



PREVENTION

INTERVENTION

TREATMENT

RECOVERY

Massachusetts Impaired Driving Program (24D First Offender)- Court Referral Form

Phone: 508-862-9929 | Fax: 508-563-3001 | Email: probationcontact@gosnold.org

Court: _____ Probation Officer: _____

Phone Number: _____ Email/Fax: _____

Under the provisions of Massachusetts General Law, Chapter 90, Section 24D, the person named below is being assigned to the Gosnold's Massachusetts Impaired Driving Program (MID). Gosnold will contact client with an appointment.

Client Name: _____ DOB: _____

SSN: _____ Address: _____

Phone Number: _____ Email: _____

The Gosnold Massachusetts Impaired Driver (MID) Program is a self-pay program, however, insurance information is still required for regulatory and reporting purposes. Please note that your insurance will not be billed.

Insurance Provider: _____ Member ID#: _____

Date of Arrest: _____ BAC: _____ Date of Disposition: _____ Probation End Date: _____

Please note that fees will be collected prior to the scheduling of any assessments. Payments can be made by card, money order or cash. All payments over \$200 must be paid by card or money order. Any waivers must be completed using Gosnold's fee waiver form and must be dated within 10 days of disposition. *Non-compliance with your payment plan will result in court notification and suspension from the program

First Offender MID Referral (Self-pay only) | 24Q Assessment (For BAL over .2)

<p><input type="checkbox"/> Option A: \$1,535.84 paid in full</p> <p><input type="checkbox"/> Option B: \$595.80 at intake- \$470.02 at week 2, \$470.02 at week 8</p> <p><input type="checkbox"/> Option C: \$795.80 at intake- \$740.04 by week 8</p> <p><input type="checkbox"/> Option D: Waiver</p>	<p>\$125 due at Intake (Billable to insurance OR self-pay)</p>
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Please note part of the program requirements includes 16 weeks of educational classes. Participants are only allotted 2 missed classes over the course of the program, which must be made up in order to complete the program. Make up classes carry a fee of \$69.44 per class. Participants will be dismissed following a 3rd absence from programming and asked to restart the program from the beginning, including payment of program fees.

The individual has been informed of program fees and agrees to pay all fees as applicable to each of the programs.

Probationer's Signature: _____ Date: _____

Probation Officer's Signature: _____ Date: _____



Coordination of Benefits/Demographic Information

Patient Name: _____ I Go By: _____

DOB: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Mailing Address (If applicable): _____ City: _____ Zip: _____

Phone Number: _____ Email: _____

Race		Language		Ethnicity		Marital Status	
<input type="checkbox"/>	American Indian/Alaska	<input type="checkbox"/>	English	<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Spanish	<input type="checkbox"/>	Non-Hispanic or Latino	<input type="checkbox"/>	Married
<input type="checkbox"/>	Black or African American	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>	Refuse to answer	<input type="checkbox"/>	Other
<input type="checkbox"/>	Other Race	<input type="checkbox"/> Other _____				<input type="checkbox"/>	Separated - Legal
<input type="checkbox"/>	Unknown					<input type="checkbox"/>	Separated - Non-Legal
<input type="checkbox"/>	White					<input type="checkbox"/>	Single Never Married
<input type="checkbox"/>	Refuse to Answer					<input type="checkbox"/>	Unmarried Couple
						<input type="checkbox"/>	Widowed

Health Insurance Information:

Primary Insurance Payor _____

Member ID Number _____

(Your member ID# will be found on the front of your insurance card)

Secondary Insurance Payor _____

Member ID Number _____

If you are not the subscriber to your insurance policy, please complete the following information

Ins. Subscriber Name _____ DOB _____

Address _____ City _____ Zip Code _____

Emergency Contact Information:

Name _____ DOB _____

Address _____ City _____ Zip Code _____

Primary Phone Number _____

Relationship to You _____

Emergency Contact information does not constitute authorization to exchange or release information related to your treatment, continuing care, or any other protected health information (PHI).

Patient/Parent/Guardian Signature: _____ Date: _____



Patient Consent Agreement

Medical Consent

I authorize Gosnold staff to provide treatment and therapy to me (or my child) and to use therapeutic procedures as necessary. In the event of an emergency, I authorize the staff to administer emergency life-saving treatment and/or to transfer me to a hospital or other medical clinic. I authorize any licensed physician, psychiatrist, psychologist or addiction or mental health counselor to treat me, as necessary.

Shared Care Policy

When and if my (or my child's) treatment requires the services of more than one clinician, these services will be provided by Gosnold clinicians. This will enable communication among Gosnold staff involved in my (or my child's) care through the use of a single medical record.

