


Moore Center / MHCGM Medication Clinic Intake Paperwork Checklist – Required

Client Name _____

Case Manager Name _____

Case Manager phone/email _____

Date to The Moore Center _____ Date to MHCGM _____

Complete? 	Page Numbers	Item Description
	1 - 2	Checklist - REQUIRED
	3 - 6	Client Information Form
	7 - 8	Medical Screening Form and Medication List
	9 - 10	Photocopy of Medication List
	11 - 12	Intake Authorization Form
	13 - 14	Informed Consent for Telemedicine
		Release of Information Forms:
	15 - 16	<ul style="list-style-type: none"> • For PCP
	17 - 18	<ul style="list-style-type: none"> • For The Moore Center
	19 - 20	<ul style="list-style-type: none"> • For DHHS (for those receiving Medicaid)
	21 - 24	<ul style="list-style-type: none"> • For additional agency (vendor) providing services
	25 - 26	<ul style="list-style-type: none"> • For HCPs, Guardian (separate ROI needed for each HCP, guardian)
	27.1, 27.2, ..., 28	<ul style="list-style-type: none"> • For additional entities providing services
	29 - 30	Copy of insurance card(s)
	31.1, 31.2, ..., 32	Documentation of Guardianship
	33.1, 33.2, ..., 34	Individual Service Agreement (ISA)
	35.1, 35.2, ..., 36	Emergency Medical Information Sheet (EMIS)
	37.1, 37.2, ..., 38	Current behavior plan (If available)
	39.1, 39.2, ..., 40	Recent neuropsychological evaluation; psychiatric consultations; or any other evaluations, assessments, or consultations that could help the provider get to know the client.
	41 - 46	Privacy & HIPAA Notices (Do not return. Yours to keep.)
	47 - 48	Clients Rights (Do not return. Yours to keep.)

This checklist is required. The Moore Center will review your intake packet once ALL items are provided. We do not review incomplete packets.

We are happy to answer any questions you might have. Please contact us:

Jennifer Darrow

Med Clinic Coordinator

The Moore Center

Jennifer.darrow@moorecenter.org

603 206-2779

Client ID: _____ **For Office Use:** Clinician: _____
 Scheduled Intake Date: _____ Time: _____ Primary Diag Code/Name: _____

CLIENT DATA

Last Name: _____ **Gender:** _____
First Name: _____ **DOB:** _____
Middle Name: _____ **Social Security #:** _____
Maiden Name: _____ **Alias:** _____

Residential Address: _____
Address City/Town State Zip

Mailing Address: _____
(Only iff different ffrom above address)

Marital Status:

(check choice)

- Civil Union
- Cohabiting
- Divorced
- Married
- Separated
- Single
- Unknown
- Widowed

Race:

(check choice)

- 2 Or More Races
- American Indian / Alaskan Native
- Asian
- Black / African American
- Hawaiian / Pacific Islander
- Unknown / Not Reported
- White / Caucasian

Ethnic Origin:

(check choice)

- Hispanic
- Not Hispanic / Other
- Unknown / Not Reported

Sexual Orientation:

(check choice)

- Bisexual
- Chose not to disclose
- Lesbian, gay or homosexual
- Other
- Straight or heterosexual
- Unknown

Primary Language: _____ **Is an Interpreter needed:** ___ Y ___ N

Phone Numbers: Home: _____ Cell: _____ Work: _____
Note: Referred from another healthcare provider (Y/N): _____

EDUCATION and EMPLOYMENT

Education: Years completed: _____ **Current Grade Level:** _____

Source of Referral:

Did you attend school in the last three months? _____

Employment Status- as of today:

(check choice)

- Employed now or past 3 months Full Time
- Employed now or past 3 months part time
- Not in the Labor Force(stud, retired,etc)
- Unemployed

CHECK ONLY THE ONE MOST APPLICABLE RESPONSE

- ACERT
- BEAS/DCYF
- College, Other Education/Trainig
- Employer/EAP
- Faith Community
- Homeless Outreach/Referral
- Hospital
- Human Service Agency, Other
- Insurance Company
- Internet/Website/Media/211
- Legal/Police/Corrections/Court
- MD, Healthcare Provider/Agency
- Mental Health Provider/Agency
- PHQ-9-EHS
- Perinatal
- School(Pre-School to Grade 12)
- Self/Family/Friend/Others
- Substance Abuse Provider/Agency

