the brookline center
for COMMUNITY MENTAL HEALTH

Registration Information

Date: _____

Name of Client: _____

Name of Parent or Guardian _____

Address: _____ Apt.: _____

Town: _____ State:_____ Zip:_____

Phone: home (____)_____ work (____)_____ cell (____)_____

Client's Gender: ☐M ☐F Date of Birth ___/___/_____ Soc. Sec. # _____
mm/dd/yyyy

Marital Status: _____

Ethnicity: ☐Asian ☐Black ☐Hispanic ☐Native American ☐White ☐Other ☐ Decline to answer

Brookline Center Therapist _____First Appointment Date _____

Check all that apply: ☐ Individual, ☐ Family, and/or ☐ Group therapy

Person to notify in emergency: Name _____relationship_____

Address:_____ Phone: _____

Employment/School Information (primary client)

Name of School (if student) _____ Grade _____

Employer's Name: _____

Partner's Employer's Name _____

Family Information

Family Members in household:

Name	Relationship to client	DOB (mm/dd/yyyy)	Soc. Sec #	Member to be seen at Center?
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

Income Information

Brookline Center policy states that clients must provide their therapists with at least 24 hours' notice when canceling an appointment. If clients provide less than 24 hours' notice, or if they miss an appointment without notifying their therapist at all, they are charged a self-pay fee. In addition, group members are permitted to miss up to two sessions per calendar year; any further missed sessions will result in clients being charged their self-pay fee. This fee is determined by income, family size, and town of residence. If a client's insurance company does not cover sessions or if clients lose their coverage, we charge this self-pay fee.

You may decline to provide income information, in which case your fee will automatically be set to our maximum charge of $165 for individual sessions and $80 for group sessions.

Please note that this fee is **not** your co-payment. We **only** charge this fee if you late-cancel, no-show, or lose insurance coverage.

	Total Annual Income of Household
Client/Guardian	
Partner	
Other	
Total	

Number of dependents (don't include yourself): adults_____ children _____

Insurance Information:

Have you used your insurance for mental health treatment this year?

☐ **Yes** ☐ **No**

If so, how many visits have you used? _____

Primary Insurance	**Company:**	
Subscriber's Name		**Subscriber's DOB: / /**
Subscriber's Address if not listed above		
Subscriber's Soc. Sec. #		
Policy Number		
Insurance Phone #		

Secondary Insurance	**Company:**	
Subscriber's Name		**Subscriber's DOB: / /**
Subscriber's Address if not listed above		
Subscriber's Soc. Sec. #		
Policy Number		
Insurance Phone #		

The Brookline Center
41 Garrison Rd.
Brookline, MA 02445
617-277-8107 fax: 617-734-6385

Release of Information to Health Insurance Company

Client name: _____ Birth date: _____

Parent or guardian (if child) _____

Maiden or other name (if applicable)_____

I request and authorize The Brookline Center to release information to my health insurance company for the purpose of claims processing.

Name of insurer	**Address**
1	
2	
3	

Time frame: The requested records or information is about health care provided during all dates of service at The Brookline Center unless limited to:

The following approximate time frame: from _____ to _____

Purpose(s) of this use/disclosure: Billing or payment operations

Type of health information to be released:
I specifically authorize the use and/or disclosure of health information necessary to process claims, including my diagnosis, treatment plan and clinical status (unless one of the following items is completed).

All health information pertaining to any medical history, mental or physical condition and treatment received *except*:

_____

Only the following records or type of health information (include dates):

_____

Expiration date: I understand that this authorization will expire three months after termination of treatment at the Brookline Center unless a specific date is noted in this space: _____

Revocation: I understand that I may revoke this authorization at any time by making a written request to the Privacy Officer at the Brookline Center. This revocation will not have any effect on actions already taken in reliance on this authorization.

Refusal to sign: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from The Brookline Center (except when I am receiving research-related treatment or receiving health care solely for the purpose of creating information for disclosure to a third party).

Consent: I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Separate signatures are required for release of HIV status, substance abuse history or results of genetic testing

- Signature:_____ Date:_____
  Client (or parent or guardian)

  Relationship to client (if parent or guardian):_____

Information regarding alcohol or drug abuse

I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this will need my further written authorization to redisclose this information.

Redisclosure: I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulation, except for substance abuse and alcohol information as noted above.

- Signature:_____ Date: _____

Information regarding AIDS/HIV status

I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) status.

- Signature:_____ Date: _____

Information regarding genetic testing

I specifically authorize the release of information regarding the results of a genetic test

- Signature:_____ Date: _____

41 Garrison Rd.
Brookline, MA 02445
617-277-8108 fax: 617-734-6385

RE: Client Name_____ Date of Birth_____

To: Primary Care Physician Dr._____
Address _____
_____
Phone _____

Dear Doctor,

Your patient has been receiving services at this Center. We would appreciate your sending the following:

1. a summary of his/her most recent physical examination or current medical record
2. a record of the patient's most recent lab work
3. the patient's current problem list
4. the patient's current medication list (if applicable)

A release of information is below. Please send them to my attention at this Center. Thank you.

