMATION

Has your child ever	Yes	No
Lived with anyone who had TB		
Coughed up blood		
Bled excessively after injury		
Attempted suicide		

Does your child	Yes	No
Wear glasses/contacts		
Have vision in both eyes		
Wear a brace/back support		
False teeth or mouth appliance		

HAS YOUR CHILD EVER HAD OR HAVE NOW

Asthma		
Bronchitis		
Tuberculosis		
Cancer or Tumor		
Diabetes		
Emphysema		
Ear, Nose, Throat Trouble		
Hearing Loss		
Chronic or frequent colds		
Hay fever		
Severe Tooth/Gum trouble		
Shortness of breath		
High blood pressure		
Pain or pressure in heart		
Heart Murmur		
Other heart issues		
Pounding heart		
Arthritis or bursitis		
Fractures (broken bones)		
Bone Joint/Deformity		
Painful or trick shoulder		
Foot trouble		
Swollen/painful joints		
Kidney trouble		
Frequent Urination		
Painful Urination		
Blood in urine		
Recurrent infection		
Frequent sore throat		

Frequent tonsillitis		
Ear/hearing problems		
Sinus problems		
Night sweats		
Cysts or growths		
Ruptures or hernia		
Recent pain/loss of weight		
Frequent indigestion		
Stomach trouble or ulcers		
Appendicitis		
Hepatitis or jaundice		
Gall bladder trouble		
Hemorrhoids/Rectal trouble		
Head injury		
Epilepsy or seizures		
Frequent/severe headaches		
Loss memory		
Periods of unconsciousness		
Paralysis, numbness, weakness		
Dizziness/fainting spells		
Nervous problems		
Alcoholism/drug addiction		
VD/syphilis/gonorrhea		
Drug allergies		
Lumps, pain or discharges		
Thyroid trouble		
Allergies (general)		
Medical restrictions		
Medications/Prescriptions/Injectables		

If yes, please explain:

_____

_____

_____

Has your child ever taken medication for depression, suicidal ideations, hyperactivity, or any other disorder? Who prescribed? When, Where, and What?

_____

_____

_____

Has your child ever been a patient in an hospital or treatment Center; Where, Why, When, and the address:

_____

_____

_____

North Central Ohio Rehabilitation Center

1440 Mt. Vernon Avenue
Marion, Ohio 43302

Confidential Release of Information

I understand that it is necessary for the North Central Ohio Rehabilitation Center to exchange information on my child, _____'s case in order to coordinate the necessary services and to provide treatment.

Some agencies that may also provide services to my child are listed below:
Marion Area Counseling Center, Marion County Court/Juvenile Justice Center, Marion County/City Schools, North Central Ohio Educational Service Center and Marion Adolescent Pregnancy Program.

Other agencies from your county of _____ that may exchange information or provide services are: Local Community Counseling Agency, Children's Services, City/County Police, City and/or County Schools, Court/Juvenile Justice Center and the Probation Officer.

Specific information to be released is:

Comprehensive evaluations and assessments (ETR, IEP, OGT results, transcripts)
Shot record
Contact information form
Summary of progress/needs
Free/Reduced/Full Pay Lunch Status

Other:

_____

_____

I understand that this consent allows for both verbal and written information. I further understand that this consent to disclose information may be revoked by the parent or guardian at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Youth's Date of Birth Youth's Signature

_____ _____ _____
Youth's Social Security Number Parent/Guardian's Signature Date

_____
Relationship

_____ _____
Witness Date

Note: As required by Section 2.3(a) Prohibition on re-disclosure of patient(s) or person(s) being identified as an individual(s) who abuse(s) alcohol or drugs. This information has been disclosed to you for the records whose confidentiality is protected by Federal Law, Federal Regulation (42 CFR Part 2) prohibits you from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

North Central Ohio Rehabilitation Center

Community Service Program

Youth Responsibility Form

As a participant in the Community Service Program, I agree to fulfill the following conditions. I understand that failure to fulfill these conditions may result in new charges being filed against me, and/or additional Community Service hours given to me.

The following are the terms and conditions of this contract:

1. I agree to complete the designated hours of Community Service for my community.
2. I am in good health, good physical condition and am able to participate in the Community Service Program. I will be prepared to work when scheduled. I will wear sturdy shoes and weather appropriate work clothes. I am not to have any visitors during work hours.
3. I understand that the use of alcohol and/or non-prescription drugs are not permitted.
4. I agree to indemnify and hold harmless the Edward J. Ruzzo Juvenile Justice Center, Marion County Commissioners, North Central Ohio Rehabilitation Center, Ohio Department of Youth Services, and its agent, from any liability resulting from any incident during my Community Service.
5. I agree to follow all instructions of the work site staff.
6. I will maintain safe work habits on the job at all times and keep my time sheet updated at the completion of each job.
7. I will take care of all equipment used on the job, reporting to the staff any problems I may have with the equipment. I am responsible for leaving all equipment and property in the same condition as I found it (except for ordinary wear and tear).
8. If I am injured during the period that I am participating in the Community Service Program, I will promptly report any such injury to the staff.
9. I understand that I will have to complete the assigned amount of hours and any additional hours which may be added due to my behavior.