Authorization to Release Information

I understand that information about my treatment is confidential (under Federal Regulations 42CFR) unless I (or my guardian) authorize the release of information with a written, signed consent. Exceptions to the signed consent include information: for medical personnel in a medical emergency; ordered by a court; about a crime or threat of a crime against program staff; that constitutes a "duty to warn" others if a patient intends harm to self or others; about elder, disabled persons or child abuse; and requested by a governmental agency for the purposes of audit or evaluation. Information regarding my health care, including payment is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I acknowledge by my signature that I have seen and been given an opportunity to read a copy of the Privacy Notice informing me or my rights under the HIPAA law.**

Personal Article and Valuables

I understand and agree that Gosnold is not liable for the loss or damage of any personal articles including money, jewelry, documents or other items which I may bring to the program site. I hold the program free from liability for losses through theft, fire or personal injury while I am a participant in the program.

Personal Responsibility for Payment

I agree to assume full responsibility for payment of services provided to me (or my child) if all or part of such services are not paid by a third party. I understand and agree that I am responsible to know or find out the coverage benefits of my health insurance plan including deductibles, co-pays, and coverage limits. If at any time during my treatment, my health insurance or payment status changes, I will notify the program. I authorize the program to disclose information as permitted by state and federal law to their legal representatives (lawyers, collection agencies, courts, etc.) to collect any unpaid fees. This authorization expires only after the program has received all payments. I understand and agree that payment of any deductible or co-insurance amount is due at the time of service unless an alternative payment schedule is arranged.

Assignment of Insurance Benefits and Authorization to Release Information

I authorize the program to receive payment directly from my insurance company for services provided and to release to the insurance company, HMO or any company representing their interests, diagnostic and therapeutic information as may be necessary to determine benefit entitlement or treatment requirements and to process claims for services. I release the program from all liability that may arise from the release of information requested. This authorization expires only after the program has received all payments. If I am a Medicare/Medigap recipient, I understand that this information will be released to the Health Care Financing Administration and its agents and/or to my Medigap insurer in order to determine these benefits or the benefits payable for related services.

Eligibility for Uncompensated or Subsidized Care

I understand that the program may require a written determination of my eligibility to receive uncompensated or subsidized care. If I apply for uncompensated or subsidized care, I agree to provide information about my income, assets and other resources as requested to determine eligibility.



Patient Rights and Responsibilities. Operating Hours. Emergency Telephone Numbers

I have been given a copy of my rights and responsibilities as a patient, a schedule of the center's hours of operation and telephone numbers to call in the event of an emergency.

Acknowledgement of Tobacco Cessation. HIV. STD, TB, and Overdose Education

I have received HIV /STD/fB information as well as information about tobacco cessation and overdose education. The material I have received includes the definitions of these diseases, symptoms, methods of transmission, treatment and prevention.

Authorization to Release Information to DPH Bureau of Substance Abuse

I understand that by checking the box below, I authorize Gosnold to give information about me to the Bureau of Substance Abuse which licenses this program. I understand that BSAS takes steps to protect my privacy and the security of information it receives. Access to this information will be limited to authorized staff and may be used by BSAS for analysis purposes. I understand that this information will be collected and **Agree** **I Do not Agree** **N/A** that BSAS can utilize personal identifying information in the collection of this data.

Program Participation

I (or my child) agree to participate in the program and follow the program guidelines. Participation in the program may include various physical and recreational activities (fitness sessions and team games, etc.). I agree to hold the program harmless from all liability due to any loss or personal injury I may experience as a result of my participation. I agree to abstain from high risk behaviors associated with the transmission of the HIV virus and Hepatitis B.

Appointment Cancellation Policy

I understand that I must provide the program with a minimum of 24 hour notice of cancellation of a scheduled appointment. If I miss three appointments without giving timely notification, Gosnold will assume that I no longer wish to participate in my treatment and will begin formal actions to terminate my treatment in accordance with Gosnold policy. Please see Patient Copy of Outpatient Missed Appointments Policy.

Permission for Staff Follow-Up after Discharge from Treatment

Gosnold Staff may wish to contact me following my discharge from care to check on my well-being or request feedback on my treatment experience. My signature below indicates my approval for such contact OR Refuse to be contacted

PATIENT: My signature certifies that I have read, understand and agree to all statements in this consent agreement including the release of information about me to the Massachusetts Bureau of Substance Abuse.

Patient Name: _____ **Guardian Name:** _____

Patient/Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____



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Telemedicine Consent Agreement

Gosnold, Inc. offers Telemedicine services as a medium to provide services when there are cultural, linguistic, geographic, or special needs that prevent patients from seeking traditional outpatient treatment sessions. Massachusetts General Law defines Tele medicine as the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment (MGL ch. 175, §47B8).