Name: _____ Date: _____ Client ID: _____

OTHER CLIENT DATA

Number living in Household: _____

* If homeless, choose option:

Living Status:

(check choice)

- CHILDRENS RESIDENTIAL TX
- CRISIS RESIDENCE
- FOSTER HOME
- * HOMELESS
- INSTITUTION
- JAIL/CORRECTIONAL FACILITY
- OTHER
- PRIVATE RESIDENCE/DEPENDENT
- PRIVATE RESIDENCE/INDEPENDENT
- RESIDENTIAL CARE
- UNKNOWN

(check choice)

- Campground
- Emergency Shelter
- Friend/Family
- Motel
- Outside/Car
- Transitional Housing

Religion: _____

Do you have Military Related Disability: __ Y __ N

Smoker:

(check choice)

- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker
- Never Smoked
- Smoker, Current Status Unknown
- Unknown If Ever Smoked

Have you or a family member ever served in the military:

(check choice)

- Family Member Only-Child
- Family Member Only-Multiple Members
- Family Member Only-Parent
- Family Member Only-Sibling
- Family Member Only-Spouse/Sign. Other
- No-Neither
- Self Only
- Self and Child
- Self and Multiple Family Members
- Self and Parent
- Self and Sibling
- Self and Spouse/Significant Other
- Unknown

Primary Care

PCP: _____

Practice: _____

PCP Address:

Address _____ City/Town _____ State _____ Zip _____

Name: _____	Date: _____	Client ID: _____
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Check Here () if LEGAL section is Not -Applicable and continue to next section

LEGAL INFORMATION

DCYF: __ Y __ N BEAS: __ Y __ N DJJS Involvement: __ Y __ N

DCYF or BEAS Contact Name: _____

Probate- Condition Discharge: Date of Commitment: _____ Date of Expiration: _____

Probate-Outpatient Commitment: Date of Commitment: _____ Date of Expiration: _____

Court Ordered Treatment: Date of Order: _____ Date of recent arrest: _____

Emergency Contact & Related Persons including Legal

REQUIRED

1) Emergency Contact Name: _____	Is Emerg Contact? __ Y __ N	Guardianship __ Ad Litem __ Estate __ Person __ Springing	Child Custody __ Joint Legal __ Legal __ Physical	Durable Power Of Attorney __ Finance __ Healthcare
Relationship: _____	Address: _____	<small>(Check appropriate boxes above <u>only</u> if they apply)</small>		
Phones: Primary _____	Secondary _____	Work _____	** For Staff Use Only ** Is there a Parenting Plan for this child? __ No __ Yes, copy has been requested. Parenting Plan has been Received __ Y __ N	

2) Name: _____	Is Emerg Contact? __ Y __ N	Guardianship __ Ad Litem __ Estate __ Person __ Springing	Child Custody __ Joint Legal __ Legal __ Physical	Durable Power Of Attorney __ Finance __ Healthcare
Relationship: _____	Address: _____	<small>(Check appropriate boxes above <u>only</u> if they apply)</small>		
Phones: Primary _____	Secondary _____	Work _____		

3) Name: _____	Is Emerg Contact? __ Y __ N	Guardianship __ Ad Litem __ Estate __ Person __ Springing	Child Custody __ Joint Legal __ Legal __ Physical	Durable Power Of Attorney __ Finance __ Healthcare
Relationship: _____	Address: _____	<small>(Check appropriate boxes above <u>only</u> if they apply)</small>		
Phones: Primary _____	Secondary _____	Work _____		

Name:	Date:	Client ID:
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FINANCIAL and INSURANCE INFORMATION

Primary Insurance:

Guarantor	Subscriber
Insurance:	Name: Relationship: DOB:
Address:	Address:
Phone:	Phone:
Policy: Coverage Effective - Expiration	Group: Subscriber Employer: Verified : Co-Pay:

Secondary Insurance:

Guarantor	Subscriber
Insurance:	Name: Relationship: DOB:
Address:	Address:
Phone:	Phone:
Policy: Coverage Effective - Expiration	Group: Subscriber Employer: Verified: Co-Pay:

Person Responsible for payment or co-payment of Services.	Name: Relationship: DOB:
<i>If NOT the client please provide contact information</i>	Address:
	Phone:

MEDICARE-D PLAN

I have NO Part D Coverage

Plan Name: _____ **Enrollment Date:** _____ **ID#:** _____

RU _____ CLINICIAN: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

**THE MENTAL HEALTH CENTER OF
GREATER MANCHESTER - MEDICAL
SCREENING FORM**

Date Completed: _____ Name _____ DOB _____ Case # _____

PCP Name & Organization: _____

Were you seen by your primary care physician within the past year? Yes No If yes, date of last visit _____

Height _____ Weight _____

Were you referred here by another healthcare provider? Yes No

Check the appropriate box below: For all yes answers, provide an explanation.	Yes	No	Explanation: dates, severity, treatments, results, etc.
Allergies to food, medicine, etc. (e.g. rash, breathing problems). <i>If yes, what are you allergic to?</i>			
Heart condition (e.g. angina, heart attack, irregular heartbeat, valve disease, and vascular condition, stroke, murmur, Rheumatic Fever).			
High Blood Pressure			
High Cholesterol			
Diabetes			
Cancer			
Kidney/Urinary Tract problem			
Epilepsy/seizures or other neurological conditions			
Thyroid problems			
Headaches			
Any serious injuries / physical limitations			
Any surgical operations or complications			
Ulcers or other digestive symptoms			
Ear/hearing problems			
Breathing problems (e.g. bronchitis, asthma)			
Arthritis, joint or bone problems			
Glaucoma or other eye conditions			
Communicable diseases (e.g. TB, hepatitis, HIV, venereal diseases or any serious consequences from a previous infection (e.g. encephalitis, meningitis)			
Liver problems			
Have you had unprotected sex in the last five years?			
Current pregnancy			
Irregular Menstrual Periods			
Perimenopause or Menopause			
Other conditions (e.g. dental)			
U. Skin Conditions (including rashes, bites, blisters, issues with bed bugs, scabies or lice within the past 3 months)			
V. Check your smoking status			
<input type="checkbox"/> Current Every day Smoker <input type="checkbox"/> Current Some Day Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked <input type="checkbox"/> Smoker, Current Status Unknown <input type="checkbox"/> Unknown if Ever Smoked			
W. Were any of your biological family members ever diagnosed with any of the following: diabetes, obesity, heart disease? If yes, please explain:			
X. Did you receive a flu vaccine in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes, what month? _____			
Y. Have you received a primary dose of COVID-19 vaccine? _____ Primary dose date (if known): _____			
Second dose? _____ Second dose date (if known): _____			
Booster dose(s)? _____ Booster date(s) (if known): _____			

Please turn over

Med Clinic Intake Packet

Current Medication List

If you do not want to hand-write the Medication List on Page 8,
use this space to insert a pre-printed Medication List.

**THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
CLIENT INTAKE AUTHORIZATION FORM**

PLEASE READ AND SIGN BELOW

Name: _____

Case #: _____

Client Rights and Privacy Practices

1. I hereby agree to evaluation and treatment by The Mental Health Center of Greater Manchester (MHCGM), which may include the use of telepsychiatry.
2. I understand that if I withhold or withdraw my consent for telepsychiatry services, it will not affect my right to care and treatment to which I am otherwise entitled.
3. I have received and understand the Client's Rights and agree to the terms in the Client Contract, including that audio and/or video recording on cell phones or other devices while in our waiting rooms or during appointments is prohibited.
4. I have been provided with The Mental Health Center of Greater Manchester's Notice of Privacy Practices.
5. I grant permission to The Mental Health Center of Greater Manchester to contact the person(s) listed as Emergency Contact(s)/Support Person (s) in the event of a crisis/emergency.
6. As part of my care and treatment and The Center's efforts to promote and enhance integrated care, The Mental Health Center of Greater Manchester may electronically transmit or receive my Protected Health Information, including substance use, in a secure and confidential manner with other healthcare providers involved in my care, through Medallies or other secure health information exchange.
7. I understand that MHCGM is comprised of a number of programs, e.g. Bedford Counseling Associates, The Cypress Center and that one medical record will be kept, which may be accessed by MHCGM providers, treatment team members and other MHCGM individuals as allowed under HIPAA.
8. Federal law 42CFR Part 2 provides confidentiality protections for records that might identify an individual directly or indirectly as having a substance use disorder.