Sincerely,

Clinician, The Brookline Center for Community Mental Health

Release of Information

I hereby authorize Dr. _____ to release information from my medical records to The Brookline Center for Community Mental Health,
41 Garrison Rd. Brookline MA 02445.

Please note any restrictions on type of information to be released:
_____

This information is not to be re-released to any person or agency except as provided by law. This release shall expire one year after the completion of my treatment The Brookline Center for Community Mental Health, unless otherwise specified. I understand I may revoke this consent to release information at any time.

I also understand that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that the above information may be protected by Federal Regulations 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Treatment Record.

_____	_____	_____
Signature of client or guardian Or parent (if client under age 16)	relationship	date

The Brookline Center
41 Garrison Rd.
Brookline, MA 02445
617-277-8109 fax: 617-734-6385

Release of Information from Primary Care Physician

Client name: _____ Birth date: _____

Parent or guardian (if child): _____

Maiden or other name (if applicable): _____

I request and authorize my (my child's) primary care physician to release health information

to The Brookline Center, attention: (name of clinician) _____

Name of primary care physician	**Address**
1	
2	

Time frame: The requested records or information is about health care provided during all dates of service at The Brookline Center unless limited to:

The following approximate time frame: from _____ to _____

Purpose(s) of this use/disclosure: Coordination of care

General Health Information

I specifically authorize the use and/or disclosure of all health information pertaining to any medical history, mental or physical condition and treatment received (unless one of the following items is checked.)

- ❑ All health information pertaining to any medical history, mental or physical condition and treatment received *except*:
  _____
- ❑ Only the following records or type of health information (include dates):
  _____

Expiration Date: I understand that this authorization will expire three months after termination of treatment at The Brookline Center unless a specific date is noted in this space: _____

Revocation: I understand that I may revoke this authorization at any time by making a written request to the Privacy Officer at The Brookline Center. This revocation will not have any effect on actions already taken in reliance on this authorization.

Refusal to Sign: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from The Brookline Center (except when I am receiving research-related treatment or receiving health care solely for the purpose of creating information for disclosure to a third party).

Consent: I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Separate signatures are required for release of HIV status, substance abuse history or results of genetic testing

- Signature:_____ Date:_____
  Client (or parent or guardian)

  Relationship to client (if parent or guardian):_____

Information regarding alcohol or drug abuse

I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this will need my further written authorization to redisclose this information.

Redisclosure: I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulation, except for substance abuse and alcohol information as noted above.

- Signature:_____ Date: _____

Information regarding AIDS/HIV status

I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) status.

- Signature:_____ Date:_____

Information regarding genetic testing

I specifically authorize the release of information regarding the results of a genetic test

- Signature:_____ Date: _____

revised 4/2003

Waiver Form

I, _____, agree to pay my co-payment/co-insurance I am responsible for according to the rules and regulations of my insurance company, _____. If, for some reason, my insurance company does not pay for services rendered by The Brookline Center, I will pay the full amount of said services unless otherwise stated by The Brookline Center.

_____ _____

Signature Date

The Brookline Center
41 Garrison Road
Brookline, MA 02445

Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: _____ Date of Birth: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of The Brookline Center, effective 4/14/03.

Signature: _____ Date: _____
Client (or parent of guardian)

Relationship/authority (if signed by authorized representative): _____

The Brookline Center for Community Mental Health Email Policy and Consent Form (rev. 9/2010)

Email and other forms of electronic communication are a very useful way for clients and clinicians to communicate about non-urgent matters. It is important to recognize their limitations. Email should be used only if the arrangement is agreed to by both parties. Prior to using email to communicate, clients should read and sign this policy.

Limitations of Email:

- Email is non-secure. Email has the same level of security as a postcard. It passes through servers that are not secure and often monitored. For clients who generate email at work, the content of the email is available, and actually owned by, the employer. Unless the recipient is unusually careful, the email folders on his/her computer can be accessed by anyone (family, roommates, casual visitors).
- Email is poorly suited for urgent communication. Clinicians do not constantly monitor their email during the day, and certainly not at night. Therefore, if a client should use email for an urgent or emergency matter, it is very likely that the clinician will not receive it in a timely manner.
- It is easy to make mistakes in addressing email. It is very easy (particularly when address fields are automatically filled in by the email program) to send an email to the wrong addressee. This exposes the sender to the risk of compromising privacy.

I understand and agree to the following:

1. Email should not be used for urgent or emergency communication. For urgent matters, please call the Center's main number, 617-277-8107
2. Appropriate use of email includes scheduling appointments, providing educational material or general medical information.
3. Email is neither secure nor private.
4. Email correspondence with clients is considered part of the clinical record, and will be filed in the client's medical record. Email correspondence will be available to other clinical and administrative staff.
5. Staff will use unencrypted emails only for the most routine kind of communication, (appointment scheduling, general advice, educational material).
6. When The Brookline Center staff send sensitive information (such as diagnostic/evaluation material, clinical issues or concerns) these will be sent as an encrypted attachment,
7. Clients are encouraged to use encryption to send information that is of a sensitive nature.

