1ST ____________
2ND ____________
BSA____________

MIND SPRINGS health
Prevention. Care. Recovery.

REGISTRATION INFORMATION

Client ID

Client Name:____

Date of Birth: ___/___/______ Social Security Number:________________ Gender: ☐ Female ☐ Male

Who referred you to Mind Springs Health? Examples: Self, Friend, Minister, School, Probation, Employer, etc.

____

If you are seeking substance use treatment and meet any one of the following please inform the staff at the front desk.

- ☐ IV drug user
- ☐ Pregnant or have dependent children
- ☐ Court ordered on an involuntary commitment

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Veteran ☐ YES ☐ NO ☐ I am a US Citizen

I am a documented immigrant ☐ YES ☐ NO
This information is used to determine public funding resources and will NOT be used to deny services.

Physical Address: ____

City:____________________________________St.:_________Zip:______________

Mailing Address same as Physical Address? ☐ Yes ☐ No

If No: Mailing Address: _______________________City:______________St.:_________Zip:__________

Primary Phone: ________________________ ☐ HOME ☐ CELL ☐ Work ☐ OTHER

Other Phone: __________________________ ☐ HOME ☐ CELL ☐ Work ☐ OTHER

Email address: ____

I prefer to be contacted via ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Do Not Contact

Primary Language: ___________________________ Other Language: ___________________________

Is an Interpreter Needed? ☐ Yes ☐ No

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

Ethnic Origin: Hispanic ☐ NO ☐ YES: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic ☐ Declined

Marital Status: ☐ Never Married/Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Education Level in Years: ________________ (High school = 12; Bachelors = 16 etc.)

Employment Status: ☐ Full Time (35+ hours/week) ☐ Part Time (less than 35 hours/week) ☐ Homemaker, not otherwise employed ☐ Supported Employment ☐ Not in Labor Force ☐ Military ☐ Unemployed ☐ Student ☐ Retired ☐ Disabled ☐ Inmate ☐ Volunteer

Sexual Orientation: ☐ Bisexual ☐ Chose not to Disclose ☐ Lesbian, Gay or Homosexual ☐ Other ☐ Straight or Heterosexual

Maiden Name: ____________________________ ☐ N/A **Preferred Name/Alias** ________________________

Place of Residence: ☐ Independent Living ☐ Assisted Living ☐ ATU Adult Only ☐ Boarding Home ☐ Correctional Facility/Jail ☐ Foster Home (Youth) ☐ Group Home (Adult) ☐ Halfway House ☐ Homeless/Lacking a Perm Residence ☐ Inpatient ☐ Nursing Home ☐ Residential Facility (MH Adult) ☐ Residential Facility (Other) ☐ Residential Treatment/Group ☐ Sober Living ☐ Supported Housing

Living Arrangements: ☐ Alone ☐ Children ☐ Father ☐ Foster Parents ☐ Guardian ☐ Mother ☐ Parents ☐ Partner/Significant Other ☐ Relatives/Kin ☐ Siblings ☐ Spouse ☐ Unrelated Person

Disabilities:_☐ None ☐ Blind/Vision Loss ☐ Deaf/Hearing Loss ☐ Developmental Disability ☐ Learning Disability ☐ Traumatic Brain Injury

Smoking /Tobacco Status:_☐ Current Smoker/Tobacco User – Every Day ☐ Current Smoker/Tobacco User – Periodically ☐ Former Smoker/Tobacco User ☐ Never Smoked/Used Tobacco ☐ Refused

Financial Information

INCOME:

Number of Children (under age of18)? ______________ Number of people this income supports: _________

Annual GROSS Household Income: $ ________________________

I receive SSI Benefits ☐ Yes ☐ NO I receive SSDI Benefits ☐ Yes ☐ NO

Your income may qualify you for a discount. Please review and complete the financial packet being provided to you at this time or you may also obtain the information at www.mindspringshealth.org. Services will not be discounted until a completed application and proof of income is received.