Assignment of Benefits

1. I authorize The Mental Health Center of Greater Manchester to verify and bill any insurance I had previously on file, or my current insurance/third party payer and the NH Department of Health and Human Services including for treatment, payment or healthcare operations.
2. I request payment from my insurance carriers be made directly to The Mental Health Center of Greater Manchester.
3. I consent to the use/disclosure of my protected health information, including substance use assessment, prevention and treatment for treatment, payment or healthcare operations.

Financial Policy

1. Insurance co-payments are payable when services are rendered.
2. Any services that are not fully reimbursed by your insurance and are indicated by your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement.
3. If correct insurance information is not presented at the time of service, you may be responsible for the full charges incurred.
4. If you do not have medical insurance, you may request financial arrangements be made prior to services being rendered. Otherwise, full payment will be expected at the time of service.
5. I acknowledge that, in the event my account balance becomes outstanding, steps may be taken to collect payment from me including, but not limited to, legal action. I consent to the disclosure of my name and other billing information to consumer credit reporting bureaus/collection agencies in the event that The Mental Health Center of Greater Manchester takes steps to collect an unpaid bill.
6. Full payment may be due at the time of service for certain services.

Client/Legal Representative Signature

Printed Name

Date

Informed Consent for Telemedicine

Name: _____

Case #: _____

I, _____, hereby consent to engaging in telemedicine with MHCGM medical
(Name of client)

staff as part of my therapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or consultation, treatment, transfer of medical data and education using interactive audio, video or data communications and it may improve my access to psychiatric services. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners who are located in sites outside of the MHCGM offices.

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality. I will refer to the Informed Consent Contract for details regarding confidentiality. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from telemedicine including, but not limited to, the minimal possibility, despite reasonable efforts on the part of MHCGM, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons. MHCGM only provides telepsychiatry (telemedicine) through HIPAA compliant, secure electronic communication of which interactive two-way real time audio and video components are utilized.
4. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee. Such inspection and copying of records shall be subject to my physician’s or distant specialist’s office policies and procedures.
5. I understand that individuals other than the distant provider may also be present and have access to my medical information during the session in order to operate the video equipment, should such equipment be utilized.
6. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the distant provider.
7. In an emergency, I understand that the responsibility of the distant provider is to advise MHCGM staff immediately.

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

Client/Guardian Signature

Date

Staff Signature

Staff Printed Name

date

I refuse to participate in telemedicine services.


Client/Guardian Signature

Date

THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
Authorization for Release of Information

(Please complete ALL sections. Missing information may cause delays or the inability to retrieve your records)
 RELEASES CAN TAKE UP TO 15 BUSINESS DAYS TO PROCESS.

FEES: There may be a charge for copying records. Please be as specific as possible about the information you are requesting, as well as the treatment date range.