Do not use e-mail to send or request very sensitive information. BCMHC cannot and does not guarantee the privacy or security of any messages sent over the Internet.

I have been informed of and understand the risks and procedures involved with using email. I understand that the confidentiality of my individually identifiable health information may be compromised when my individually identifiable health information is sent through electronic transmission via -mail. I agree to the terms listed above. I hereby voluntarily request the use of email as one form of communication with my clinician, and with other staff of The Brookline Center.
Client (or parent) name _____

Signature:_____Date:_____

the brookline center
for COMMUNITY MENTAL HEALTH

Email Address: _____

The Brookline Center has a multidisciplinary staff of social workers, psychologists, mental health counselors, psychiatric nurses, and psychiatrists. Many of these clinicians are independently licensed while some are completing their graduate training. All of the clinicians in training are closely supervised by a senior staff clinician licensed by the Commonwealth of Massachusetts. The services you or your child receives may be from either a licensed clinician or a clinician in training. We encourage you to talk with your (your child's) clinician should you have any questions.

By signing this form, I acknowledge that I have read and understand this policy.

Client signature: _____

Client printed name: _____

Date: _____

If client under age 18:

Parent/guardian signature: _____

Parent/guardian name: _____

Brookline Center for Community Mental Health
Guidelines for Treatment of Children and Adolescents

Welcome to The Brookline Center for Community Mental Health. We are about to begin some very important work with you and your child. It is important that we have a clear understanding of how we can most effectively help your child or adolescent. Please review the following information carefully and feel free to raise any questions you may have with your clinician.

Consent for Evaluation and Treatment:
The Brookline Center for Community Mental Health believes that therapeutic intervention with children and adolescents is best conducted in active collaboration with parents and/or guardians. While the nature and extent of that collaboration may vary depending on circumstances, it is our guiding principle that therapy is most successful when all parents are supportive of the process.

Therefore, in order for us to proceed, all parents with legal custody are required to give written consent for a child to be in therapy, even if parents are separated or divorced. If there is a disagreement, when possible, we will communicate with each of the parents and try to reach a consensus. If we are unable to reach a timely resolution, we may refer parents to mediation or recommend a guardian ad litem (GAL). In the event a parent has sole legal custody, we may ask for a copy of the court decree before proceeding with treatment.

Initial sessions will involve an evaluation of your child's needs. By the end of the evaluation, we will offer feedback and recommendations for you and your child. The evaluation period is a time to review the goals of treatment and to decide whether your clinician is the most appropriate choice to provide services to your child.

Communication with Parents and Guardians:
As parents or guardians, you are amongst the most important people in your child's life and it is necessary for you to be a partner in your child's therapy. *At minimum, we request that parents meet with us at least every three months.* More frequent contact is typically necessary.

At times, it may be difficult for a child, particularly an adolescent, to have a working relationship with a therapist if they think everything will be shared with their parents. Therefore, it is very important at the onset of therapy that we establish how much information will be communicated.

In families where there is a divorce or separation, it is also very important that we establish at the onset of therapy how communications will be handled with each parent.

Communication with Others:
It is helpful for us to exchange information with your child's pediatrician to insure that medical and mental health issues are coordinated. We routinely ask parents to sign a permission form allowing us to communicate with medical providers.

We also generally seek permission to communicate with your child's school in order to fully understand and address your child's academic needs. We are very careful about what information is shared with your child's school and would only do so with your written permission.

Confidentiality:
We are required by state law to keep a written record of your child's evaluation and treatment. In general, the law protects the confidentiality of all communications between a client and a clinician. Information can only be shared with the written permission of a parent or guardian. There are a few

notable exceptions in which we are legally obligated to disclose information even without your permission:

- If there is concern that you/your child is at risk for harming yourself/themselves or another person, we are required to take the appropriate measures that may include contacting a hospital, the police, or potential victim.
- When we have reason to believe that a child is being abused or neglected, we are mandated to file a report with the appropriate state agency.
- When a judge issues an order requesting testimony or records, we are usually require to release them to the court.
- There are circumstances in which both parents may have equal access to their child's records, even if one parent has sole physical custody.

Custody or Visitation Disputes:
As clinicians who are invested in maintaining neutrality, we are not in the position of providing custody evaluations. We are committed to providing children a safe therapeutic environment so that they can openly discuss their feelings without fearing that there will be any consequences. If disputes are ongoing or unresolved, we may recommend the services of a Guardian Ad Litem (GAL) or a parent coordinator.

I have reviewed and received a copy of the Guidelines for Child and Adolescent Treatment. I give permission for my child to receive services from The Brookline Center:

Child's Name: _____

X Signed: _____ Date: _____

Relationship to child: (parent/guardian) _____

Signed: _____ Date: _____

Relationship to child: (parent/guardian) _____