My signature indicates that I have had these responsibilities explained to me, that I understand them and agree to them.

_____ _____

Staff Signature Youth

_____ _____

Date Parent/Guardian

NORTH CENTRAL OHIO REHABILITATION CENTER

CONSENT AND RELEASE OF LIABILITY FORM

Community Service Activities / Educational Activities / Field Trips (event)

The following counties: Marion, Crawford, Hardin, Morrow, Wyandot, and Other

(Location)

I, the parent of _____ (child) do hereby consent and agree that _____ (child) can participate in the Community Service Activities, Educational Activities and Field Trips provided by the North Central Ohio Rehabilitation Center. I understand and expressly assume for the above named child all of the risks and dangers which may be encountered preliminary to, during, and subsequent to this trip, including travel to and from the site of the outing. I further release and agree to indemnify and hold the releasers harmless from any and all liability, actions, causes of action, and claims of any kind or nature whatsoever, whether foreseen or unforeseen arising out of the above-named child's participation in this trip, associated activities, and travel to and from, the outing on account of injury or loss to his person or property, whether caused by negligence, breach of contract or otherwise which he may ever have against the releasers, their successors, assigns, officers, designees, Marion County Commissioners, agents, representatives of North Central Ohio Rehabilitation Center, employees, or agents. I also expressly covenant and agree not to sue the North Central Ohio Rehabilitation Center, Marion County Commissioners, its agents, representatives, officers, or employees for any injury or damages of any kind which may occur as a result of the above named child's participation and transportation to and from the outings and activities associated therewith.

_____ _____

Signature of Parent Date Signature of Child Date

_____ _____

Signature of Probation Officer Date Signature of NCORC Staff Date

Emergency Name and phone # _____

North Central Ohio Rehabilitation Center

1440 Mt. Vernon Avenue
Marion, Ohio 43302

Recreational Release

I, _____, parent/guardian give my permission for my child, _____, to participate in recreational art, restitution, yoga (Stretching &Toning, in no religious form) and any other supervised activities. Permission is also granted for transportation by NCORC staff to said activities.

Medical Limitations/information (asthma, diabetes, broken bone, etc):

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____

Treatment:

_____
_____
_____

_____ _____

Parent/Guardian Date Witness Date

North Central Ohio Rehabilitation Center
Youth fellowship permission form

While at NCORC I, _____, hereby request:

_____ to attend both FCA and Youth Fellowship groups

_____ to not attend either group

_____ to attend FCA only

_____ to attend Youth Fellowship group only

I understand that these groups are nondenominational in nature. Meaning, they do not adhere to the beliefs/practices of any one religious group. This means that I am free to discuss/explore my own spirituality as it pertains to me. I further understand that leaders of these groups will not impose their beliefs on me, nor am I permitted to impose my beliefs on others.

I understand that I may feel free refuse to attend these groups at anytime, without repercussions for choosing not to attend. I further understand that if I choose to attend these groups I am to be respectful of beliefs of others (even though they may/may not apply to my own personal beliefs).

I understand that free time is permitted if I choose not to attend these groups in designated areas. These areas vary according to the size of the group attending youth fellowship.

These youth fellowship groups come under two titles:

FCA (Fellowship of Christian Athletes) – This group is staff lead. It is offered in many of the school systems, during out of school hours. You are not required to be an athlete to attend. This group allows for spiritual exploration and fellowship. Learning about the group and choosing to attend may help you to find new positive experiences, establish positive friendships, and allow for positive fellowship even after your release.

Youth Fellowship Group – This group is lead by an area community volunteer. This group explores spiritual exploration and fellowship. These groups are not lead in area school systems. However, they will allow for you to discuss any issues/concerns that you may have during your stay and provide spiritual guidance.

_____ _____

Youth signature Date

I hereby: _____ approve _____, for my child to attend youth fellowship group(s), if he so chooses to attend.

_____ _____

Parent/guardian signature Date

_____ _____

Witness Date

HAIRCUT DISCLAIMER

While your son is at NCORC, he will be required to receive a haircut. A licensed hair stylist will be available to administer haircuts at no cost to you. The hair cut is necessary to maintain hygiene and sanitary conditions while in our facility. The hair cut will be in a fashion that is neat, off the collar, out of the eyes and off the ears. We do not allow any designs, coloring, or un-natural style (i.e.: the hair does not grow that way naturally).

