Aurora Mental Health Center
Live Life to the Fullest

11059 E. Bethany Drive
Suite 200
Aurora, CO 80014
303.617.2300
www.aumhc.org

Welcome to Aurora Mental Health!

Please complete the included documents and bring them with you to your appointment. Your appointment is scheduled for _____.

Included in this packet are the following documents:

1. Registration Form (3 pages): Please include as much information as possible and mark NA for unknown information.
2. Release of Information (1 page): Please fill out a release for any family member, primary care provider, other providers, and other mental health programs that you would like to have access to your treatment information at Aurora Mental Health. It is up to you who has access so you can fill out as many as you like, or none.
3. *MINORS ONLY* Attestation of Medical Decision Making (1 page): Indicate who has medical decision making for the minor and sign. Please note what documentation is required and bring that with you to the appointment.

If you have additional questions or concerns about this documentation you are welcome to ask those questions of the provider before signing the documents, please arrive a few minutes before your appointment to allow adequate time for review. If you are unable to fill out the information then please arrive 15 minutes before your scheduled time to complete paperwork. All minors must be accompanied by a parent or legal guardian.

We look forward to working with you!

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Client Registration Document

CID:

Legal Last Name	Legal First Name

Preferred Name / Nickname	Social Security #	Date of Birth
	___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___

Address	City	State	Zip

County	School	School District

Primary Phone Number	Type (check only one)	Contact Preference (check all that apply)
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	☐ Home ☐ Mobile ☐ Work ☐ School	☐ Do Not Call ☐ Do Not Leave Message

Alternate Phone Number	Type (check only one)	Contact Preference (check all that apply)
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	☐ Home ☐ Mobile ☐ Work ☐ School	☐ Do Not Call ☐ Do Not Leave Message

Appointment Reminder Phone Number	How would you like to receive the reminders? (check only one)
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	☐ Phone Call, leave message if not answered ☐ Phone Call, do not leave message ☐ Text Message (mobile only)

Email Address	Primary Language	Secondary Language	Legal Gender
			☐ Male ☐ Female

Primary Care Provider Name	Phone Number		
	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		
Address	**City**	**State**	**Zip Code**

Emergency Contact Name	Relationship	Phone Number		
		(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		
Address ☐ Resides with Client		**City**	**State**	**Zip Code**

Guardian Name ☐ Same as Emergency Contact	Relationship	Phone Number		
		(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		
Address ☐ Resides with Client		**City**	**State**	**Zip Code**

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Client Registration Document

CID:

Other Household Members	Name	Birth Date	Relationship
		__/__/____	
		__/__/____	
		__/__/____	
		__/__/____	
		__/__/____	

Living Arrangements *(check all that apply)*

- ☐ Alone
- ☐ Partner/Significant Other
- ☐ Father
- ☐ Guardian
- ☐ Relative(s)
- ☐ Mother
- ☐ Child(ren)
- ☐ Spouse
- ☐ Foster Parent(s)
- ☐ Sibling(s)
- ☐ Unrelated Person(s)

Place of Residence *(check only one)*

- ☐ Independent Living
- ☐ Homeless
- ☐ Nursing Home
- ☐ Residential (Other)
- ☐ Inpatient (Hospital)
- ☐ Sober Living
- ☐ Residential (Adult MH Facility)
- ☐ Foster Home (Youth)
- ☐ Assisted Living
- ☐ Acute Treatment Unit (Adult)
- ☐ Group Home (Adult)
- ☐ Correctional Facility/Jail
- ☐ Boarding Home (Adult)
- ☐ Supported Housing
- ☐ Halfway House
- ☐ Residential (Treatment/Group)

Employment *(check only one)*

- ☐ Full-Time (35+ hours/week)
- ☐ Part-Time (<35 hours/week)
- ☐ Supported Employment
- ☐ Military
- ☐ Volunteer
- ☐ Disabled
- ☐ Student
- ☐ Inmate
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed

$ _____ ☐ per Year ☐ per Month

Household Income

# of people supported by income _____ *(include yourself)*

# of children which you are responsible _____ *(under age 18)*

Primary Income Source *(check one only - largest source)*

- ☐ Legal Employment
- ☐ Public Assistance / Welfare
- ☐ Disability / Worker's Compensation
- ☐ None
- ☐ Pension / Retirement / Social Security
- ☐ Other: _____

Social Security Income

- SSI (Supplemental Security Income): ☐ Yes ☐ No
- SSDI (Social Security Disability): ☐ Yes ☐ No

Are you now, or have you ever been in the military? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No ☐ I don't know

If Yes, Do you want them added to your medical chart? ☐ Yes ☐ No

Race *(check all that apply)*

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian
- ☐ Declined

Ethnicity *(check all that apply)*

- ☐ Not Hispanic
- ☐ Hispanic / Mexican
- ☐ Hispanic / Cuban
- ☐ Hispanic / Puerto Rican
- ☐ Other Hispanic
- ☐ Declined

Marital Status *(check only one)*

- ☐ Never Married
- ☐ Married
- ☐ Married, Separated
- ☐ Divorced
- ☐ Widowed

Gender Identity *(if legal gender differs, check only one)*

- ☐ Male
- ☐ Female
- ☐ Transmale/Transman/FTM
- ☐ Transfemale/Transwoman/MTF
- ☐ Genderqueer/Gender-Non-Conforming
- ☐ Different Identity: _____

