AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*** All sections on authorization form must be completed in order to be valid***

Client Name: ______________________________ **DOB:** ___________ **Case #:** ______________________

I hereby authorize Center for Life Management (CLM) to ☐ **Obtain from** ☐ **Disclose to** ☐ **or Exchange my protected health information including psychiatric/mental health information with:**

Name: ____ ☐ Check if PCP

Address: ____ ☐ Request Records

Phone: ______________________________ Fax: ______________ ☐ Send Records

Information to be released / obtained / exchanged (check all that apply):

**please note information to be disclosed is limited to the minimum necessary for the purpose stated below.*

☐ Intake / Assessment ☐ Psychiatric Evaluation / MD Consults ☐ Treatment / Service Plan ☐ Labs

☐ Progress Notes ☐ Complete Record ☐ Other (specify) ______________________

Dates of treatment: ________________ to ____________________ or ☐ Check here for all dates of treatment

- *I understand that I may inspect or obtain a copy of the protected health information described by this authorization.*
- *I understand that I may revoke this authorization at any time by notifying CLM in writing. However, revocation does not cover information that was received or disclosed prior to CLM receiving revocation.*
- *I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.*
- *I understand that Center for Life Management (CLM) shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.*
- *For cases where parents share joint custody; at the discretion of CLM, records released to one parent with joint custody may be disclosed to the other parent without specific request.*

I AUTHORIZE CLM TO RELEASE / OBTAIN THE FOLLOWING INFORMATION:

PLEASE INITIAL AS APPROPRIATE

_________ **Alcohol and/or Drug Treatment Information** (I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.)

_________ ***PLEASE NOTE:** When client is 12 yrs or older and seeking substance abuse treatment independently, client's initials only are needed.

_________ **HIV Related Information** (I understand that I have the right to refuse release.)

The purpose of the release is(Specify): ____

Client Signature: ______________________________ Date: ______________________________

Parent/Guardian Signature: ______________________ Date: ______________________________

Witness Signature: _____________________________ Date: ______________________________

To receiving provider: This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. 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 C.F. R. 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.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ON THE CONCLUSION OF YOUR TREATMENT.

Center for Life Management (CLM) - Medical Records Department
10 Tsienneto Road, Derry, NH 03038 - Phone: (603) 434-1577 - Fax: (603) 965-0227

07.07

CENTER FOR LIFE MANAGEMENT CLIENT RIGHTS STATEMENT

As a client of Center for Life Management, you have rights that will be respected and maintained. Your most important right is the right to know what your rights are and the right to complain when you believe that your rights have been violated. No client shall be deprived of any legal right to which all citizens are entitled solely by reason of their admission to the mental health services system. Some of these rights are outlined below. If you would like a complete copy of the State regulation that governs these rights, please ask a staff member for a copy of He-M 309: Rights of Persons Receiving Mental Health Services in the Community.

PERSONAL RIGHTS

- to not be discriminated against
- to be treated with dignity and respect
- to be free from abuse, neglect, and exploitation
- to confidentiality: some exceptions are outlined below
- to complain about a violation of rights

SOME EXCEPTIONS TO CONFIDENTIALITY

- to secure payment
- when reporting abuse, neglect or exploitation of disabled adults or of children to the Division of Behavioral Health
- in cases of an Involuntary Emergency Admission or Guardianship proceedings
- when you are a danger to yourself or others
- to family members or other person who lives with the client or provides direct care to the client (under certain circumstances)

TREATMENT RIGHTS

- to adequate and humane treatment
- to make decisions about your services
- to treatment based on generally accepted clinical and professional standards
- to a mutually agreed upon treatment plan
- to services in the least restrictive setting
- to be informed of all significant risks, benefits, side affects, and alternative treatment and services
- to be fully informed of your diagnosis and prognosis
- to seek changes in services or treatment
- to refuse medication and treatment (except in Involuntary Emergency Admissions)
- to consultation and second opinions
- to have someone with you at treatment meetings where informed decision-making is required
- to freedom from restraint and seclusion except for personal safety
- to receive adequate written notice prior to suspension or termination of treatment with explanations as to the reason, and for the right to appeal the action
- to an explanation of the purpose of the Individual Service Planning (ISP) treatment planning process including goals, objectives, timelines, reviews, and crisis plans

