CHD
positively *life* changing

For Office Use Only:	
❑ OBHS	❑ H&W
❑ IHT	❑ TM
❑ DBT	
Site: _____	Date:_____

CENTER FOR HUMAN DEVELOPMENT I CENTRTAL REGISTRATION
INTAKE FORM

Please complete the following information, printing clearly:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Gender:
Preferred Language:	Race/Ethnicity:	
Mailing Address:	City, State & Zip Code:	
Telephone Number:	OK to leave message: ❑ Yes ❑ No	
Legal Guardian: *(if applicable)*		

Insurance Information:

Insurance Name:	Member ID:	
Subscriber's Information *(if different than self)* Name:	Subscriber: Date of Birth: --/--/---- Social Security Number: ---/--/----	
Subscriber Mailing Address:	City, State & Zip Code:	
Telephone Number:	OK to leave message: ❑ Yes ❑ No	

Referral Information:

Referral Source:	Preferred Appointment Days: ❑ M ❑ T ❑ W ❑ Th ❑ F ❑ Sa
Preferred Times: ❑ Morning ❑ Afternoon ❑ Evening	Prefer to see a female or male therapist: ❑ Male ❑ Female
Possible Substance Use Treatment: ❑ Yes ❑ No	Outreach services requested: ❑ Yes ❑ No
Reason for referral/presenting problem:	

CHD CARE FINDS A WAY

Personal Information

Legal name _____ Date of birth _____

Preferred name _____

Address _____

Mailing address _____

Ethnic Group	Race	Veteran Status
☐ Hispanic/Latinx	☐ Asian	☐ Not a Veteran
☐ Not Hispanic/Latinx	☐ American Indian/ Alaska Native	☐ Armed Forces Service Medal Veteran
☐ Unknown	☐ African American	☐ Disabled Veteran
☐ Decline to specify	☐ Caucasian	☐ Individual with Disability
	☐ Other	☐ One-Year Recently Separated Veteran
	☐ Unknown	☐ Other Protected Veteran
		☐ Special Disabled Veteran
		☐ Three-Year Recently Separated Veteran
		☐ Vietnam Era Veteran

Language

☐ English	☐ ភាសាខ្មែរ (Khmer/Cambodian)	☐ Русский (Russian)
☐ Española (Spanish)	☐ Française (French)	☐ Tiếng Việt (Vietnamese)
☐ Português (Portuguese)	☐ 한국어 (Korean)	☐ 中文 (Chinese)
☐ العربية اللغة (Arabic)	☐ Other:_____	

Disability	Allergies	Special Communication needs
☐ Blind/Visually Impaired	_____	☐ None
☐ Deaf/Hearing Impaired	_____	☐ TDD/TTY Device
☐ Developmental Disability	_____	☐ Language Interpreter Services
☐ Learning Disability	_____	☐ Sign Language Interpreter
☐ Other Health Impairment	_____	☐ Assistive Listening Device
☐ Sensory/Communication	_____	☐ Other

Primary Care Physician

Practice Name:		Provider Name:	
Address:			
		Date of last PCP appointment	
Phone Number:			

_____

Verified in Netsmart by Date

CHD CARE FINDS A WAY

Center for Human Development, Inc. (CHD)
Insurance Reimbursement/Fee Payment Agreement

