Southeast Kansas Mental Health Center

Face Sheet

ADAS ___Yes ___No _____%
DX _____
For CA Staff Use Only

Date _____ E-mail _____ Case No. _____

Name _____ Date of Birth _____ Age _____

Social Security # _____ Military/Veteran Status ☐ Yes ☐ No

Females Only: Maiden name _____ Former married names _____

Address _____ City/State/Zip _____

Phone # _____ Work Phone # _____

Cell Phone # _____ County of residence _____

We may contact you and/or leave a message regarding your appointment times unless instructed otherwise _____

If less than 6 months in this county, please specify previous county of residence _____

Do you have a legal guardian? ☐ No ☐ Yes If Yes, please provide the following:

Legal Guardian _____ Phone # _____

Address _____

Legal Custody Status (check one) ☐ A. No JJA/DCF involvement ☐ D. Child in JJA Custody/out-of-home ☐ G. Child in JJA custody/lives at home ☐ J. Under supervision of JJA/not custody ☐M. Child in DCF custody/out-of-home ☐P. Child in DCF custody/lives-at-home ☐S. Under DCF supervision, not custody ☐ Other- Explain

Employment Status (check one) ☐ 2. Part-time (less than 35 hrs) ☐ 3. Full-time (more than 35 hrs) ☐ 4. Retired ☐ 5. Unemployed ☐ 6. Active Military Duty ☐ 7. Not in labor force

Marital Status (check one) ☐ 1. Never Married ☐ 2. Married ☐ 4. Divorced ☐ 5. Separated ☐ 6. Widowed ☐ 7. Common-law ☐ 00. Other

Student Status (check one) ☐ 1. Full Time Student ☐ 2. Part-time Student ☐ 3. Not a student

School _____

Race (check one) ☐ White ☐ Black or African American ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian ☐Pacific Islander ☐ Asian ☐ Other

Ethnicity ☐ Hispanic ☐ NOT Hispanic

Primary Language _____ Other languages spoken _____

Primary Care Provider _____ Primary Care Provider Telephone # _____ Referred By _____

Gender (check one) ☐ 1. Male ☐ 2. Female ☐ 3. Transgender male to female ☐ 4. Transgender female to male

Party responsible for account _____ Relationship _____

Social Security # _____ DOB: _____ Email _____

Have you received previous mental health services? ☐ Yes or ☐ No If yes, please list:

Name of Facility	Address	Inpatient/Outpatient	Dates

Client Employment Information (if not employed, head of house employment information)

Employee Name _____

Employer _____ Occupation _____

Name (spouse) _____

Employer _____ Occupation _____

Address/City/State/Zip _____ Phone _____

List sources of household income*	Source	Gross Monthly Amount

* ***Proof of income must be attached for fee adjustment.***

List those dependent upon household income

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Emergency Contact Name _____ Telephone # _____

Address _____

You have the right to use Advance Directives. Please indicate below if you have written Advance Directives,. If not, a form can be provided, but is not required for treatment. ☐ Yes or ☐ No (Advanced Directives are your written health care choices).

Reimbursement Information

PRIMARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

SECONDARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

1. Is the patient a Veteran? ☐ Yes ☐ No
   a. Did the VA refer you here for treatment? ☐ Yes ☐ No
   b. Does the patient have a VA "fee basis ID card?" ☐ Yes ☐ No

   Veterans Administration Authorization: Does the patient authorize you to bill the VA? ☐ Yes ☐ No

2. Do you have a Federal Black Lung card? ☐ Yes ☐ No
   Are the services you are receiving today related to lung disease? ☐ Yes ☐ No
   If yes, submit claims to: Federal Black Lung Program, PO Box 740, Lanham, Maryland 20706

3. Is this medical condition due to an accident of any kind? ☐ Yes ☐ No
   If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ Other

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of accident _____ Employer Name and Address _____

Names of Workers Compensation Insurance _____

Name of Person or company Insured _____

Insurance company Claim or Policy # _____

Worker's compensation Claim # _____

Name of Worker's Compensation Agency where claim was filed _____

Address _____

Has the case been settled ☐ Yes Date _____ ☐ No

Name of Patient's Legal Representative in this case (if any) _____

Phone number of Legal Representative _____

AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE INFORMATION:

Date of Accident: _____ If other than auto, describe accident _____

Business /Property Owner _____ Address: _____ Telephone#: _____

Type of insurance: Premises Medical _____ Liability _____

Name of Policy holder _____ Address of Policyholder _____

Policy Number or Claim ID Number _____ Insurance Company _____

Address of Insurance company _____

Legal Representative& Phone number for this case (if any) _____

Southeast Kansas Mental Health Center

Agreement for Financial Responsibility

Client _____ Case # _____

2019		***Fees are subject to change without notice***	
Type of Service		Unadjusted Fee	Adjusted Fee**
Assessment (Counselor or QMHP)	90791	$ 200.00 per hour	$
Assessment (Psychiatrist)	90792	$ 210.00 per hour	$
Individual/Family Therapy (Counselor or QMHP)	90837	$ 210.00 per hour	$
Group Therapy	25000	$ 90.00 per hour	$
Community Psychiatric Support	31000	$ 140.00	$
Medication Review	99213	$ 130.00 per hour	$
Injections	96372	$ 40.00 per appointment	$
Targeted Case Management	34000	$ 25.00 per unit*	$
Attendant Care	33000	$ 10.00 per unit*	$
Psychosocial Group	32000	$ 10.00 per unit*	$
Peer Support (Individual)	35000	$ 15.00 per unit*	$
Outpatient Treatment Program Chemical Abuse Services	90837	$ 210.00*	$
Psychological Evaluation	14000	$ 210.00 per hour	XXXX
Alcohol/Drug Diagnostic Evaluation	90791	$150 per evaluation***	XXXX
Alcohol/Drug Information School (Adult)	61000	$100.00***	XXXX
Alcohol/Drug Information School (Adolescent)	61000	$50.00***	XXXX
Tobacco Cessation	90829	$60.00	XXXX
Tobacco Cessation Class	25200	$40.00	XXXX

** - A unit is 15 minutes.* *** - Proof of income must be attached before fee is adjusted.* ****-No fee adjustment.*

PLEASE READ THIS CONTRACT BEFORE SIGNING

I authorize use of this form for all my insurance submissions.
I authorize the Center to act as my agent in helping me obtain payment from my insurance.
I authorize payment directly to the Center for services rendered. I understand that a claim will be filed at the unadjusted cost per hour. If my insurance does not reimburse the Center in the amount of my fee, I understand that I am responsible for my bill.
I authorize the Center to disclose information needed for billing purposes to all my insurance companies. I acknowledge receipt and I have reviewed and understand the Financial Policies. I agree to comply with these policies.
I understand that 24 hours notice is required when canceling or rescheduling my appointment and that missed appointments will be charged at the sliding scale rate.
I certify that I have received the Guide to Services, Welcome brochure, and Notice of Privacy Practices, and Clients Rights.
I certify that I understand my rights and responsibilities.
I certify that I have provided accurate information.
I certify that I have read and agree to this contract.
I certify that the fee was discussed with me.

_____ _____ _____

Client/Parent or Legal Representative Date Witness

PLEASE MAKE COPY FOR CLIENT - ORIGINAL IS FILED IN CASE RECORD

Southeast Kansas Mental Health Center

Informed Consent For Voluntary Initial Assessment and Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in an evaluation at Southeast Kansas Mental Health Center. The purpose of this evaluation is to assess my current mental health or substance abuse needs and to develop specific treatment recommendations related to my concerns that have brought me to the Center.

I understand that the initial evaluation will be conducted by _____.

The evaluation will consist of interviews, but I may also be asked to participate in psychological testing to more thoroughly assess my needs.

I understand that my therapist may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing higher quality service to me. I am aware that I may be asked to see additional professional staff who may participate in my evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are specified in the *Privacy Policy* of which I have been given a copy.

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the evaluation is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with my therapist my diagnosis and treatment, including alternatives to these recommendations.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

I understand that some services may be made available through telemedicine and not in person with a provider. I have the right to not have services provided by telemedicine.

I hereby consent to participate in the process of assessment and treatment at Southeast Kansas Mental Health Center.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

BACKGROUND INFORMATION

Please take time at home to complete this information form. It may be easier to remember this information at home than at the office. Bring the completed form with you to your appointment. Completing this information before you arrive, will help to shorten the time needed during the appointment. If a section of the form does not have enough space, write on the back of the page. This information is protected under Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records and the Health Insurance Portability and Accountability Act (HIPAA).