FOR THOSE ELIGIBLE FOR STATE SUPPORTED SERVICES

- to choose either of the following methods by which my ISP is developed
  - through a formal client centered conference that is a meeting at a mutually convenient time and place with the psychiatrist and other involved persons approved by me, such as family members, CLM staff, representatives of other agencies providing services to me such as vocational rehabilitation, friends, an attorney, legal representative, a peer advocate and/or others with relevant knowledge or expertise
  - through a less formal method that shall include one or more one-on-one or small group meetings with the psychiatrist and/or others by phone, in person and/or through other effective means.
- to have ten days to make a decision after receiving the written explanation regarding the method to develop the ISP
- to consult with family, friends, therapists, advocates and others before making the decision regarding the method to develop my ISP

These treatment rights do not require CLM to provide services or administer treatment that it considers unreasonable, unnecessary and/or against the clinical judgment of its professional staff. To assure a safe environment for all persons I understand that no firearms or other weapons are allowed on CLM premises except by law enforcement personnel, in the line of duty.

If you feel that your rights have been violated, we urge you to contact us at any of the CLM sites or offices. You may do so by phone or in writing. Address your concerns to The Client Rights Investigator at Center for Life Management, 10 Tsienneto Road, Derry, NH 03038 or call 434-1577.

Client Signature	Date	Parent/Guardian/DPOA	Date
I understand that checking this box constitutes a legal signature.		I understand that checking this box constitutes a legal signature.	

WHITE COPY TO CLIENT AND YELLOW COPY FOR RECORD

Center for Life Management (CLM)
Participation, Service & Payment Agreement – Adult Services

Client Name ________________________ Record Number __________

We are glad you have chosen CLM to provide your mental health care. Please read and familiarize yourself with our Participation, Service & Payment Agreement. It is essential that your services be provided in a mutually respectful and confidential manner consistent with the stipulations of this agreement and policy. It is also important that your account be kept up-to-date so that we can continue to offer you the highest quality care possible. Thank you for carefully reviewing and acknowledging the information below.

Informed Consent to Treatment

I voluntarily seek and consent to treatment from the staff of Center for Life Management ("CLM"). I understand that the staff at CLM will provide me with their very best treatment and I also understand that no healthcare provider can guarantee results of treatment. I understand that I am responsible for actively and honestly participating in my treatment. I also understand that I am responsible for asking questions about any policy procedure or treatment that I do not understand or agree with, and I understand that I can accept or refuse any treatment. I further agree to read any papers that I am asked to sign in connection with my treatment at CLM.

During my involvement at CLM, I expect that services will be discussed with me. Information of my involvement will be kept confidential by CLM. No information will be released without my written consent, except in cases of emergency, and as required or allowed by State and Federal Law.

I understand that Federal Law 42 CFR Part 2 prohibits the release of substance use information without my written permission.

I affirm that I have received a copy of:

- "*About Our Services*"
- "*Client Rights Statement*"
- "*Statement of Privacy Practices*"
- *"Statement of 42 CFR Part 2 Confidentiality" (only for substance use programs)*

Payment Agreement

1. I understand that my insurance may not cover all or any of the services received from CLM. This includes co-payments, deductibles (or Medicaid In/Out spend-down) and services not covered by my policy. I understand that I am fully responsible for payment for services rendered in the event that my health insurance does not reimburse CLM for all or part of the service fees.

2. I understand that, except in an emergency situation, CLM expects a minimum of 24 hours' notice if I must cancel an appointment. In the event of an emergency, I understand that I must give notice of cancellation as soon as it is reasonably possible to do so. In turn, I understand that CLM will make every attempt not to cancel my appointment except in cases of staff illness or other emergency reasons.