Client name: _____ Date of birth: _____

- I hereby authorize CHD to release any information necessary to process a claim for benefits.
- A photocopy of this authorization has equal vadility. This authorization also pertains to any member covered on a family basis under my insurance plan. Also, I hereby authoriza all payments to be made directly to CHD for services for which I, or my dependents may be elibgible.
- Payment for service must be made at the time of service. We request that fees be paid to the Administrative Assistants, prior to each session.
- Occasionally, Clinicians are Subpoenaed to court to testify in support of a client's legal matter. I undertand that if a CHD employee is subpoenaed on behalf of myself, or my child, I am responsible for and agree to pay for preparation and testimony time at the agency's regular charge. Further, I understand that such fees are not subsidized on the sliding fee scale, nor covered by insurance.
- I understand that charitable donations to the agency are intended to assist clients who cannot afford the full fee. I certify that I have fully disclosed all relevant financial information if I am requesting a sliding fee scale.
- I will notify the agency of any substantial change in my financial situation, so that adjustments may be made to my sliding fee.
- I understand that I may request a review of my fee and payment record at any time.
- I have received a copy of the "No Surprise Billing Act".
- I have received a copy of the Sliding Fee Scale Policy and Procedure.

_____

Signature of Client or Personal Representative Date

_____

Personal Representative's name (Please print) Relationship to Client

Center for Human Development, Inc. (CHD)
NOTICE OF PATIENT RIGHTS

Client Name _____ DOB _____

CHD is committed to providing services that ensure competent and considerate care for all clients.

You have the right to:

- Freedom from physical and psychological abuse
- Freedom from strip searches and cavity searches
- Freedom from use of seclusion or restraint in outpatient treatment
- Control over your bodily appearance, provider, however, on program premises, the licensee may prohibit attire and personal decoration which interfere with treatment
- Access to your client record in the presence of the administrator or designee unless there is a determination that access to parts of the record could cause harm
- Challenge information in your client record by submitting a statement of clarification or letter of correction signed by both you and the clinician
- Obtain a copy of the client record as specified in 105 CMR 164.083
- Of confidentiality of your record secured as required by 105 CMR 164.084
- Terminate treatment at any time, except in the case of an individual committed to treatment under M.G.L. c. 123, § 35
- Freedom from coercion
- Treatment without regard to race, ethnicity, creed, national origin, religion, sex, sexual orientation, gender identity, ability to speak English, age or disability
- Treatment in a manner sensitive to individual needs and which promotes dignity and self-respect
- Full disclosure regarding fee charged
- Grieve actions or decisions of the provider regarding your treatment
- Freedom to practice your religious faith
- Request referral to a facility which provides treatment in a manner to which you DO NOT have a religious objection
- Drug screens conducted in a manner which preserves your dignity and when, the drug screen is by urine sample, accommodates any medically confirmed inability to give urine by providing an alternative effective means of screening such as oral swab
- Contact the Department of Public Health, Bureau of Substance Abuse Services and the Executive Office of Health and Human Services
- The right to be treated with respect and with due consideration for your privacy
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- The right to participate in decisions regarding their health care, including the right to refuse treatment

Under the Federal Regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R., Pts. 160 & 164, your alcohol and/or drug treatment records are protected and cannot be disclosed without your written consent otherwise provided for by the regulations.

You also have the right to file a complaint with the Clinic Director at any site, or with the agency's Director of Compliance and Quality or Vice President of Clinical Services.

These rights shall apply to every client in our facility. Every client shall receive a written copy of these rights upon admission to the agency. These rights shall be posted in each facility.

Please see the agency's Notice of Privacy Practices to learn more about how medical information about you may be used and disclosed and how you can access to this information.

I have received a copy of these rights:

_____

Signature of Client or Personal Representative Date

_____

Client or Personal Representative's Name *(Please print)* Relationship to Client

CHD CARE FINDS A WAY

This Authorization Form is filed at the following CHD Program:
(For Office Use Only)

AUTHORIZATION AND CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

Full Name of Client:	Other Name(s) Used / Alias:	Today's Date:

Client Address:	Client/Guardian Primary Phone: ( )
Date of Birth: ____/____/____	(If Applicable) Legal Representative's Name and Relationship to Client:

I authorize the Center for Human Development to release and receive information from or to the person, agency or facility named below, verbally or in writing, as indicated in this authorization. PRIMARY CARE PROVIDER

Name of the Person, Agency and/or Facility Information can be shared with:	
Address:	Phone/Fax:
Person, Agency, or Facility's Relationship to the Client:	