I understand that participation in Gosnold's Telemedicine services requires the following:

- Secure and Confidential Teleconferencing portals that meets or exceed American Telemedicine Association Standards including the minimum bandwidth requirement and a diagonal display of 22 inches or greater. Gosnold's telemedicine systems meet or exceed the HIPAA/HITECH security standards through the use of encryption and through on site physical security controls.
- Telemedicine Providers must be psychiatrists, psychiatric nurse practitioners/mental health clinical specialist or licensed counselors. All providers must be licensed in the state of Massachusetts and credentialed to provide telemedicine services as an individual provider or performing the service as an employee of Gosnold, Inc.
- The standard of care delivered via video conferencing will be equivalent to the standard of care delivered on a face-to-face basis or any other type of care that can be delivered to the patient. This includes meeting privacy, security, and confidentiality requirements. Any service rendered through telehealth must meet the same medical necessity as face to face encounters.
- Telemedicine shall not include the use of facsimile machine email communication, Skype/Facetime or other non Hf PAA compliant avenues
- Prescribing medications via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the prescriber in accordance with current standards of practice.

I have been advised of the potential risks, and consequences of Telemedicine participation including those that could occur during the delivery of the service. I understand that any security protocols that fail during telemedicine sessions could result in a breach privacy or personal medical information. I understand that deficiencies or failures in telemedicine equipment could result in a delay of treatment. I understand that participation in the telemedicine service is voluntary and that I have the right to receive in-person care upon request. My signature certifies that I have read, understand and agree to all statements in this consent agreement.

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

Gosnold

Consent To Use Electronic Communication

Patient Name (print): _____

Phone: _____

Email: _____

Gosnold has offered to communicate using the following means of electronic communication ("the Services"):

Text Messaging (including instant messaging)

Risks of using electronic communication

Gosnold will use reasonable means to protect the security and confidentiality of information sent and received using the Services. However, because of the risks outlined below, Gosnold cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to other parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communication can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of Gosnold or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While Gosnold will attempt to review and respond in a timely fashion to your electronic communication, Gosnold cannot guarantee that all electronic communications will be reviewed and responded to within a specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters. If your electronic communication requires or invites a response from Gosnold and you have not received a response within reasonable time, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on Gosnold's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- Gosnold may forward electronic communications to staff and those involved in the delivery and administration of your care. Gosnold might use one or more of the Services to communicate with those involved in your care. Gosnold will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

Gosnold

Consent To Use Electronic Communication

You and your Gosnold provider will not use the Services to communicate sensitive medical information about matters specified below:

- Sexually Transmitted Disease
- AIDS/HIV
- Mental Health
- Developmental Disability
- Substance Abuse
- Other

If other please specify:

- You agree to inform Gosnold of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying Gosnold in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- Gosnold is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform Gosnold of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to Gosnold.
- Ensure Gosnold is aware when you receive an electronic communication from Gosnold, such as by a reply message or allowing "read receipts" to be sent.
- Take precaution to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to Gosnold.
- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call Gosnold or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

Other conditions of use in addition to those set out above:

Patient Acknowledgment and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services described above. I understand and accept the risks outlined above associated with the use of the Services in communications with Gosnold staff. I consent to the conditions and will follow the instructions outlined above as well as any other conditions that Gosnold may impose on communications with patients using the Services. I acknowledge that either I or Gosnold may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient Signature: _____ **Date:** _____



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Please Note:

On the next two pages you will be asked to fill out an authorization to exchange information for your PCP/Primary Care Physician and an Emergency Contact individual.

Please do not alter these forms by changing them. These forms are required to be part of your record.

If you need additional exchange of information forms for other individuals/agencies, please ask your intake clinician or case manager for additional forms.

If you do not have or choose to not name your PCP/Primary Care Physician please write None or Refused in the Person/Agency field, sign and date the bottom of the form.

We do ask that you provide us with someone we may contact in the event of an emergency if possible.

Thank you.

**AUTHORIZATION TO
EXCHANGE CLIENT
INFORMATION**



200 Ter Heun Drive
Falmouth, MA 02540
508-540-6550 ex. 5418
Fax: 508-564-9518
Gosnold.org

Patient Information (Please Print)

Patient Name: _____ Date of Birth: _____
Patient Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Email: _____

Refusal:

I am unable/refuse to provide a release of information for Emergency Contact Primary Care Provider Behavioral Health Provider
Checking this box would render this invalid

I hereby authorize Gosnold to:

Please choose one or both: Release my medical record information to Obtain medical information from

Name/Facility: _____ Relationship: **Emergency Contact**
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Fax #/Email: _____

Purpose of Request:

To provide ongoing care/treatment Emergency contact
 Other (please explain): _____

Specific Records to be released/timeframe of release:

Release of information valid for: One time disclosure 2 years unless revoked (in writing)

Please choose below:

Please provide a copy of my entire record* Please provide billing information
 Please provide a copy of 2 years of my records* Please provide presence in treatment with written or verbal communication
 Please communicate my presence in treatment with my emergency contact including but not limited to wellness checks, emergent hospitalizations, consecutive missed appointments
 Please provide a copy of my specific information as outlined below*

Program(s): _____ Specific Information to Release: _____ Date(s) of Treatment: _____ to _____

*Copy fee may apply COPY FEE: Pursuant to chapter 135 of the Acts of 2003, "An Act Establishing Reasonable Fees for Copying Medical Records", Mass General Law Ch. 111, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies

Restricted Authorization to Release Protected Information:



IMPORTANT - It is extremely important that you select either you "DO" or "DO NOT" for each item contained in this section Authorization to Release Protected Information. Please do not skip any line as it could impact our ability to fulfill your request and cause additional delays.