Pronoun *(check only one)*

- ☐ He / Him
- ☐ Xe
- ☐ She / Her
- ☐ They / Them
- ☐ Other: _____

Sexual Orientation *(check only one)*

- ☐ Straight/Heterosexual
- ☐ Declined
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Don't Know
- ☐ Other: _____

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Client Registration Document

CID:

Disabilities (check all that apply)		Accomodations Needed (check all that apply)	
☐ Deaf/Hearing Loss	☐ Traumatic Brain Injury (TBI)	☐ Interpreter	☐ Transportation Assistance
☐ Blind/Vision Loss	☐ Developmental Disability	☐ Sign Language	☐ Reading Assistance
☐ Learning Disability	☐ Other: _____	☐ Accessible Room	

Primary Insurance	Insurance ID Number	Group Number

Policy Holder Name ☐ Same As Client	Policy Holder Birth Date	Phone Number
	__/__/____	(___) ___-____

Secondary Insurance	Insurance ID Number	Group Number

Policy Holder Name ☐ Same As Client	Policy Holder Birth Date	Phone Number
	__/__/____	(___) ___-____

Is your visit related to an accident or work injury?	If yes, who should be billed for services?
☐ Yes ☐ No	

How were you referred here for treatment?	What organization or individual referred you to us?

In case of Emergency, I authorize the Center to notify my Emergency Contact list above.
In addition, your signature indicates that you authorize the Center to call/text/email you based on your stated preferences with the understanding that some electronic forms of communication may leave your privacy open to others.

Client Signature	Date

Parent/Guardian Signature	Date

Office Use Only
(all information on this form is required to complete a Registration)

Forms/Agreements Given ☐ English ☐ Spanish ☐ Not Given ☐ Declined ☐ N/A

Insurance Cards Scanned ☐ Yes ☐ No **Identification Cards Scanned** ☐ Yes ☐ No

AURORA MENTAL HEALTH CENTER

11059 East Bethany Drive Suite 200 • Aurora, CO 80014 • Ph 303.617.2300
AuMHC Contact Person: Tricia or Diana in Medical Records • Fax 303.617.2445 • Ph 303.617.2336

AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____ _____
Client Name (please print) SSN (last 4 digits) Date of Birth CID

I authorize Aurora Mental Health Center to <u>exchange</u> information with:

_____ _____ _____
Name of Person or Organization Phone Fax

_____
Street Address City / State / Zip Code

I request that records/information be released in the following format:

☐ Verbal Information ☐ Printed ☐ Electronic ☐ Certified

I request that the records/information be released in the following manner:

☐ Mail ☐ Fax ☐ Picked up ☐ Secure Email *(If selected, please provide email: _____)*

The information to be disclosed includes the following <u>checked</u> documentation:

☐ Complete Record *Or check below:*

☐ Medication History ☐ Psychiatric / Psychological Evaluations ☐ Progress Notes
☐ Care Plans ☐ Discharge Summaries ☐ Lab Studies
☐ Intake Assessment ☐ Other _____

Dates include: From _____ To _____ ☐ Last 4 weeks ☐ Last 6 months ☐ Last year ☐ Other: _____

The purpose for the release is: ☐ Continuity of care ☐ Other: _____

I UNDERSTAND that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Information about a Substance Use Disorder may not be re-disclosed by the recipient without my written consent unless otherwise provided for in the relevant rules (42 C.F.R. Part 2).

I UNDERSTAND that if I chose to disclose information indicating HIV / AIDS, that information may be contained in the records to be released to the above named individual or agency.

I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, two years from the date of my signature. I release the Center from all liability for disclosing the requested information.

I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

NOTICE TO THE RECIPIENT OF THE INFORMATION

Federal law (42 C.F.R. Part 2) prohibits unauthorized disclosure of these records. 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.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Please print name of Legal Representative Phone

If you are not the client, please identify your authority to act on the client's behalf:
Parent of minor / Guardian / Custodian / GAL / MDPOA / Personal Representative (Executor of Estate) (Documentation required)

I hereby revoke this Authorization to Release Information.

_____ _____
Signature of Client or Legal Representative Date

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Attestation of Medical Decision Making for Minor Child

Client Name:_____ **Date of Birth**:_____ CID:_____

I, _____ state and attest that I may legally consent to mental health, medical, and/or substance abuse treatment for the above named minor child under the following authority (Please initial):

_____ **Biological/Adoptive parent or Legal Guardian**

_____ **has sole Medical Decision Making Authority** (If you are separated or divorced from the child's other biological parent please provide legal documentation that explicitly states that you have sole medical decision making authority.)

Medical Decision making is shared between:
_____ **and** _____
(In the case of separation or divorce, Aurora Mental Health Center requires that both parents/legal guardians consent to mental health treatment. As the presenting parent, please provide contact information for the other parent/legal guardian and we will outreach them and ask for their consent to treat the minor:
Address:_____ **Phone Number**:_____

If the other parent/legal guardian is not available to sign, please explain below:

_____ **Self**: Minor over the age of 15 who wishes to consent for services

_____ **Department of Human Services Representative**: (DHS is required to consent to treatment for children in their custody and to provide legal documentation demonstrating they hold medical decision making authority; attach e-signed referral to indicate legal authority and consent for treatment.)

_____ **Other**: please explain below and attach document verifying legal authority:

Please note that without the required legal documents we will not be able to treat the minor child

Parent/Guardian/Client Signature:_____ **Date**:_____

Parent/Guardian/Client Signature:_____ **Date**:_____