<p>1. Please print patient legal name (name of person receiving services)</p>	<p>Legal Name: _____ Case #: _____</p> <p>Previous/Preferred Name (if applicable): _____</p> <p>Date of Birth: _____ Phone #: _____</p>
<p>2. Who can we get your medical record information from?</p> <p>AND/OR</p> <p>Who do you want to receive your medical record information?</p>	<p>Please list the specific hospital, physician office, other agency or support person (One provider/facility/person per release form)</p> <p>I hereby authorize the facility/provider/support person listed below to:</p> <p><input type="checkbox"/> Release/Obtain medical records <input type="checkbox"/> Speak to/discuss with</p> <p><input checked="" type="checkbox"/> Both release/obtain medical records and discuss information with</p> <p>Facility/Provider/Person: _____</p> <p>Address: _____</p> <p>Phone #: _____ Fax #: _____</p>
<p>3. Protected Health Information to be released:</p> <p>What do you want shared?</p>	<p><input checked="" type="checkbox"/> Complete Record (Please be aware that by checking this box you could receive and possibly be charged for items from the record that may not be necessary such as demographic information)</p> <p>IF COMPLETE RECORD WAS CHECKED ABOVE, STOP HERE AND MOVE TO SECTION 4.</p> <p><u>If you do not wish to include the complete record, check the items below that you want to share from your record:</u></p> <p><input type="checkbox"/> Assessments <input type="checkbox"/> Treatment Plans/Reviews <input type="checkbox"/> Progress Notes <input type="checkbox"/> Summaries <input type="checkbox"/> Treatment Status</p> <p><input type="checkbox"/> Insurance/Billing <input type="checkbox"/> Diagnosis <input type="checkbox"/> Letters/Forms <input type="checkbox"/> Demographics Info <input type="checkbox"/> Medical Screening</p> <p><input type="checkbox"/> Legal Docs (specify; e.g., CD, Guardianship)</p> <p><input type="checkbox"/> Research Records – include all items protected under a Certificate of Confidentiality <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Physician Orders/Med List (NOTE: Your medication history may include dates outside the "treatment dates" specified above.)</p> <p><u>THIS RELEASE COVERS ALL TREATMENT DATES UNLESS A PARTICULAR DATE(S) ARE SPECIFIED BELOW:</u></p> <p>From: _____ To: _____</p> <p>(We do not accept "All" for dates of service)</p> <p>Is this request for us to obtain psychotherapy notes? (these are notes that exist outside the patient record)</p> <p><input type="checkbox"/> Yes, then this is the only item you may request on <u>this</u> authorization</p>
<p>4.</p> <p></p> <p>IMPORTANT</p>	<p>It is extremely important that you select either "YES" or "NO" for each item contained in this section.</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No – Information can be obtained/released concerning my alcohol or substance use disorder (SUD) treatment</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No – Information can be obtained/released concerning my HIV/AIDS status</p>
<p>5. Purpose of Release (Why is it needed?)</p>	<p><input checked="" type="checkbox"/> Continuing Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Personal Use/Review <input type="checkbox"/> Insurance/Benefits</p> <p><input type="checkbox"/> Attorney/Legal <input type="checkbox"/> Discharge Planning <input checked="" type="checkbox"/> Care Coordination <input type="checkbox"/> Treatment Planning</p>

Patient Legal Name: _____

Case #: _____

I understand that:

1. I am consenting to the releasing and/or obtaining of psychiatric information.
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. The information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the Privacy Regulations.
5. Federal rules 42CFR Part 2 prohibits further disclosure of SUD information unless expressly permitted by written consent and restricts any use of information to investigate or prosecute with regards to a crime any patient with a substance use disorder, except in connections with a crime committed on the premises or against a SUD provider, or consistent with 42 CFR Part 2 section 2.65.
6. I understand that I have a right, upon request, to a list of entities to which my information has been disclosed pursuant to the general designation.

This release expires six months following my discharge from The Mental Health Center unless a shorter period is specified here: _____.

For persons whose case is closed at the time this release is completed, the release will expire in 6 months unless a shorter period is specified here: _____.

Signature of Patient/Former Patient

Date (REQUIRED)

OR

Signature Parent/Legally Authorized Representative

Date (REQUIRED)

Printed Name of person signing & Relationship of person signing (e.g., Parent, Guardian, Power of Attorney)


MHCGM STAFF USE:

Patient requested copy of Authorization to Release Information

THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
Authorization for Release of Information

(Please complete ALL sections. Missing information may cause delays or the inability to retrieve your records)
 RELEASES CAN TAKE UP TO 15 BUSINESS DAYS TO PROCESS.

FEES: There may be a charge for copying records. Please be as specific as possible about the information you are requesting, as well as the treatment date range.