3. I understand that CLM expects payment at the time of service and that is it CLM's policy that services may be terminated or suspended due to refusal to pay.

4. I understand that CLM has established a DNA **(Did Not Arrive) policy. Except when prohibited by law, I understand that I will be charged a $30.00 fee if I fail to notify the office at least 24 hours in advance of not being able to keep my scheduled medical or therapy appointment.** I understand that CLM expects this DNA charge to be paid in full before attending my next scheduled appointment.

5. I authorize release of medical and other information about me necessary to process claims for medical benefits and to secure payment and I request that payment of government benefits be made to CLM, unless otherwise noted.

I agree that CLM may use the following methods to contact me regarding my appointments:

e-mail: ______________________________________,
address

voice mail: ______________________________________,
phone number

text message: ______________________________________.
cell number

<u>Acknowledgement of Participation, Service & Payment Agreement</u>

I understand that this Agreement is in effect throughout my entire course of treatment at CLM.

I have received answers to my questions about the items above.

______________________________	____________________	_____________
Signature of Client or Guardian	Print Name	Date

CLM Center for Life Management

Name:__________________ ID Number:__________ Date:__________
Marital Status:__________________ Employment Status:__________________
Number of Children:__________

HEALTH HISTORY

Please check if you have/had problems related to the areas indicated.

1. GENERAL	YES	NO
Weight Change	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fatigue	☐	☐
2. EYES		
Glaucoma	☐	☐
Cataracts	☐	☐
Wears Glasses	☐	☐
Blurred or Double Vision	☐	☐
3. EARS, NOSE, THROAT		
Wears Hearing Aid	☐	☐
Hearing Loss with No Aid	☐	☐
Dizziness	☐	☐
Pain	☐	☐
4. RESPIRATORY		
Shortness of Breath	☐	☐
Trouble Breathing	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Chronic Cough	☐	☐
5. CARDIOVASCULAR		
Heart Attack	☐	☐
Chest Pain/Angina	☐	☐
Heart Murmur	☐	☐
Rapid Heart Beat	☐	☐
High Blood Pressure	☐	☐
Congenital Heart Condition	☐	☐
6. GASTROINTESTIONAL		
Ulcers	☐	☐
Stomach Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Gastro-esophageal Reflux	☐	☐
Nausea	☐	☐
7. ENDOCRINE SYSTEM		
Diabetes	☐	☐
Hypo/Hyper Thyroid	☐	☐

8. URINARY SYSTEMS	YES	NO
Urinary Tract/Bladder Infections	☐	☐
Incontinence	☐	☐
Trouble Urinating	☐	☐
Kidney Problems	☐	☐
9. REPRODUCTIVE		
PMS	☐	☐
Post or Menopausal	☐	☐
10. SKIN		
Rashes	☐	☐
Dry Skin	☐	☐
Jaundice	☐	☐
Melanoma	☐	☐
11. NEUROLOGIC		
Stroke	☐	☐
Seizures	☐	☐
Head Injury	☐	☐
Tingling	☐	☐
Numbness	☐	☐
12. MUSCLES/JOINTS		
Arthritis	☐	☐
Weakness	☐	☐
Frequent Falls/Unsteady	☐	☐
13. BLOOD/LYMPHATIC		
Bruising/Bleeding Easily	☐	☐
Anemia	☐	☐
Swollen Lymph Nodes	☐	☐
14. PSYCHIATRIC		
Sleep Disturbance	☐	☐
Feeling Anxious	☐	☐
Feeling Depressed	☐	☐
Suicidal	☐	☐
Substance Abuse	☐	☐
15. SMOKING STATUS		
Do You Smoke?	☐	☐

If yes, how much per day __________________

16. ALCOHOL USE		
Do you consume alcohol?	☐	☐

If so, how much/how often? __________________

OTHER MEDICAL CONDITIONS/ADDITIONAL COMMENTS:

Please complete the back of form as well.