North Central Ohio Rehabilitation Center

Youth media permission form

During times when the media is present at NCORC I, _____, hereby request:

_____ that my son not be photographed by the media

_____ that my son not be questioned by the media

_____ to be photographed by the media

_____ to be questioned by the media

I understand that:

1. No youth shall be photographed or videotaped in a manner that would identify the youth.
2. If the identify of a youth is inadvertently revealed to the media, the media must agree not to disclose that identity.
3. The media agrees not to question the youth unless prior authorization has been given from the Director.
4. The media agrees not to ask staff any questions, which would require answers that would reveal either identifiable descriptions or the identity of any youth who are or have been under the care of NCORC.
5. The media agrees that an article or news segment aired will not reveal the identity of any youth who are or have been under the care of NCORC.

_____ _____

Parent/guardian signature Date

VISITATION RULES

In Person Visits Rules

- Visits will begin and end at the scheduled time. If you arrive late, you will still be required to end your visit at the scheduled time.
- Only guardians are allowed to visit if youth is on Citizen level (orange) or on probation (yellow).
- Deputies (green) and Executives (blue) may visit with guardians, grandparents, and siblings.
- All siblings (regardless of their age) and grandparents must be accompanied by a parent or guardian.
- Absolutely **no** weapons are allowed at the facility.
- **No** food or drink is allowed in the visitation room.
- Guests must remove coats, hats and watches.
- All guests must go through the metal detector. Guests may be "wanded" and frisked before a visit.
- All pockets must be emptied and all contents (including wallet, cell phone, etc) placed in a locker. Purses are not allowed in the building.
- **No** mail, pictures, etc can be exchanged during a visit.
- Anyone intoxicated or high, or suspected of being such will not be allowed to visit.
- If a visitor is acting in a manner that is inappropriate, belligerent, or aggressive, the visitation will immediately be terminated.
- Those people not permitted to visit must wait outside the facility.
- While in the visitation room, guests may not look through the windows to see other youth.
- There is to be no discussion of youth in this facility.
- The hands of the youth and all guests must be visible sight at all times (on top of the table).
- Youth cannot accept any gift, item, etc from someone during a visit.

Zoom Visit Rules

- Zoom visits will begin and end at the scheduled time. If you arrive late, you will still be required to end your visit at the scheduled time.
- You can not call other individuals on the phone (3 way) during a zoom visit.
- **Only** approved visitors are allowed to participate in zoom (siblings, grandparents, parents, legal guardians)
- **No** social media, sharing of content during visit (no photos, Facebook, snapchat, Instagram, music, inappropriate material, etc)

By signing below, I understand the above visitation rules. I also understand and acknowledge that if any of these rules are violated, visitation with your son will be suspended until circumstances are reviewed by administration.

_____ _____
Youth Signature Date

_____ _____
Parent/guardian signature Date

_____ _____
Parent/guardian signature Date

Primary email for zoom visits: _____

Primary cell phone number for zoom visits: _____

NORTH CENTRAL OHIO REHABILITATION CENTER - 1440 MT VERNON AVENUE, MARION, OHIO 43302 - 740-386-2232

RELEASE OF INFORMATION

YOUTH INFORMATION

LAST NAME: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

PERSON(S)/FACILITY TO SEND INFORMATION AND/OR RECEIVE INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE DISCLOSED (PLEASE CHECK ALL THAT APPLY)

□ Evaluation (s)
□ Diagnosis (If applicable)
□ Treatment Plans
□ Progress Review(s)
□ AOD Assessment (if applicable)
□ Substance Abuse Test Results
□ Medical/Medication Reports
□ Discharge Summary
□ Coordination of Care
□ Appointments and Scheduling
□ Court Reports
□ Other _____
_____

Method of disclosure □ Mail □ Verbal (Phone) □ Email □ Fax

The information indicated will be disclosed unless specific restrictions are noted:

_____
_____
_____
_____

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. 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

NORTH CENTRAL OHIO REHABILITATION CENTER - 1440 MT VERNON AVENUE, MARION, OHIO 43302 - 740-386-2232

PLEASE INITIAL ALL LINES BELOW

_____ I UNDERSTAND THAT UNDER STATE AND FEDERAL CONFIDENTIALITY PROVISIONS, ONLY THE INFORMATION SPECIFIED CAN BE RELEASED TO THE SPECIFIED PERSON OR AGENCY.

_____ I UNDERSTAND THAT NCORC CANNOT ENSURE THAT THE RECIPIENT WILL MAINTAIN CONFIDENTIALITY OF THE INFORMATION I HAVE AUTHORIZED TO BE RELEASED.

_____ I UNDERSTAND THAT THIS AUTHORIZATION WILL BE HONORED UNLESS REVOKED VERBALLY OR IN WRITING. REVOCATION MAY BE MADE AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. TO REVOKE AN AUTHORIZATION, NOTIFY NCORC.