Advance Directives

Would you like information about Advanced Directives? ☐ Yes ☐ No

If you have Advanced Directives in place, may we have a copy? ☐ Yes (*Please bring a copy to our office).* ☐ No

Emergency Contact Information:

Name: ____ Relationship to Client: _______________

Living with Client ☐ YES ☐ NO

Address: ____City:________________St.:__________Zip:__________

Phone #___________________________

Parent/Guardian Information:

Name: ____ Relationship to Client: _______________

Living with Client ☐ YES ☐ NO

Parent/Guardian DOB ______________________ Social Security # ______________________

Address: ____City:________________St.:__________Zip:__________

Phone #___________________________

1ST ____________
2ND ____________
BSA___________

Insurance Information

Reason for Seeking Services: ________ for persons with health insurance only, enter number from the Reason for Seeking Services List

☐ I have Medicaid ☐ I have health insurance of my own ☐ I have health insurance through spouse/parent

If client is a minor, is there a divorce decree indicating which insurance is primary ☐ Yes ☐ NO

I have EAP benefits through my employer ☐ Employer: ____

EAP benefits may require an authorization which is your responsibility to obtain. Please contact your Human Resources Dept. for further information.

Primary Insurance Company Name:___________________________________ Policy # __________________

Subscriber/Policy Holder's Name: _____________________________________ Relationship to Client ________

DOB: _____________________Employer _______________________________

Secondary Insurance Company Name:___________________________ Policy # ___________________

Subscriber/Policy Holder's Name: _____________________________________ Relationship to Client ________

DOB: ______________________ Employer ______________________________

PLACE INITIALS AS APPLICABLE

___ I hereby apply for services for myself and/or my dependents at Mind Springs Health. I attest that 1) the above stated number in household is correct; 2) my reported household income is correct; 3) I understand that payment must be made at the time of service.

___ I attest that I and/or my dependents are uninsured or have insurance coverage that does not include mental health and/or substance abuse benefits. I wish to apply for a sliding scale fee.

___ If applicable, I request my insurance company or other third party coverage to pay all claims directly to Mind Springs Health. I authorize payment of insurance benefits directly to Mind Springs Health for services rendered. I authorize Mind Springs Health to release all information with respect to me and/or my dependents as may be required to process the insurance claim. I authorize my insurance company to release to Mind Springs Health any information regarding my insurance claims with Mind Springs Health I understand that I am financially responsible to Mind Springs Health for any monies paid directly to me by my insurance company for those same services.

_______ I agree that by providing my contact information I may be contacted via auto-dialer technology, prerecorded messages, or text, for the purposes of appointment reminders, payments or to exchange information about my treatment. I understand that I can revoke the consent to receive contact via auto-dialer technology, prerecorded messages, or text, by notifying a staff member at Mind Springs Health and indicating this change on a new Registration Information form.

____ ______________________
Printed Name Client/Authorized Person Date

____
Client or Authorized Person's Signature

CONSENT TO DISCLOSURE OF SUBSTANCE ABUSE INFORMATION

Print Name of Patient ____

DATE OF BIRTH ______________ CLIENT ID___________

I authorize Mind Springs Health to disclose information concerning my, or the above named patient's, treatment for alcohol and, or, drug abuse, to: my health insurer _________________________(insurance company name), Rocky Mountain Health Partnerships, the Colorado Department of Human Services, Office of Behavioral Health; and the Colorado Department of Health Care Policy and Financing.

I also authorize Rocky Mountain Health Partnerships, and the Colorado Department of Human Services, Office of Behavioral Health, to further disclose information concerning my, or the above named patient's, treatment for alcohol and, or, drug abuse, to the Colorado Department of Health Care Policy and Financing.

I authorize such disclosures for the purpose of payment and collection, care coordination, utilization management, quality assurance, and handling grievances and appeals.

I understand that if I do not sign this consent form, my insurer may refuse to pay for my, or the above named patient's, treatment and that Mind Springs may decline to provide treatment.

This consent is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it.

If not previously revoked, this consent will terminate upon on the date that I am, or the above named patient is, no longer a Colorado Medicaid member or no longer insured by the above named insurer or two years from the date of my signature, whichever is earlier.

____ ___________________

Signature of Patient, Parent or Guardian Date

Client ID:______________________________ Client DOB ______________________________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:____ DATE:____________________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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 ________

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