ALLERGIES:

CURRENT MEDICATIONS			
NAME	DOSE	FREQUENCY	REASON FOR TAKING

HOSPITALIZATIONS		
DATE(S)	NAME OF FACILITY	REASON

MEDICAL PROVIDERS	NAME	PHONE	DATE LAST SEEN	REASON FOR SEEING
PRIMARY CARE PROVIDER				
SPECIALIST				
SPECIALIST				
SPECIALIST				

FAMILY MEDICAL HISTORY:

	Which Family Member?		**Which Family Member?**
Cancer/Tumor	________________	Diabetes	________________
Heart Disease	________________	Mental Illness	________________
Epilepsy	________________	Other Significant Illness	
Alcoholism	________________		________________
			________________

COMMENTS OF REVIEWER:

Reviewed by:____ Date:______________

Revised 1/5/2022

NOTICE REGARDING THE CONFIDENTIALITY OF
ALCOHOL AND DRUG TREATMENT INFORMATION

Client Name: ________________________________ **Client #:** ____________________

As a patient receiving substance use disorder (SUD) treatment services at Center for Life Management, the records and information concerning your SUD treatment are subject to heightened privacy protections under a federal law known as "Part 2." *See* 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2.

Under Part 2, we may not disclose records or information about your SUD treatment, including acknowledging your current or past presence at our practice, **unless**:

1. You or your personal representative consent to disclosure in writing;
2. The disclosure is allowed by a court order;
3. The disclosure is made to medical personnel to respond to a medical emergency you are experiencing and you lack capacity to consent to disclosure;
4. The disclosure is made to authorities to report suspected child abuse/neglect or inability to care for self as required by law;
5. The disclosure is made for qualifying research, audit, or program evaluation purposes;
6. The disclosure is made in connection with a suspected crime committed on our premises or a crime against any person who works for us or about any threat to commit such a crime;
7. The disclosure is made to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the Health Insurance Portability and Accountability Act and/or related laws or regulations; or
8. The disclosure is made to a public health authority and involves information relating to the cause of your death.

Other than as stated above or as allowed by applicable law, we will not use or disclose your SUD treatment records or information without your written consent. Violation of Part 2 is a crime and suspected violations may be reported to the U.S. Attorney's Office for the District of New Hampshire at (603) 225-1552 or usanh.webmail@usdoj.gov.

______________________________ ____________________ ____________

Signature of Client or Guardian Print Name Date

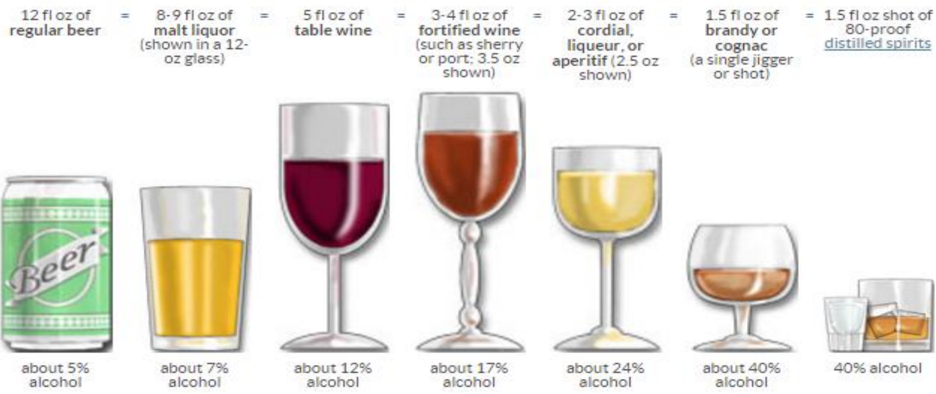
CLM Center for Life Management

Date: ______________________
Name: _____________________
ID: ________________________

PHOENIX

Please take this opportunity to answer the following questions.

