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?
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

Payment at Time of Service

All Center clients are asked to pay their full copays and deductibles at time of service. To provide services using clients' health insurance, the Brookline Center is legally obligated to attempt to collect the full co-pay and deductible amounts due from clients. Failing to do so could result in the termination of our contract with the insurance company and disrupt our ability to serve the community.
Payment options include cash, check, and credit card. Clients or their parent/guardian can opt to store their credit card information securely on file with the Brookline Center, allowing for automatic payment of copays, deductible expenses, and other treatment-related costs. To sign up for this service, please fill out a form at the front desk or at our website (www.brooklinecenter.org/forms).

No Show and Late Cancellation

Clients should notify the program or clinician no less than 24 hours in advance of their appointment time if they are unable to keep their appointment. If notification is provided less than 24 hours in advance or if a client doesn't attend an appointment without notifying the program or clinician in advance, a no-show or late cancel fee will be charged to cover administrative and other costs for the visit. This fee will be $90 for all individual visits.

Please note that this fee is **not** charged to clients who receive their insurance through Mass Health per State regulations.

Insurance Information:

If we do not have your most updated health insurance information The Brookline Center may charge you a self-pay fee determined by your income and household size.

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 relationship date
Or parent (if client under age 16)

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

<u>Waiver Form</u>

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. The Brookline Center 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:________________

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: _______________________________

Guidelines For Treatment Involving Children and Adolescents

Welcome to The Brookline Center for Community Mental Health. We look forward to working with you. It is important that we have a shared understanding about the work we are about to begin together. Please review the following document carefully and feel free to raise any questions you may have with your child's clinician.

As a brief overview, this document discusses topics such as:

- Your consent to allow us to work with your child
- Our expectations of communication between the child's clinician and the parent/s or guardian/s
- Expectations around communication with third parties
- The role of the parent/s or guardian/s and the clinician/s when there are custody or visitation disputes
- Our fee structure and what you will be responsible for
- Additional considerations for family therapy

Consent for Treatment
The Brookline Center for Community Mental Health believes that therapeutic interventions that involve adolescents and children are best conducted in active collaboration with parents or guardians. The nature and extent of active collaboration may be influenced by various factors – developmental, dynamic, and situational – but the intent to work collaboratively nevertheless remains a guiding principle in our practice. To the extent that it is possible, we seek to nurture each child's relationships with the significant adults in his/her/their life. For this reason, we believe that all parents or guardians, especially those with legal custody, need to be involved in, and supportive of, the treatment if it is to succeed.

Therefore, we won't start treatment unless all parents or guardians with legal custody give us written consent to proceed. If there is disagreement, we will communicate with the parents and try to reach consensus. If we are not able to resolve it in a timely way, we may need to postpone starting treatment and refer parents to a mediator or to a guardian ad litem. Likewise, if one parent withdraws permission during treatment, we will suspend treatment until the issue is resolved.

We believe it is in the child's best interest to have all of their parents support their treatment. Therefore, in situations in which one of the parents does not have legal custodial rights, we will request permission from the custodial parent to contact the other parent and to set up a plan for regular communication, unless there is a specific contraindication due to safety or clinical concerns. We will not initiate treatment until these issues have been clarified and resolved.

Evaluation and Treatment Planning
Prior to starting treatment, the Center will require: copies of court documentation indicating custody arrangements, allowances, or restrictions for contact between parent and minor child; court orders for counseling; and/or any other legal documentation related to the medical care of the child. Treatment begins with an evaluation that includes determining if the Center can meet the needs of the family and the appropriateness of ongoing treatment. In the event that it is our clinical opinion that treatment is no longer viable or beneficial, or is beyond our purview, we reserve the right to terminate treatment and refer the client to a clinician who specializes in the appropriate specialty cases.

Communication with parents and guardians
We strongly believe in communicating with parents and guardians during the course of treatment. At a minimum, we expect you to be available for at least monthly meetings unless otherwise noted in the treatment plan. Often more frequent contact is necessary. Regarding safety, we will contact parents immediately if a child is engaging in dangerous or unsafe behavior. Likewise, we expect parents to contact their child's therapist if they have concerns about a child's safety.

Center policy stipulates that communication between parents and staff occurs in person or during scheduled telephone calls. Email and text correspondence is only appropriate for routine matters (e.g., scheduling appointments) and should not be used to communicate clinical or legal information, nor to forward correspondence to or from third parties, unless expressly requested by the therapist. Please see the Center's email policy for more information

Privilege and Confidentiality: The child-client whose parents are divorced or in the process of divorce has his/her/their own confidentiality rights and evidentiary privilege with respect to his/her/their relationship with the therapist. In these separation/divorce situations, a clinician may not be permitted to share the substance of what the child-client has discussed in individual sessions nor to provide copies of therapy notes just because a parent asks for this information. This information may only be released with a court order or with the signed, informed consent of a mature minor unless otherwise specifically permitted.