_____ I UNDERSTAND THAT IF THE PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION IS NOT A HEALTH CARE PROVIDER OR A HEALTH PLAN OR IS NOT OTHERWISE COVERED UNDER THE FEDERAL PRIVACY REGULATIONS, THE RELASED INFORMATION MAY BE RE-DISCLOSED AND WILL NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY LAWS. I UNDERSTAND THAT CERTAIN PERSON'S OR ORGANIZATIONS MAY NOT RE-DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION.

_____ I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY, AND I VERIFY THAT I HAVE BEEN GIVEN THE CHANCE TO ASK AND RECEIVE ANSWERS TO QUESTIONS. I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED UPON SIGNING THIS AUTHORIZATION.

_____ I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THIS FORM.

_____ I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE UPON THE FOLLOWING SPECIFIC DATE OR EVENT. (Not to exceed one year). Please describe:

_____
_____
_____
_____

Youth Signature: _____ Date: _____

Parent/guardian: _____ Date: _____

Witness: _____ Date: _____

Revocation of ROI – Signature: _____ Date: _____

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. 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

NORTH CENTRAL OHIO REHABILITATION CENTER

1440 MT VERNON AVENUE, MARION, OHIO 43302, 740-386-2232

Informed Consent

We would like to take this opportunity to welcome you and provide some information that applies to our program that also includes counseling and case management services. Signing this document is an agreement that you understand the following information.

1. INITIAL INTAKE
   At intake you will be given information regarding groups, individual sessions, case management, in addition to a handbook with all the information you should know while in the program. You will be asked to complete screening tools to assess your needs to be placed in the appropriate community.
2. COUNSELING SESSIONS
   Counseling sessions will be weekly, group sessions will be daily, case management sessions as needed.
3. CONFIDENTIALITY
   All information regarding the specific nature of your counseling is maintained at NCORC and is considered confidential within the office unless specified by you in a release of information that allows for the exchange of your information. However, we work as a team and reserve the right to utilize consultation with other clinical staff at the office as deemed necessary. We follow HIPPA, 42 CFR and maintain confidentiality and privacy rights. Limits of confidentiality – we are bound to report suspected child abuse/neglect, harm to self/others or to follow court orders. Your rights regarding your confidential information – get a copy of your medical record, correct your medical record, request confidential communication, ask us to limit the information we share, get a list of those with whom we have shared your information, get a copy of this privacy notice, choose someone to act for you, file a complaint if you believe your privacy rights have been violated. Under 42 CFR Federal law and regulations protect the confidentiality of alcohol and drug abuse records maintained by this program. Generally the program may not inform a person outside of the program that a youth attends the program, or disclose any information identifying a youth as an alcohol or drug abuser unless: The youth or guardian consents in writing, the disclosure is allowed by court order, the disclosure is made to medical personnel in a medical emergency or qualified personnel for research, audit, or program evaluation, suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a youth either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities (See 42 U.S.C. 280dd-3 and 42 U.S.C. 28033-3 for Federal laws and 42 CFR Part 2 for Federal Regulations)

4. RIGHTS
   You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual, orientation, age, religion, or national origin. You have the right to ask questions about any aspect of therapy and about your therapists specific training and experience. You have the right to expect that our therapists maintain appropriate professional boundaries.
5. CONSENT TO TREATMENT
   Your signature below indicates that you have read this agreement and the HIPPA notice of Privacy Practices and agree to their terms.
6. PARENT/LEGAL GUARDIAN CONFIRMATION OF AUTHORITY TO MAKE MEDICAL DECISIONS
   If signing for a minor, by signing below, I confirm that I am the legal parent or guardian of the child named below and have the legal authority to make medical decisions on their behalf. I understand that providing false information regarding my legal status as the parent or guardian may result in legal consequences.
   I understand that behavioral health services may include, but are not limited to, discussions on family history, educational achievements, and aspirations, criminal history, and any medical/drug, drug treatment history. Services may include, but are not limited to: Intake, Screenings, Clinical interviews, Individual sessions, group sessions, case management, planning for discharge. I understand that my child's provider will review my child's symptoms and behaviors in order to diagnose or rule out diagnoses for my child based solely on evidence, even if it is a diagnosis that I may disagree with. I give consent for my child's provider to diagnose or treat my child as is deemed clinically appropriate.
7. OPTION FOR IN-PERSON OR TELEHEALTH FAMILY SESSIONS.
   Many of our families live a distance away and therefore the option of Telehealth (Zoom) can be made available for the required family sessions while your son is in our program.

Youth Legal Name (Print): _____

Youth Legal Name (Signature): _____

Date: _____

Parent/Legal Guardian (Print): _____

Parent/Legal Guardian (Signature): _____

Date: _____