I DO I DO NOT specifically authorize the release of information above regarding my mental health diagnosis or treatment.
 I DO I DO NOT specifically authorize the release of information regarding any alcohol, drug, and/or substance abuse, diagnosis or treatments.
 I DO I DO NOT specifically consent to the release of any test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical record.**

I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). Additionally, my signature below authorizes the release of my medical information regarding HIV antibody and antigen test as required by M.G.L.c.111 § 70F. A general authorization for the release of 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. I also understand that I may withdraw this permission at any time by submitting written notification of such revocation. Otherwise, this permission will expire six months following the termination of treatment in ALL Gosnold programs. I have read and understand the above statements and do hereby voluntarily consent to the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release Gosnold and its employees or representatives from any liability arising from the release of this information, provided said release of information is done substantially in accordance with applicable law.

**Note: Gosnold must obtain authorization for each requested release of HIV/AIDS information

Signature of Patient: _____ Date: _____

Signature of Guardian/Parent (when applicable): _____ Date: _____

Gosnold Staff Signature/Title: _____ Date: _____

PATIENT SELF ASSESSMENT

Patient Name: _____ Date of Birth: _____

Current Date: _____

MEDICAL STATUS:			
Please indicate if you have any of the following conditions:			
1.	ALLERGIES	NONE	YES, Please list: _____
2.	GENERAL HEALTH STATUS	GOOD	FEVER OTHER: _____
		POOR	
		FAIR	Height _____ Weight _____
3.	EYES	NONE	VISION CHANGES GLAUCOMA
		GLASSES/CONTACTS	OTHER _____
4.	EARS, NOSE AND THROAT	NONE	SINUSITIS SORE THROAT HEARING LOSS
		TROUBLE SWALLOWING	DENTURES
		TROUBLE WITH TEETH	OTHER _____
5.	HEART	NONE	HISTORY OF HEART (CARDIAC) DISEASE PALPITATIONS HIGH BLOOD PRESSURE HIGH CHOLESTEROL POOR CIRCULATION OTHER
6.	LUNGS	NONE	ASTHMA SHORTNESS OF BREATH COUGH OTHER
7.	STOMACH AND INTESTINES	NONE	CONSTIPATION DIARRHEA PAIN GERD HEPATITIS/LIVER DISEASE OTHER
8.	REPRODUCTIVE AND URINARY	NONE	PMS URINATION PROBLEMS ABNORMAL PERIODS SAFE SEX PRACTICES SEXUALLY ACTIVE OTHER METHOD OF BIRTH CONTROL: _____
9.	MUSCLES AND BONES	NONE	MUSCLE WEAKNESS HX INJURY TREMORS MUSCLE OR JOINT PAIN OTHER

10.	PAIN	NONE	IF YES, LOCATION: _____		
		SEVERITY (lowest)1	10(highest)		
11.	SKIN	NONE	RASH	BRUISES	
			TRACKMARKS	OTHER	
12.	NEUROLOGICAL	NONE	MEMORY PROBLEMS	DIZZINESS	HEAD INJURY
			TROUBLE WALKING	NUMBNESS SEIZURES	
			HEADACHE		
13.	ENDOCRINE / METABOLIC	NONE	DIABETES:	INSULIN DEPENDENT	NIDDM
			THYROID PROBLEMS	LIVER PROBLEMS	OTHER

MEDICAL HISTORY	YEAR DIAGNOSED	CURRENTLY BEING TREATED?
Please list any significant medical conditions you have been diagnosed with or are currently being treated for:		

TUBERCULOSIS SCREENING QUESTIONNAIRE			
HISTORY AND RISK FACTORS	YES	NO	UNSURE
Have you ever had a positive blood test or skin test for TB? if YES, LIST DATE:			
Have you ever been diagnosed (Chest X-Ray) with Active TB? IF YES, LIST DATE OF COMPLETED TREATMENT: IF NO TREATMENT, EXPLAIN:			
Have you ever been exposed to anyone who has TB?			
Have you ever lived or traveled for more than one month in Asia, Africa, Eastern Europe, the Middle East, Russia, Central or South America, or the Caribbean?			