The following information may be released and received (Please have the individual or legal representative initial each item that is to be released/received :)

	Assessment Information		Hospital Discharge Planning		Physical Health Records
	Benefits/Services Needed		Housing Information		Progress Notes
	Criminal Justice Records		Laboratory Records		Psychological Records
	Educational Records		Medical Diagnosis		Treatment/Service Plans
	Employment/Voc. Records		Medication Information		Other (specify below):
	Financial Information		Mental Health Diagnosis		

My information will be used for the following purposes – the purpose(s) MUST be listed:

Special Authorization for Substance Use Disorder Treatment Information:

SUBSTANCE USE INFORMATION: I understand that, if I am specifically receiving services from a federally funded substance use treatment program at CHD, my records are protected by the Federal regulations governing CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS , 42 CFR Part 2 (Part 2). Part 2 generally requires the written consent of the person served before making a disclosure of protected records. Consent must always be written and include specific information about the recipient of the records and the records to be shared. I further understand that Part 2 allows circumstances in which this information may be disclosed without my consent such as internal communications, medical emergencies, reports of alleged child abuse or neglect and others. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In addition, I understand that these regulations will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug use program from re-disclosure except to a lawful holder for payment or healthcare operations or treatment purposes.

Substance use treatment information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

Initial here to allow release	I specifically authorize the release of information pertaining to any drug and alcohol use, diagnosis or treatment for the purposes of:
	This information is limited to:
If the initial box is left blank then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any drug and alcohol use, diagnosis or treatment.	

Special Authorization for Protected Health Information Related to HIV/AIDS and Sexually Transmitted Diseases

HIV/AIDS information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

_____ Initial here to allow release	I specifically authorize the release of information pertaining to **HIV/AIDS diagnosis or treatment** for the purposes of:
	This information is limited to:
If the initial box is left blank, then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any HIV/AIDS diagnosis or treatment.	

STD information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

_____ Initial here to allow release	**I specifically authorize the release of information pertaining to sexually transmitted diagnosis or treatment for the purposes of:**
	This information is limited to:
If the initial box is left blank then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any sexually transmitted diagnosis or treatment.	

I also understand that:

My records are protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information that is specified above will be disclosed pursuant to this authorization and the HIPAA privacy law may no longer protect that it.

My records are protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA) may be disclosed without my consent for Treatment, Payment or Healthcare Operations (TPO). This would include purposes such as quality assurance, utilization review, credentialing, billing and other activities that are part of ensuring appropriate treatment and payment. HIPAA also allows disclosure without my consent for certain public interest-related activities.

CHD may disclose confidential information to a provider of support services only under written agreement in which all providers understand they will safeguard and not disclose the information further.

I understand that this authorization for release is not a condition for provision of care. If I choose to not complete this form, I will still receive all applicable services for my care.

In an emergent situation, that puts me or others in threat of harm, information about me and my treatment may be disclosed without my consent, at the minimum necessary, to protect the health or safety of all. This includes situations where my medical or psychiatric advance directive may need to be enacted.

CHD will use my information, to the minimum necessary, in order to coordinate care, deliver services and operate as a sound business entity as per HIPAA and 42CFR Part 2 laws. CHD employees, auditors, funding sources, insurance companies, and other oversight and regulatory bodies may have access to my protected health information without my consent for these purposes.

I understand I have the right to receive a list of the releases the release, transfer, provision of access to, or divulging in any other manner of information outside the CHD's holding the information of my personal health information (with exceptions per law) under HIPAA for the last 6 years and under Part 2 for the last 2 years. I also understand that any request I may have to obtain this list of entities must be submitted in writing.

I further understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

This authorization is valid from the date in which I sign this authorization and will remain in effect until whichever following event occurs the earliest: 1) The date I revoke this authorization, 2) the date I am discharged from CHD, Inc. 3) Once the item requested has been received, or 4) end date.