Communication with other parties

We will obtain written permission from you before we communicate with other agencies or individuals about your child. In most cases, it is very useful for us to be able to exchange information with your child's pediatrician to insure that the medical and mental health issues are coordinated. We routinely request that parents sign a form giving us this permission. We generally seek permission to communicate with a child's school. This helps us learn about how your child is functioning in school and help teachers or school administrators respond better to his/her/their needs. As mandated reporters there are confidentiality limits we abide by, please refer to the Notice of Privacy Practices for more information.

In disputes about child custody, a court-appointed guardian ad litem might have access to your child's records if the court gives them this authority. Likewise, if we receive a court order (signed by a judge) then we must release information to the court.

Custody or Visitation Disputes

We are committed to remaining neutral so that the treatment remains a safe environment in which a child can discuss all of his/her/their feelings without fearing that they will influence the outcome of the dispute or alienate one or the other of their parents.

The parent/guardian role: We request that each parent agree to limit communication with the child's therapist to that parent's direct relationship with the child/children, and not to share information or criticism regarding the other parent's relationship with the child/children. We request that email correspondence from each parent/guardian be limited to practical matters. We request that each parent support the child's therapy by refraining from overt criticism or from asking the child to reveal the content of their sessions.

The clinician's role: Our approach dictates that whenever possible we seek to preserve a child's attachment to all of his/her/their parents, even in situations where parents have severe disagreements over custody or visitation arrangements. The role of providing psychotherapy to children and their families is fundamentally different than the role of evaluating custodial or visitation agreements. It is outside the scope of work of therapists or staff at the Brookline Center to make recommendations regarding these matters. If asked, we will tell parents to seek the help of a specialist in the community who can provide an independent evaluation. As part of providing you with the highest possible quality of care, your child's therapist will routinely consult with other Center staff including peers and supervisors.

Fees

Billable time includes individual, parent, family, and psychopharmacology sessions, no-show and late cancel sessions, and the clinician's collateral time including activities such as phone calls, emails,

attending meetings, reviewing correspondence, and generating any requested documentation. These services are billed as permitted by insurance. In cases of shared legal custody we routinely take credit card information from both parents and bill all sessions equally unless other arrangements are made in advance.

All clinical visits, including parent meetings and child therapy, will be billed at the client's customary charge as set at the time of registration. Parents are responsible for any co-pays at the time of each visit. Regular attendance is expected. Cancellations within 24 hours or absences will be billed at the self-pay charge. Please see as well the Center's fee policy.

There are times when it is clinically indicated for sessions to be supplemented by collateral services that include consultation with third parties. This may include, but is not restricted to, other mental health professionals, school personnel, guardians ad litem, and attorneys. Consultations that are not covered by insurance may be billed at the self-pay rate (in 15 min units). Preparation of documents and review of correspondence may also be billed at the self-pay rate.

In the event the clinician is required to attend Court or a hearing, parents/guardians may be billed for all time required including preparation, travel, and attendance. As this is a non-covered service, these activities will be billed at a pre-determined rate based on the time involved and the expertise required to fulfill the request.

Family Therapy

The above Guidelines for Treatment Involving Children and Adolescents also apply when children are involved in family therapy. However, such cases warrant some additional considerations. Family therapy differs from child therapy in that family therapy targets relationships and the dynamics within the family system. In our clinical approach to family work we define "the client" as the family system itself, or as the relationship(s) between family members. However, for insurance purposes one (or more) family members will need to be identified as "the client."

The family therapist may meet with different configurations or subgroups of the family members, but the ultimate focus will always remain on the family relationships. For example, the family clinician may provide parent guidance, give parents feedback, and/or gather information from parents either separately or together. Rest assured that even during meetings with various family member configurations, the focus will remain on the agreed-upon family therapy objectives and treatment goals.

Confidentiality in family therapy differs somewhat from confidentiality in individual child therapy. When multiple members of the family are involved in family therapy the clinician may share more information with parents than is possible in individual treatment. The information shared will be at the discretion of the family therapist depending on the goals and objectives of the treatment. Also of note, in cases with families who are divorced or in the process of divorcing we will not conduct family therapy without the active participation of both parents.

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

Child's Name: ____

Signed: ______________________________________ Date: ______________________

Relationship to child: (parent/guardian) _______________________________________

I agree to pay all fees associated with extensive collateral work that is not covered by health insurance. This includes, but is not limited to attendance at meetings, consultation with third parties, or report preparation. I understand I will be charged at the self-pay fee rate.

Signature:________________________________ Date:__________________