	YES	NO	UNSURE
Have you recently lost weight of 10 pounds or more?			
Have you had a fever of more than 100 degrees F recently?			
Have you felt unusually tired recently?			
Do you have (or have had) any of these conditions (circle if yes): Diabetes Rheumatoid Arthritis Kidney Disease Colitis Cancer HIV Infection Stomach or Intestinal Surgery			
Are you taking any medications that your doctor said could weaken your immune system or increase your risk of infections?			
SYMPTOM SCREENING	YES	NO	UNSURE
Currently, do you have any of these symptoms?			
1) Coughing for more than 2-3 weeks?			
2) Coughing up blood?			
3) Weight loss of more than 10 pounds for no known reason?			
4) Fever of 100°F (or 38°C) for over 2 weeks?			
5) Unusual or heavy sweating at night?			
6) Unusual weakness or extreme fatigue?			
STD / HIV / HEPATITIS SCREENING QUESTIONNAIRE			
<p>List below are some key risk factors for STDs, HIV, and Hepatitis Infection. Please read the list below and answer the questions below based on what risk factors may apply to you:</p> <p>RISK FACTORS:</p> <ul style="list-style-type: none"> - History of other STDs (Gonorrhea, Chlamydia, Syphilis, Herpes, Anal/Genital Warts (HPV), or Viral Hepatitis) - Have been told you have Hepatitis A, B, or C - Past or Current Sexual activity with: <ul style="list-style-type: none"> - IV drug users, - prostitutes, - persons with STDs/HIV/Hepatitis infections - persons who you do not know their health history or status - Past or current: <ul style="list-style-type: none"> - Unprotected oral, anal or vaginal sex (no barriers, condoms) - Sex for money, drugs, shelter or food - Sex while using alcohol or drugs (Intoxicated or high) - For women only: History of bacterial vaginosis, recurrent yeast, or cervical cancer - Hepatitis symptoms: Jaundice (yellowing of eyes, skin, gums, nailbeds), liver enlargement <p>The more risk factors (above) that apply to you, the higher risk you have for being exposed to either STD, HIV or Hepatitis infection. Activities that involve exposure to any other person's blood (anal sex, needle sharing) place you at higher risk for HIV or Hepatitis (blood-borne infections).</p>			

Based on the risk factors that apply to you, on a scale of 1-10, how would you rate your risk for STDs? (unprotected sex, history of STDs, infections) →			
.....			
Based on the risk factors that apply to you, on a scale of 1-10, how would you rate your risk for HIV or Hepatitis Infection? (blood-borne exposure - unprotected anal sex, needle sharing, history of other STDs or infections) →			
.....			
	YES	NO	UNSURE
STD TESTING:			
Have you ever been tested for STDs?			
Would you like counseling or testing for STDs?			
HIV TESTING:			
Have you ever been tested for HIV infection?			
Would you like counseling or testing for HIV infection?			
HEPATITIS TESTING:			
Have you ever been tested for Hepatitis infection?			
Would you like counseling or testing for Hepatitis infection?			

LIFESTYLE HEALTH FACTORS	YES	NO
1. Do you use any tobacco products? If so, how much: rarely less than 1/2 pack/day 1 pack/day 2+ packs/day For how long? _____ years		
2. Would you be interested learning how to stop smoking?		
3. Do you drink alcohol?		
4. Do you use any recreational drugs?		
5. Any recent changes in activity level or exercise tolerance?		
6. How often do you exercise? Never/Rarely 1-2 times/week 3-4 times/week Every day		
7. How much caffeine do you drink? Never/Rarely 1-2 times/week 3-4 times/week Every day		

NUTRITION SCREEN	YES	NO
Describe your eating pattern: (check all that apply) Regular (3 meals/day) Regular (1-2 meals/day) Day Snacks Night Snacks Varies: at least 1 meal/day Varies: periods of hunger/fasting Constant hunger		

	YES	NO
Have you experienced:		
1. A weight loss or gain of more than 10 pounds in the last 3 months?		
2. A decrease in food intake and/or appetite recently?		
3. A diagnosed eating disorder (anorexia, bulimia, hyperphagia, etc.)		
4. Eating habits that concern you or may indicate an eating disorder (binge eating, vomiting, any changes in eating)?		
5. Food intolerances or allergies? Describe:		
6. Dental problems? Describe:		
7. Conditions, treatments, or medications that may affect your ability to tolerate food intake or maintain your health? (AIDS, Cancer, chemotherapy, bariatric surgery, colostomy, GERD, etc.) Describe:		
8. Gastrointestinal problems that may affect your ability to tolerate food intake or maintain your health? (diarrhea, constipation, indigestion, gall bladder, difficulty swallowing, etc.) Describe:		
AMBULATION AND FALL RISK	YES	NO
1. Are you able to do activities of daily living independently? (i.e., walk, sit, stand, do chores without needing others to help)		
2. Do you use any aids to ambulate?*		
Cane Walker Crutches Wheelchair		
3. Do you have a physical disability that needs accommodation?*		
If Yes, please describe:		
4. Have you fallen in the past 6 months?*		
How many times have you fallen? Briefly describe:		
*IF YOU HAVE A DISABILITY OR NEED ANY HELP WITH ACCESS OR NAVIGATING OUR OFFICE, PLEASE LET OUR STAFF KNOW IMMEDIATELY SO WE CAN HELP YOU.		