<p>1. Please print patient legal name (name of person receiving services)</p>	<p>Legal Name: _____ Case #: _____ Previous/Preferred Name (if applicable): _____ Date of Birth: _____ Phone #: _____</p>
<p>2. Who can we get your medical record information from? AND/OR Who do you want to receive your medical record information?</p>	<p>Please list the specific hospital, physician office, other agency or support person (One provider/facility/person per release form)</p> <p>I hereby authorize the facility/provider/support person listed below to: <input type="checkbox"/> Release/Obtain medical records <input type="checkbox"/> Speak to/discuss with <input checked="" type="checkbox"/> Both release/obtain medical records and discuss information with</p> <p>Facility/Provider/Person: _____ Address: _____ Phone #: _____ Fax #: _____</p>
<p>3. Protected Health Information to be released: What do you want shared?</p>	<p><input checked="" type="checkbox"/> Complete Record (Please be aware that by checking this box you could receive and possibly be charged for items from the record that may not be necessary such as demographic information)</p> <p>IF COMPLETE RECORD WAS CHECKED ABOVE, STOP HERE AND MOVE TO SECTION 4.</p> <p><u>If you do not wish to include the complete record, check the items below that you want to share from your record:</u></p> <p><input type="checkbox"/> Assessments <input type="checkbox"/> Treatment Plans/Reviews <input type="checkbox"/> Progress Notes <input type="checkbox"/> Summaries <input type="checkbox"/> Treatment Status <input type="checkbox"/> Insurance/Billing <input type="checkbox"/> Diagnosis <input type="checkbox"/> Letters/Forms <input type="checkbox"/> Demographics Info <input type="checkbox"/> Medical Screening <input type="checkbox"/> Legal Docs (specify; e.g., CD, Guardianship) <input type="checkbox"/> Research Records – include all items protected under a Certificate of Confidentiality <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Physician Orders/Med List (NOTE: Your medication history may include dates outside the “treatment dates” specified above.)</p> <p><u>THIS RELEASE COVERS ALL TREATMENT DATES UNLESS A PARTICULAR DATE(S) ARE SPECIFIED BELOW:</u></p> <p>From: _____ To: _____ (We do not accept “All” for dates of service)</p> <p>Is this request for us to obtain psychotherapy notes? (these are notes that exist outside the patient record) <input type="checkbox"/> Yes, then this is the only item you may request on <u>this</u> authorization</p>
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Date (REQUIRED)

OR

Signature Parent/Legally Authorized Representative

Date (REQUIRED)

Printed Name of person signing & Relationship of person signing (e.g., Parent, Guardian, Power of Attorney)


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Med Clinic Intake Packet

Copy of Insurance Cards

Please insert the copy of the insurance cards in place of this page.

Med Clinic Intake Packet
Documentation of Guardianship

If the client has a Guardian, please insert that documentation in place of these pages.

If the client does not have a Guardian, please have them sign below and keep this page in the packet.

This certifies that I do not have a Guardian:

Client Name, printed

Client Signature

Date

Med Clinic Intake Packet
Individual Service Agreement (ISA)

Please insert the ISA in place of this page.

Med Clinic Intake Packet
Emergency Medical Information Sheet (EMIS)

Please insert the EMIS in place of this page.

Med Clinic Intake Packet

Current Behavior Plan

Please insert the current Behavior Plan in place of this page.

Med Clinic Intake Packet

Evaluations, Consultations, Assessments

Please insert the following in place of this page:

- Recent neuropsychological evaluation
- Psychiatric consultations
- Any other evaluations, assessments, or consultations that could help the provider get to know the client.

THE MENTAL HEALTH CENTER OF GREATER MANCHESTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH AND SUBSTANCE USE) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is issued by the Mental Health Center of Greater Manchester (“The Center”). If you have any questions about this Notice, please contact our Privacy Officer.

Protected Health Information (“PHI”) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how your PHI may be accessed, used and disclosed. It also describes your rights to access and control your PHI.

As a provider of health care, we are required by federal and state law (including HIPAA and 42CFR Part 2) to maintain the privacy of PHI and to provide you with this Notice of our legal duties and privacy practices. We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. We will provide you with any revised Notice of Privacy Practices upon request; you may either call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. We will also promptly post the revised Notice of Privacy in our reception area.