I have been offered a copy of this form for my personal records (Check one): ☐ Accepted ☐ Declined This form has been fully explained and I certify that I understand all of the above information.

Start Date:_____ End Date: _____

Signature of Individual/Legal Representative: _____

Witness Signature: _____

CHD CARE FINDS A WAY

This Authorization Form is filed at the following CHD Program:
(For Office Use Only)

AUTHORIZATION AND CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

Full Name of Client:	Other Name(s) Used / Alias:	Today's Date:

Client Address:	Client/Guardian Primary Phone: ( )

Date of Birth: ____/____/____	(If Applicable) Legal Representative's Name and Relationship to Client:

I authorize the Center for Human Development to release and receive information from or to the person, agency or facility named below, verbally or in writing, as indicated in this authorization. EMERGENCY CONTACT

Name of the Person, Agency and/or Facility Information can be shared with:	
Address:	Phone/Fax:
Person, Agency, or Facility's Relationship to the Client:	

The following information may be released and received (Please have the individual or legal representative initial each item that is to be released/received :)

	Assessment Information		Hospital Discharge Planning		Physical Health Records
	Benefits/Services Needed		Housing Information		Progress Notes
	Criminal Justice Records		Laboratory Records		Psychological Records
	Educational Records		Medical Diagnosis		Treatment/Service Plans
	Employment/Voc. Records		Medication Information		Other (specify below):
	Financial Information		Mental Health Diagnosis		

My Information will be used for the following purposes – the purpose(s) MUST be listed:

Special Authorization for Substance Use Disorder Treatment Information:

SUBSTANCE USE INFORMATION: I understand that, if I am specifically receiving services from a federally funded substance use treatment program at CHD, my records are protected by the Federal regulations governing CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS , 42 CFR Part 2 (Part 2). Part 2 generally requires the written consent of the person served before making a disclosure of protected records. Consent must always be written and include specific information about the recipient of the records and the records to be shared. I further understand that Part 2 allows circumstances in which this information may be disclosed without my consent such as internal communications, medical emergencies, reports of alleged child abuse or neglect and others. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In addition, I understand that these regulations will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug use program from re-disclosure except to a lawful holder for payment or healthcare operations or treatment purposes.

Substance use treatment information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

____ Initial here to allow release	I specifically authorize the release of information pertaining to any drug and alcohol use, diagnosis or treatment for the purposes of:
	This information is limited to:
If the initial box is left blank then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any drug and alcohol use, diagnosis or treatment.	

Special Authorization for Protected Health Information Related to HIV/AIDS and Sexually Transmitted Diseases

HIV/AIDS information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

_____ Initial here to allow release	I specifically authorize the release of information pertaining to **HIV/AIDS diagnosis or treatment** for the purposes of:
	This information is limited to:
If the initial box is left blank, then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any HIV/AIDS diagnosis or treatment.	

STD information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

_____ Initial here to allow release	**I specifically authorize the release of information pertaining to sexually transmitted diagnosis or treatment for the purposes of:**
	This information is limited to:
If the initial box is left blank then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any sexually transmitted diagnosis or treatment.	

I also understand that:

My records are protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information that is specified above will be disclosed pursuant to this authorization and the HIPAA privacy law may no longer protect that it.

My records are protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA) may be disclosed without my consent for Treatment, Payment or Healthcare Operations (TPO). This would include purposes such as quality assurance, utilization review, credentialing, billing and other activities that are part of ensuring appropriate treatment and payment. HIPAA also allows disclosure without my consent for certain public interest-related activities.

CHD may disclose confidential information to a provider of support services only under written agreement in which all providers understand they will safeguard and not disclose the information further.

I understand that this authorization for release is not a condition for provision of care. If I choose to not complete this form, I will still receive all applicable services for my care.