CURRENT MEDICATIONS		
MEDICATION NAME	DOSAGE (Mg, # of PILLS, ETC)	TIMES PER DAY

MEDICAL / PSYCHIATRIC PROVIDER INFORMATION	
PRIMARY CARE PHYSICIAN (PCP):	
NAME:	
LOCATION/CLINIC NAME:	
DATE OF LAST APPOINTMENT:	
PSYCHIATRIST:	
NAME:	
LOCATION/CLINIC NAME:	
DATE OF LAST APPOINTMENT:	
CLINICAL THERAPIST:	
NAME:	
LOCATION/CLINIC NAME:	
DATE OF LAST APPOINTMENT:	
PHARMACY:	
NAME:	
ADDRESS:	
PHONE NUMBER:	FAX NUMBER:

Patient/Parent/Guardian: _____ Date: _____ Time: _____

Please review the MID Client agency agreement that you will sign in this DocuSign packet, along with the FAQs listed below prior to outreaching the program for questions or concerns. All documentation is required.

Primary Contacts:

Program Coordinator for Court Mandated Services:
Amber Peaslee 978-757-4581

FAQs:

Q: How long does the program take?

A: At minimum the program will take 18-20 weeks from the date of your intake, however due to intake availability and group enrollment limitations, it could take up to 24-36 weeks from your disposition to complete.

Q: Where is the program held?

A: The program is 100% virtual. Microsoft Teams is utilized for intakes and groups. It will require an email address to attend.

Q: Why do you charge \$1,535.84 for the program?

A: Gosnold is not involved in deciding the cost of the program, the annual program fee for MID is issued by the Massachusetts State Commission and Bureau of Substance Abuse Services. *Please refer to your MID agreement for a breakdown of this fee.*

Q: I paid the court, why am I paying Gosnold?

A: The fees paid to the court do not include MID costs, this fee is due directly to the agency rendering your services.

Q: When can I schedule my Intake?

A: Your intake can be scheduled when all the following have been completed:

- Gosnold has received your referral notice and required services from the Massachusetts Probation services, or the Registry of Motor Vehicles.
- You have completed the required paperwork via DocuSign, mail, or in person.
 - *Once completed, call the office to pay and schedule your intake.*
- You have made your initial payment for the program per your payment schedule selection. *Payments can be made by phone, or at one of our outpatient sites.*

Q: Why can't I have a sooner intake appointment so I can get my hardship license?

A: There is limited availability for intakes and a high volume of referrals.

Q: What is the next step after my intake?

A: Once your intake is completed, you will then choose a group to commit to (16 weeks) you will be notified of when the group has an opening available and be given a start date. Group start is dependent on the number of enrollees at any given time and can take several weeks to begin.

Q: When can I get my license back?

A: If you are applying for a hardship license, your hearing should not be scheduled until after the date of your intake. Enrollment verification paperwork will not be provided until you have attended, and successfully completed, your intake to the MID program.

A: If you are not applying for a hardship license, check with the RMV or court on your suspension length.

Q: How can I get assistance if I have technical difficulties with Microsoft Teams, am not able to log into group, or do not have access to a computer?

A: It will be your responsibility to obtain the necessary assistance to successfully attend and complete the program. The program coordinator can be reached for guidance if available, please refer to your MID agency agreement for office hours. Microsoft Teams can be downloaded as apps on smart phones or tablets.

Q: Can I transfer to a different class if I want to?

A: No. Unless there are extenuating circumstances approved by the program and probation department, you must commit to the 16 weeks of attendance in the class of choice.

Q: Can I attend two groups a week and complete the program quicker?

A: No. BSAS Requires 16 weekly sessions.

Q: I cannot attend these classes due to my work schedule do you have another option?

A: No. The service options provided are the options available. You are required by the state of Massachusetts to attend and complete all aspects of the MID program, and it is your responsibility to plan with your employer or other conflicts to do so.

Q: The clinician "kicked me out" of group how can I get credit?

A: Credit will not be given if absent or removed from the group for your conduct, safety, or other reason(s) violating program rules. These may include, but are not limited to, being intoxicated or under the influence of alcohol or drugs, driving or being in a moving vehicle, being in a public place or having people in the vicinity of your device/audio/video.



200 Ter Heun Drive, Falmouth, MA 02540

508.540.6550 ext. 5418

Fax: 508.564.9518

www.gosnold.org

AUTHORIZATION TO EXCHANGE CLIENT INFORMATION

Please submit a copy of this form with all correspondence.

Patient Name: _____ SS# _____ Date of Birth: _____

Patient Address: _____ Phone: _____

I hereby give my permission for the Gosnold treatment programs to exchange the information indicated in the list below with the person/agency identified below.