PERMITTED USES AND DISCLOSURES

General Rules

Federal law allows a health care provider to use or disclose PHI as follows:

- You. We will disclose your PHI to you, as the covered individual, at your request.
- Authorization. We will disclose your PHI pursuant to the terms of an authorization signed by you.
- Personal representative. We will disclose your PHI to a personal representative designated by you to receive PHI, or a personal representative designated by law such as the parent or legal guardian of a child or representative of the estate of a deceased individual.
- Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. Treatment refers to the provision and coordination or management of healthcare and related services by one or more health care providers, including consultation or referral. For example, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist laboratory or pharmacy) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.
- Payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. Payment refers to the collection of premiums,

reimbursements, coverage, determinations, billing, claims management, medical necessity determinations, utilization review, and pre-authorization services. For example, we may provide portions of your PHI to our billing company and your health plan to get paid for the health care services we provided to you. We may also disclose your PHI to another health care provider for its payment activities if it received your PHI for treatment purposes.

- Health care operations. We may disclose your PHI in order to operate this practice. Health care operations refer to specified administrative support activities by or for a health care provider, including quality assessment and improvement, peer review, training and credentialing of providers, and legal and auditing functions. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you.
- Appointment reminders and other notifications. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives.
- Qualified Service Organization Agreement (QSOA)/Business Associates. We will share your PHI with third party “business associates” or QSOA’s that perform various activities (for example, billing or transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we have a written agreement that contains terms that will protect the privacy of your PHI.
- Other uses and disclosures. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Uses and Disclosures Allowed Without Authorization or Opportunity to Agree or Object

Federal law also allows a health care provider to use and disclose PHI, without your consent or authorization, or opportunity to agree or object, in the following ways:

- As required by law. When a disclosure is required by Federal, state, or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
- For public health activities. For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information, and we may provide coroners, medical examiners, and funeral directors necessary information relating to an individual’s death.
- For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

- For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
- For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
- To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes.
- For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.
- To medical personnel. Disclosure is made to medical personnel in a medical emergency.
- The disclosure is made in connection with a suspected crime committed on the premises or a crime against any person who works for us or about any threat to commit such a crime.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

- Others Involved in Your Healthcare. If you agree or do not object, we may disclose to a member of your family, a relative, a close personal friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care or payment for your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

You have the following rights with respect to your PHI:

- Limit Uses. The right to request limits on uses and disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but except as specified below, we are not legally required to agree to it. If we agree to your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to use. However, In the event you pay in full for the services we have provided and request that we not disclosure PHI to your health plan, we will honor that request.
- Alternative Modes of Communication. The right to choose how we send PHI to you. You have the right to ask that we send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means. We must agree to your request so long as we can easily provide it in the format that you requested.
- Access. The right to see and get copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. You are also entitled to an electronic copy of your Electronic Health Record ("EHR"), if one exists. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
- Copies. If you request paper copies of your PHI, we may charge you \$0.25 (twenty-five cents) for each page. For EHR, you may be charged the cost of labor to produce the electronic copy or make the electronic transmission. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
- Accounting of Disclosures. The right to get a list of the disclosures we have made. You have the right to get a list of instances in which we have disclosed your PHI for a period of up to six years prior to the date of the request except for disclosures that you have authorized.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable fee for each additional request.

- Amendment of Records. The right to correct or update your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and notify others that need to know about the change to your PHI.
- Fundraising Communications: We may to use your PHI to communicate with you about our own fundraising initiatives or allow our business associates to communicate with you for that purpose. **YOU HAVE THE RIGHT TO INSTRUCT US NOT TO COMMUNICATE WITH YOU FOR FUNDRAISING PURPOSES. IF YOU WOULD LIKE TO OPT OUT OF RECEIVING FUNDRAISING COMMUNICATIONS FROM US, YOU MAY CONTACT OUR PRIVACY OFFICER.**
- The Center's Privacy Officer may be reached by phone or mail at:

Privacy Officer
Mental Health Center of Greater Manchester
401 Cypress Street
Manchester, NH 03103-3699
Phone: (603) 668-4111

COMPLAINTS

You may file a complaint with us by notifying The Center's Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact The Center's Privacy Officer at (603) 668-4111 for further information about the complaint process. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

EFFECTIVE DATE OF NOTICE

This Notice was published and becomes effective on **September 11, 2019.**

THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
CLIENT'S RIGHTS AND RESPONSIBILITIES

The Mental Health Center of Greater Manchester is committed to provide you with the best service possible and to do so with full respect for your rights, feelings and opinions that will ensure your personal privacy, individuality and dignity.