In an emergent situation, that puts me or others in threat of harm, information about me and my treatment may be disclosed without my consent, at the minimum necessary, to protect the health or safety of all. This includes situations where my medical or psychiatric advance directive may need to be enacted.

CHD will use my information, to the minimum necessary, in order to coordinate care, deliver services and operate as a sound business entity as per HIPAA and 42CFR Part 2 laws. CHD employees, auditors, funding sources, insurance companies, and other oversight and regulatory bodies may have access to my protected health information without my consent for these purposes.

I understand I have the right to receive a list of the releases the release, transfer, provision of access to, or divulging in any other manner of information outside the CHD's holding the information of my personal health information (with exceptions per law) under HIPAA for the last 6 years and under Part 2 for the last 2 years. I also understand that any request I may have to obtain this list of entities must be submitted in writing.

I further understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

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I have been offered a copy of this form for my personal records (Check one): ☐ Accepted ☐ Declined This form has been fully explained and I certify that I understand all of the above information.

Start Date:_____ End Date: _____

Signature of Individual/Legal Representative: _____

Witness Signature: _____

CHD CARE FINDS A WAY

This Authorization Form is filed at the following CHD Program:
(For Office Use Only)

AUTHORIZATION AND CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

Full Name of Client:	Other Name(s) Used / Alias:	Today's Date:

Client Address:	Client/Guardian Primary Phone: ( )
Date of Birth: ____/____/____	(If Applicable) Legal Representative's Name and Relationship to Client:

I authorize the Center for Human Development to release and receive information from or to the person, agency or facility named below, verbally or in writing, as indicated in this authorization.

Name of the Person, Agency and/or Facility Information can be shared with:	
Address:	Phone/Fax:
Person, Agency, or Facility's Relationship to the Client:	

The following information may be released and received (Please have the individual or legal representative initial each item that is to be released/received :)

	Assessment Information		Hospital Discharge Planning		Physical Health Records
	Benefits/Services Needed		Housing Information		Progress Notes
	Criminal Justice Records		Laboratory Records		Psychological Records
	Educational Records		Medical Diagnosis		Treatment/Service Plans
	Employment/Voc. Records		Medication Information		Other (specify below):
	Financial Information		Mental Health Diagnosis		

My Information will be used for the following purposes – the purpose(s) MUST be listed:

Special Authorization for Substance Use Disorder Treatment Information:

SUBSTANCE USE INFORMATION: I understand that, if I am specifically receiving services from a federally funded substance use treatment program at CHD, my records are protected by the Federal regulations governing CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS , 42 CFR Part 2 (Part 2). Part 2 generally requires the written consent of the person served before making a disclosure of protected records. Consent must always be written and include specific information about the recipient of the records and the records to be shared. I further understand that Part 2 allows circumstances in which this information may be disclosed without my consent such as internal communications, medical emergencies, reports of alleged child abuse or neglect and others. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In addition, I understand that these regulations will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug use program from re-disclosure except to a lawful holder for payment or healthcare operations or treatment purposes.

Substance use treatment information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

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Special Authorization for Protected Health Information Related to HIV/AIDS and Sexually Transmitted Diseases

HIV/AIDS information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

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	This information is limited to:
If the initial box is left blank, then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any HIV/AIDS diagnosis or treatment.	

STD information will NOT be released unless you specifically authorize it by putting your initials in the relevant space below and by completed each blank.

_____ Initial here to allow release	**I specifically authorize the release of information pertaining to sexually transmitted diagnosis or treatment for the purposes of:**
	This information is limited to:
If the initial box is left blank then CHD will void out this space by placing an "x" to acknowledge no release of information pertaining to any sexually transmitted diagnosis or treatment.	

I also understand that:

My records are protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information that is specified above will be disclosed pursuant to this authorization and the HIPAA privacy law may no longer protect that it.

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Start Date:_____ End Date: _____

Signature of Individual/Legal Representative: _____

Witness Signature: _____