Name:____ **Date:**______________
First Middle Last

Do you live alone? __Yes __No

I live with: __husband / wife / common-law / partner __parent(s) __children / number________

__friend(s) __other____

Spouse: husband / wife / common-law / partner

Name:____ **Age:**________
First Middle Last

Children: How many children do you have?______

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Name:____________________________ Sex: M F Age:_____ Living with you? Yes No

Prescription Medication: Are you currently taking any medication? __No __Yes

Medication:________________________ Dose:__________ Frequency:__________

Why Prescribed?______________ When Prescribed?________ Doctor______________

Medication:________________________ Dose:__________ Frequency:__________

Why Prescribed?______________ When Prescribed?________ Doctor______________

Medication:________________________ Dose:__________ Frequency:__________

Why Prescribed?______________ When Prescribed?________ Doctor______________

Parents:

Are your parents still living? **Mother:** Yes No: Year Died _____ **Father:** Yes No: Year Died _____

Mother: **Name:** _____ **Age:**____
First Middle Last

Address: _____ **Phone:** _____
City State Zip

Father: **Name:** _____ **Age:**____
First Middle Last

Address: _____ **Phone:** _____
City State Zip

Emergency Contact Person: __Spouse __Parent __Child __Other / Relationship_____

Name: _____
First Middle Last

Address: _____ **Phone:** _____
City State Zip

Brothers / Sisters: Also, provide names of deceased brothers and sisters. List the year they died.

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Name: B S _____ **Age:**____ **City he/she lives in?**_____
First Middle Last

Employment History: List your work history for the past five years.

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Employer:______________________________ Type Of Work:______________________

City:______________________ From – To:_____________________

Legal History: List your lifetime arrest record. **Location:** Where was the court? Name the City or County and State.

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Date:___________ Offense:_______________________ Alcohol / Drug Related: __Yes __No

Location:_____________________ Jail Time: __No __Yes / How Long? _______________

Mental Health Treatment History:

Have you ever been admitted to a hospital or treatment center for mental health problems? __No __Yes

Date:_________ **Name Of Hospital/Center:**______________________________ **Number Of Days:**_____

Date:_________ **Name Of Hospital/Center:**______________________________ **Number Of Days:**_____

Date:_________ **Name Of Hospital/Center:**______________________________ **Number Of Days:**_____

Date:_________ **Name Of Hospital/Center:**______________________________ **Number Of Days:**_____

Date:_________ **Name Of Hospital/Center:**______________________________ **Number Of Days:**_____

Alcohol Drug Treatment History:

Have you ever been in a treatment center for alcohol / drug problems? __No __Yes

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

Date:_________ **Name Of Treatment Center:**______________________________ **Number Of Days:**_____

City:__________________________ __**Inpatient or** __**Outpatient** **Completed:** __Yes __No

SUPPORTIVE COMMUNITY RESOURCE NEEDS ASSESSMENT

Complete this **Needs Assessment Tool** and bring it with you to your Alcohol Drug Evaluation. Focus on making healthy changes in your life. Use this opportunity to focus on your self and **become aware of life issues or concerns you would like assistance resolving.** During the Alcohol Drug Evaluation, your Counselor may also identify some issues that you may wish to address. **Mark each item below that applies to you. Your Counselor may be able to provide contact information for a Supportive Community Resource for each specific need.**

Basic Needs

___ food assistance
___ cash assistance
___ help to find housing for: ___ low income; ___ abused women; ___ homeless
___ help weatherizing / repairing my home
___ help with my utility bills
___ employment
___ child care
___ education
___ church
___ disaster assistance
___ Kansas Identification Card
___ other _____

Physical Health

___ Kansas Medical Card
___ low income ___ medical clinic ___ dental clinic
___ testing | ___ treatment for ___ sexually transmitted infections ___ Hepatitis C ___ HIV / AIDS
___ test for TB
___ help to stop smoking
___ help to lose weight
___ prescription payment
___ hearing test ___ hearing aid
___ disability application
___ support group for _____
___ other _____

Mental Health

___ Mental Health Therapy for ___ my self ___ family member _____
___ parenting skills
___ current abuse or ___ history of abuse | ___ emotional ___ physical ___ sexual
___ I have been accused of abusing | ___ spouse ___ child ___ other | kind of abuse _____
___ referral for psychiatric medication
___ referral for Case Manager
___ disability application
___ support group for _____
___ other _____

Legal

___ attorney for | ___ divorce ___ disability ___ protection from abuse order ___ other _____
___ drivers license ___ ignition interlock device
___ urinalysis

SEK812

Southeast Kansas Mental Health Center

TEMPORARY VERIFICATION OF INCOME
For Chemical Abuse Services

Please check one:

☐ I, _____, verify that my household income (including spouse) is:

(Please complete one of the following)

$_____ per hour, working _____ hours per week

$_____ per week

$_____ per month

$_____ per year

My spouse's income is:

$_____ per hour, working _____ hours per week

$_____ per week

$_____ per month

$_____ per year

I will bring paycheck stub(s) or income tax return as proof of my household income on my next visit.

_____

Signature

_____

Date