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

Southeast Kansas Mental Health Center

**********MEDICARE ONLY**********

CLIENT'S NAME: _____ CASE #_____

MEDICARE ID#_____

ONE TIME AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Southeast Kansas Mental Health Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

SIGNATURE DATE

WAIVER OF LIABILITY STATEMENT

Medicare and other insurances will only pay for services that it determines to be reasonable and necessary under section 1862(a) (1) of the Medicare law. If Medicare or other insurances determines that a particular services, although it would otherwise be covered, is not reasonable and necessary under Medicare or other insurance programs standards, Medicare or other insurances will deny payment for that service. I believe that, in your case, Medicare and other insurances are likely to deny payment for one of the following reason(s): a) Family Therapy, b) Individual therapy when provided on the same day as a Medication Review, c) Individual Therapy provided by a therapist who is not a qualified Medicare provider or d) televideo. Qualified Medicare providers include M.D., Ph.D., and LSCSW's.

"I have been notified by my provider that he or she believes, that in my case, Medicare and other insurances are likely to deny payment for the services identified above, for the reason(s) stated. If Medicare or other insurance denies payment, I agree to be personally responsible for payment."

If you have Supplemental Insurance or Medicaid, the charge will be submitted to them. There is a possibility that they may allow the charge, even though Medicare has denied it. You will be responsible for payment on any unpaid charge.

_____ _____

SIGNATURE DATE