Person/Agency: Probation Dept: Massachusetts Probation Services Relationship: Probation Officer

Address: _____

Telephone #: _____ Fax #: _____ Email: _____

Type of Information to be Exchanged:

- Psychiatric Information
- Medical (including physical exams, relevant labs, radiology, and procedures.)
- Substance Use Disorder Information
- STD/TB Information
- Biopsychosocial
- Discharge Summary
- Psychological Tests
- Admission Notes
- Progress Notes
- Treatment Plan
- Continuing Care Plan
- Presence in Treatment
- Other: Massachusetts Impaired Drivers Program

I specifically authorize the release of information above regarding any alcohol, drug, and/or substance abuse, diagnosis or treatments.

HIV/AIDS. I specifically consent to the release of any test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical record.

I specifically authorize the release of information above regarding my mental health diagnosis or treatment.

The information is needed for the following purpose:

- To provide ongoing care/treatment
- Emergency contact including but not limited to wellbeing checks, emergent hospitalizations, consecutive missed appointments
- I refuse/am unable to allow the release of information for my emergency contact, Primary Care Provider or Behavioral Health Provider

Other (explain): _____

I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). Additionally, my signature below authorizes the release of my medical information regarding HIV antibody and antigen test as required by M.G.L. c.111 § 70F. A general authorization for the release of 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. I also understand that I may withdraw this permission at any time by submitting written notification of such revocation. **Otherwise this permission will expire six months following the termination of treatment in ALL Gosnold programs.**

I have read and understand the above statements and do hereby voluntarily consent to the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release Gosnold and its employees or representatives from any liability arising from the release of this information, provided said release of information is done substantially in accordance with applicable law.

*Note: Gosnold must obtain authorization for each requested release of HIV/AIDS information

Signature of Patient/Parent/Guardian: _____ Date: _____

Gosnold Staff Signature/Title: _____ Date: _____



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I specifically authorize the release of information above regarding my mental health diagnosis or treatment.

The information is needed for the following purpose:

- To provide ongoing care/treatment
- Emergency contact including but not limited to wellbeing checks, emergent hospitalizations, consecutive missed appointments
- I refuse/am unable to allow the release of information for my emergency contact, Primary Care Provider or Behavioral Health Provider

Other (explain): _____

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Signature of Patient/Parent/Guardian: _____ Date: _____

Gosnold Staff Signature/Title: _____ Date: _____



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

Massachusetts Impaired Drivers (MID) Program

Statewide Client-Agency Agreement Contract

Welcome to Gosnold's Massachusetts Impaired Drivers (MID) program. The goal of our program is to provide an educational experience related to alcohol and other drug use, its effect on driving and other life problems. It is the intent of our program to raise your awareness and to influence behavioral changes, thereby lowering your risk for any future DUI and/or other substance use-based problems. Although your enrollment is mandated, we hope your experience will nonetheless be positive. We are here to assist you in whatever way we can.

This document will serve as an agreement between you and our agency. It is intended to inform you of the rules and expectations of our program. Violation(s) of the rules/expectations often have serious consequences, so please read this document carefully before signing it. The intake counselor will clarify any questions you might have and the MID Program Coordinator is available to help you with any unresolved questions. You may reach the Program Coordinator during regular business hours (8:00 a.m. to 4:00 p.m.) by calling (978) 757-4581. The administrative staff can be reached at (508) 862-9929.

If you are refused admission into our program, we must justify your refusal based on a clinical reason and make a recommendation to the court (or referring agency) for a more appropriate level of care. Please be advised that every MID program in the state must comply with the following rules, expectations, and reporting procedures. Upon written request, you have a right to review your records. The time and place for the review will be arraigned. The Program Director or Executive Director will be present at the review. You have the right to grieve any specific agency policy or procedure. State regulations require this agency to have a written grievance procedure, which is available for your review upon request. The Clinical Director may make periodic visits to a group in order to ensure the quality.



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

Program Content

You are expected to attend 40 hours of programming, as follows:

- One individual intake session (not to exceed 90 minutes)
- Thirty-two (32) hours of psycho-educational group sessions (one two hour session each week for 16 weeks)
- Participate in a mid-point assessment review.
- Two (2) hours of victim impact awareness
- Four (4) hours of attendance at a community-based self-help meeting
- One individual discharge (exit) session (not less than 30 minutes)

It is your responsibility to complete each aspect of the MID Program. Failure to do so will result in a notification being sent to your referring court and possible suspension/termination. It is your responsibility to stay in contact with the program until you receive a formal certificate/letter of completion.

Attendance and Tardiness Policy

Your attendance at all groups is required. Attendance is taken at each group. In the unlikely event that you must miss a group because of an emergency, you must contact your group facilitator immediately and documentation will be required. All absences must be made up. If you are absent more than two times during the course of the program your participation will be suspended until the matter can be reviewed. This might result in a court hearing as it is a violation of your probation. If the court allows you to return to the program you may restart the program from week one.

You are expected to schedule and attend your exit interview. If you need to cancel your appointment you must do so a minimum of 24-hours in advance. If you fail to do so, the program may assess a make-up fee. A limited number of cancellations will be permitted before the program suspends you.

You are required to be on time for all groups including the victim-impact sessions. If you are late for a group you may not be allowed in, an absence will be charged that will require a make-up group session. If the tardiness results in your 3rd absence, then you will be suspended pending a court review.