Phoenix Questions	Check one answer only for each question.
Consumer's Employment Status	☐ 1. Employed (competitively employed full or part time, includes supportive employment) ☐ 2. Not in labor force (retired, sheltered workshop, volunteer, homemaker, student, disabled) ☐ 3. Unemployed (seeking employment but not currently working) ☐ 4. Not available
Consumer's Living Status	☐ 1. Private residence (house, apartment, hotel, dorm, barrack or single room occupancy) ☐ 2. Supportive housing (subsidized housing or a financially supported private residence, HUD, Section 8, sheltered care) ☐ 3. Foster Home (licensed home to provide foster care and therapeutic foster care facilities) ☐ 4. Residential Care (group home, therapeutic group home, board and care, residential treatment, rehabilitation center) ☐ 5. Crisis Residence (residential stabilization program, limited for persons until they reach stabilization) ☐ 6. Children's Residential Treatment (organization, not licensed as a psychiatric hospital used to provide provisions of planning programs of mental health treatment with residential care for children) ☐ 7. Institutional Setting (skilled nursing/intermediate care, nursing home, institution for mental disease, inpatient psychiatric hospital, state hospital, veteran's affair hospital) ☐ 8. Jail/Correction Facility (jail, correctional facility, detention center, prison, youth authority facility, juvenile hall, boot camp, or boys ranch) ☐ 9. Homeless (lacks fixed, regular and adequate nighttime residence, homeless shelter, temporary residence for people being institutionalized) ☐ 10. Other (please indicate):



The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

CLM Center for Life Management

Date: ___________________________

Name: ___________________________

ID: ___________________________

Please use the Standard drink to measure the amount of aclohol consumed.

AUDIT (Alcohol Use Assessment) **In the last 12 months…**	**Check one answer only for each question**				
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 time a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last 12 months		Yes, within the last 12 months
Has a relative, or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?	No		Yes, but not in the last 12 months		Yes, within the last 12 months

CLM Center for Life Management

Date: ___________________________
Name: ___________________________
ID: ___________________________

DAST

Please take this opportunity to answer the following questions

DAST (Drug Abuse Screening Test): **<u>All</u> questions are regarding the past 12 months and not regarding the following drugs- Alcohol, Tobacco and Caffeine.**	**Check yes or no to these questions**	
	Yes	No
Have you used drugs other than those required for medical reasons?		
Do you abuse more than one drug at a time?		
Are you unable to stop using drugs when you want to?		
Have you ever had blackouts or flashbacks as a result of drug use?		
Do you ever feel bad about your drug abuse?		
Does your spouse (or parents) ever complain about your involvement with drugs?		
Have you ever neglected your family because of your use of drugs?		
Have you engaged in illegal activities to obtain drugs?		
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?		

Center for Life Management

Date: ______________________
Name: ______________________
ID: ______________________

PHQ-9 DEPRESSION

Please take this opportunity to answer the following questions.

Check one box only for each question

PHQ-9 (Depression)	**Not at all**	**Several days**	**More than half of the day**	**Nearly every day**
Over the last 2 weeks, how often have you been bothered by a little interest or pleasure in doing things?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by feeling tired or having little energy?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by a poor appetite or overeating?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐
I made plans to end my life within the last two weeks.	No ☐		Yes ☐	

CLM Center for Life Management

Date: ________________________

Name: ________________________

ID: ________________________

GAD-7(ANXIETY)

Please take this opportunity to answer the following questions

Check one answer only for each question

GAD-7 (Anxiety)	**Not at all**	**Several days**	**More than half of the day**	**Nearly every day**
Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by worrying too much about different things?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by trouble relaxing?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by being so restless that it is hard to sit still?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by becoming easily annoyed or irritable?	☐	☐	☐	☐
Over the last 2 weeks, how often have you been bothered by feeling afraid as if something awful might happen?	☐	☐	☐	☐