Mental Health PARTNERS
Healthy Minds, Healthy Communities

MHP Registration Form

303-568-4231 Fax

admissions@mhpcolorado.org

Reset Form

Date:

Referral Source Information

Referral Source:	Would you like MHP to coordinate your care with this agency/ individual? If yes, please be sure to fill out a MHP Authorization to Release Information Form. YES ☐ NO ☐
Contact Person:	
Contact's Info:	

New Client Information

First, Middle, Last Name:	
Date of Birth:	Social Security #:
Primary Language:	Is a translator needed? YES ☐ NO ☐
Legal Gender:	Gender Identity:

Street Address:	City:	State:	Zip Code:
Phone #:	Is it alright to leave a message on this number? YES ☐ NO ☐		
Other Phone #	Is it alright to leave a message on this number? YES ☐ NO ☐		
Additional Contact Information (e-mail address, etc.):			

Emergency Contact (*Required for persons under 18)	Full Name: Relation to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐
Primary Caregiver (*Required for persons under 18)	Full Names: Relations to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐
Mental Health Decision Maker (*Required for persons under 18)	Full Names : Relations to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐

Financially Responsible Party (if other than yourself):	Full Name:		Relation to Client:	
	Phone #:		Is it alright to leave a message on this number? ☐ YES ☐ NO	
	Street Address:	City:	State:	Zip Code:

Insurance Information

Insurance #1	Policy Holder Name:	DOB:	Relation:
	Company:		
	Company Phone #:		
	Policy #/ Member ID:		
	Group Number:		
	Group Name:		
Insurance #2	Policy Holder Name:	DOB:	Relation:
	Company:		
	Company Phone #:		
	Policy #/ Member ID:		
	Group Number:		
	Group Name:		

Income Information

MHP offers a financial assistance program. Persons who qualify will be eligible for a $5 monthly fee.** ***In order for MHP to determine whether or not you may be eligible for a reduced fee under certain circumstances we need to gather some basic financial information.

Size of Household (Please include yourself, spouse and any dependent children): _____

Gross Household income (Please indicate whether this number is annual, monthly, weekly etc.): $_____

***Please turn page over**

1. Are you currently having any thoughts of suicide or self-harm? YES ☐ NO ☐

2. Are you currently having any thoughts of homicide or harm to others? YES ☐ NO ☐

3. Are you hearing or seeing things others do not appear to be hearing or seeing? YES ☐ NO ☐

If you are currently experiencing any of the issues above and would like to speak to someone right away, please contact our 24/7 emergency team at 1-844-493-TALK. You are also welcome to drop in any time of day or night 7 days a week at 3180 Airport Rd. Boulder, CO

If yes to questions 1, 2 or 3, please provide more details below:

In a couple of sentences, please describe the reason for seeking mental health and/or substance abuse services:

Have you ever had therapy in the past? If so, were you given a mental health and/or substance abuse diagnosis (please describe)?

In the past year, have you used drugs, alcohol or non-prescribed medications? If so, please list the substance(s) and when it/ they were last used:

Were any of these substances used intravenously or injected? YES ☐ NO ☐

Do you have any dependent children? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐

If so, what is your due date? _____

Are you currently on probation? YES ☐ NO ☐ YES ☐ NO ☐

If yes, please provide contact information for your probation/parole officer: _____

Do you have any obstacles to transportation that would prohibit them from going to an MHP location? YES ☐ NO ☐

Additional Comments or special needs to assist in planning for services:

Effective date: _____ **CID#**_____

Please check one: Send Information Now☐ **Request Information Now**☐ **File for Future/As Needed Use**☐ **One-time release only**☐

MENTAL HEALTH PARTNERS

1455 Dixon Avenue, Lafayette, CO 80026 Phone 303-247-8791 FAX 303-484-4485 (Clinical Records)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:_____ Client's Date of Birth: _____

(Include client's AKA, maiden name, etc. of person receiving services at MHP)

I authorize that information may be exchanged between the following named individual or entity and Mental Health Partners (MHP):

*Name: _____ Relationship to Client: _____

Address/e-mail: _____ Phone: _____

_____ FAX: _____

☐ *Check here if this is for your Primary Care Physician*

☐ *Check here if you want to authorize release of your substance use disorder treatment information to all your past, present and future treatment providers as a general designation authorization*

***If using this form to release your SUBSTANCE USE DISORDER TREATMENT information to anyone who is NOT 1) providing treatment, or 2) paying for treatment <u>you must indicate a specific individual (not an agency or entity) to receive that information by their first and last name</u>.**

The purpose of the disclosure is: (It is required to check one of the purposes below or provide a specific purpose)

☐ Client requested letter ☐ Coordination of care ☐ Communicate about therapy results and/or attendance

☐ Obtain/maintain housing ☐ Obtain/maintain benefits ☐ Obtain/maintain employment/supported employment

Other (Please Specify): _____

_____

_____

Please check any items below to release the following information:

☐ **All my physical and mental health treatment records, Including HIV/AIDS (unless restricted below)

☐ **All my substance use disorder treatment (drug and alcohol) records (this can be restricted below)

☐ Diagnosis

☐ Medications

☐ Progress Notes

☐ Treatment Plan(s)

☐ Psychological Evaluation

☐ Psychiatric Evaluation

☐ Emergency Services Reports (§ 27-82 commitments)

☐ Psychiatric Progress Notes

☐ Employment

☐ Benefits

☐ **HIV/AIDS

☐ Other (Please Specify additional items to release) _____

_____

☐ **Drug and Alcohol Evaluations

☐ Physical Examination

☐ Information provided by client to receive benefits

☐ Service Attendance Dates

☐ Lab Reports

☐ Patient Assistance Program (PAP) Information

☐ Intake/Admission Information

☐ Information needed to complete application for organization

☐ Discharge Summary

☐ Housing

☐ Education

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (*protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions, and any other information in your medical record **unless restricted as follows**: _____
_____

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to the MHP Privacy Officer or his/her designee. If not revoked earlier, this release/authorization will expire **two years** from the most recent date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as an original. I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at MHP.

MHP does not recommend electronic format (such as e-mail, texting with clinical staff) as a means of communication with MHP employees. There is some risk that any protected health information that may be contained in such e-mail or text may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, you are acknowledging that electronic media is not secure, and you are releasing MHP from any liability relating to unauthorized disclosure of PHI contained in electronic media correspondence. Charges for copies may apply: $16.50 for up to 10 pages; $.75 for pages 11-40; $.50 for each additional page; $10 for electronic format.

(***Optional***) I restrict this release to the following dates of service: ___/___/_____ and ___/___/_____.

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including your authority to act for client

Date of Signature

_____ _____
Signature and Date to Extend Request

Signature and Date to Extend Request

_____ _____
Signature and Date to Extend Request

Signature and Date to Revoke Authorization

***NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION: This information has been disclosed to you from records protected by Federal Law (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Rev. 11/18 sea