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

Communication with your Probation Officer/Court

The program participants rights to confidentiality are protected by Federal Law (42 C.F.R. Part 2). Your Probation Officer will be notified when there is a violation of program non-compliance. In general, the only information that is routinely communicated is 1) did you attend your intake session; 2) your attendance during the group process and further assessments; and 3) did you complete every aspect of the program, including your financial obligation. When necessary, your Probation Officer will be notified if you are deemed a high risk to yourself and others as a result of your current alcohol and/or drug use. The program will not disclose "confidential communications" reported by the client unless it pertains to the following: 1) it is necessary to protect against a threat to life or of serious bodily injury or 2) is necessary to investigate or prosecute an extremely serious crime or 3) in connection with a proceeding in which the client has already presented evidence concerning confidential communication.

Sobriety policy

You are expected to abstain from alcohol and all illicit substances for a period of 24-hours prior to the start of any program activity. If you are suspected of drinking or using illicit substances you will be asked to take a breathalyzer or other form of toxicology test (e.g., urine test) voluntarily. Your failure to submit will result in your immediate suspension. If you are asked (at the client's expense) to take a urine test, the program staff will assist you with information on where one can be conducted. You will be expected to complete the urine test within a specified period of time set by the program. If a test indicates the presence of alcohol or an illicit substance(s), you will immediately be suspended from the program pending a court hearing and your probation officer will be notified. In addition, if during this incident you drove to class you will be asked to secure your car and arrange for alternative transportation (the program staff can assist you with this when applicable). If you insist on driving your car, the police will be notified. You will also be subject to a random breathalyzer test at any time as a means to ensure safety of all participants and the integrity of the program.



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

Suspension from the Program for Inappropriate Behavior

The following behaviors may result in suspension from the program:

- Possession of anything considered dangerous to self or others
- Possession of alcohol or any illicit substance
- Verbal abuse, vulgarity, racial, ethnic, sexual or religious slurs
- Disruptive behavior {talking, sleeping, etc.}
- Threats, negative gestures or any acts of violence
- Continued {after being warned to discontinue} rudeness, demeaning or disrespectful speech or other behaviors that lead to the disruption of the group
- Improper dress and/or poor hygiene, as determined by staff
- Failure to adhere to the expectation that participants maintain the confidentiality of each group member's right to privacy

Smoking Policy

Smoking is not allowed anywhere on the property.

Class Cancellation Policy

In case of inclement weather or other emergency that may cause a group session to be cancelled, it is your responsibility to contact the program to obtain information regarding cancellation. If a group is cancelled, the expected timeframe for completion of the program will be extended.

Updated Client Information

You are required to inform the MID program of any changes to your home and mailing address and phone number(s).



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

Release of Information Forms and Confidentiality

MID programs have a dual service relationship between you and the District Court Probation Office from which you were referred. Because of this, you will be requested to sign a Release of Information Form that will allow staff to disclose pertinent information to the court. You may also be asked to sign other release forms to assist staff with communicating and informing other pertinent parties. If you are under the age of 21 and attending this program to satisfy the court and/or the Registry of Motor Vehicles, you will be required to sign a Release of Information Form for the Registry. During the intake session you will have your confidentiality rights thoroughly explained to you, including areas of discussion in group where information can be shared without your consent. You have the right to withdraw your release at any time; however, doing so may impact your continued participation in the program.

Documentation of Enrollment for Hardship License/ Under 21 y/o - 180 day wavier

At this time of this intake you should be aware of your eligibility for either a Hardship license or under 21y/o - 180 day wavier or both. If you need a letter of enrollment for either consideration, a letter will be made available upon the completion of the initial intake session. Our program reserves the right to withhold this letter based on clinical findings in the initial intake.

MID Program Fees

Your payment options have been explained to you (either by the court or our fiscal department). The fee for this program is \$1342.56, as established by the Massachusetts Rate Setting Commission. The program fee is inclusive except for additional fees that may be assessed for makeup sessions, missed appointments and costs for toxicology



PREVENTION | INTERVENTION | TREATMENT | RECOVERY

(drug) tests. If you have been granted a program fee waiver by the court, you will be expected to pay for additional fees. These fees will not exceed the established unit cost of the service by the Commission (i.e., \$28.94 per 15 minutes individual session and \$69.44 per 2-hour group session). The program may excuse make-up fees with legitimate and documented proof of the absence. You have agreed to a payment schedule. Failure to adhere to your payment schedule could result in your suspension from the program. Counselors and business staff are available to discuss any difficulties you have with making your payment. Completion certificates will be withheld until all fees are paid in full. If a Judge terminates you from further participation and you have paid for services not yet rendered, then you are entitled to a refund.

I have read the above statements and have had all of my questions answered. By signing this document I attest that I agree with and will adhere to each aspect of this document.

Participant Name

Date

Gosnold Staff

Date