1. You will not be discriminated against because of race, color, age, national origin, sex, including gender identity and sexual stereotypes, disability or degree of handicap. If you need legal counsel, you have the right to obtain that service.
2. Under Title VI of the Civil Rights Act, which is a U.S. Law, you have a right to competent language services if you have limited ability to speak English, and under the Americans with Disabilities Act, you have the same right if you are Deaf or Hard of Hearing.
3. Unless you have a guardian or activated Durable Power of Attorney (DPOA), who makes financial and/or treatment decisions, or in certain emergency situations specified by law then you have the right to make decisions and act independently on them. You have the right to be advised of the consequences of your decisions/actions. You have the responsibility to participate in your treatment plan.
4. Personal privacy will be maintained at all times, for example: you may talk to someone alone or, you will not be fingerprinted, photographed or recorded without your permission.
5. Services provided to you will be in keeping with accepted clinical and professional standards provided by qualified staff which may include the use of telepsychiatry. You have the right to information regarding your provider's professional code of ethics, education and practice limitations. You have the right to be referred to other provider's when appropriate. You have the right to be informed of your diagnosis, purpose, goals, techniques, risks and benefits of treatment. You have the right to be informed of the services available and decide on services in which you want to participate. You may withhold or withdraw your consent for telepsychiatry services – it will not affect your right to care and treatment to which you are otherwise entitled.
6. You have the right to an individualized treatment plan which is based on an initial and ongoing evaluation of your needs and the goals you want to reach. You have the right to services, which promote independence and least restrict your freedom while still enabling you to meet your treatment goals. You have the right to clear information addressing time of sessions, fees, third party requirement procedures, absences and emergency procedures. You have the right to request, through your clinician, a treatment plan conference. MHCGM is comprised of a number of programs, e.g., Bedford Counseling Associates, The Cypress Center, and that one medical record will be kept, which may be accessed by MHCGM providers, treatment team member and other MHCGM individuals as allowed under HIPAA.
7. Federal law 42CFR Part 2 provide confidentiality protections for records that might identify an individual directly or indirectly as having a substance use disorder.
8. You have the right to advance directives for medical care (living will and durable power of attorney for healthcare).
9. You have the right to seek out a second opinion or consult with another service provider at your own cost.
10. You have the right to be free from restraint except in an emergency.
11. You have the right to be treated in a safe environment; therefore, no pets (except for service animals, pets in HUD residences; or by special exception), alcohol, drugs, weapons or ammunition are to be brought into Center facilities, or in a staff member's or mental health center vehicle.

12. Treatment is routinely terminated based on a joint decision made by you and your therapist. Either of you, however, can terminate treatment independently, the basis for which will be documented in your clinical record. If The Mental Health Center decides to terminate services because of endangerment to clients or staff, you have the right to appeal. While the appeal is pending, service to you will not be terminated unless a safety risk is present.
13. Treatment shall not be suspended unless prior written notice was given, this notice may be given as an item in the individual service plan or in written rules of the program or service. The maximum length of a suspension shall be five program days. You have the right to appeal.
14. If you are dissatisfied with the service you have received, you have the right to have your concern respectfully heard and any failure corrected.
 - a. You may discuss the concern with your current treatment providers.
 - b. If you are not satisfied by their response, or should you prefer to talk with someone else, you may directly contact:
 - 1) your therapist's director
 - 2) the Center's Complaint Manager for informal resolution
 - 3) the NH Bureau of Mental Health Services Office of Client and Legal Services for a formal resolution
 - c. You are financially responsible for all charges related to your care. You have the right to request evaluation for a discount for the cost of your services not covered by insurance. You may request the evaluation through the Business Office representative at your program location.

Payments made may be applied to the oldest balance first.

Any problem having to do with charges or billing should first be discussed with the Business Office staff. If the problem is not resolved, you may contact the Director of Client Accounts.
15. Your medical records are only guaranteed to be retained by us for the duration required by current law.