



Face Sheet

ADAS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % DX <input type="text"/> For CA Staff Use Only
--

Date _____ E-mail _____ Case No. _____

Client Name _____ Preferred Name _____

Age _____ Date of Birth _____ Client Social Security # _____ Military/Veteran Status Yes No

Females Only: Maiden name _____ Former married names _____

Client 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 _____

Client 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

Client 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

Client Marital Status (check one) 1. Never Married 2. Married 4. Divorced 5. Separated

6. Widowed 7. Common-law 00. Other

Client 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 _____

Has the client received previous mental health services? Yes or No If yes, please list:

<u>Name of Facility</u>	<u>Address</u>	<u>Inpatient/Outpatient</u>	<u>Dates</u>

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 _____

Subscriber's Name _____

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) _____



Agreement for Financial Responsibility

Client _____ Case # _____

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

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*	\$
ADSAP Evaluations	14000	\$150.00 for 2 hours	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

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.
 I certify that I have received the Welcome brochure, Notice of Privacy Practices, Good Faith Estimate, 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.

 Provider Name

 Client/Parent or Legal Representative Date Witness

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



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 a licensed professional at Southeast Kansas Mental Health Center.

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

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



ADULT INTAKE ASSESSMENT¹

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only:

ID: _____ Date: _____

Time In/Out: _____ Units: _____

Intake Assessment, Code ADMN (New) or ADMR (Reopen)

IDENTIFYING INFORMATION

Client Name: _____ DOB: _____ Age: _____

Male Female

Height: _____ Weight: _____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

Cultural Identity: _____

How long in area? _____ Type of Residence: _____

Who referred you?

self

family member

mental health professional

ad in phone book

agency

Other _____

friend

law enforcement

physician/nurse

minister

co-worker

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason you are seeking help today? _____

How would you rate the severity of this problem? mild moderate significant extreme

How long have you had this problem? _____

How often does the problem occur? constantly daily weekly monthly less often

On the next page are some common problem areas for adults. To help focus on the most important issues, please complete the following checklist.

¹Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

Has there been:

Suicide thinking or attempts In the last month? Today _____

Thoughts of harming others or attempts In the last month? Today _____

In what ways have the problems troubled you? _____

What do you hope to get from treatment? _____

What do you expect from your treatment team? _____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in your treatment? _____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

Is there a court order to receive treatment? yes no

STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **three (3)** resources (**strengths**) that will help in your treatment?

- | | | |
|---|---|---|
| <input type="checkbox"/> Family Support | <input type="checkbox"/> Network of Friends | <input type="checkbox"/> Spiritual |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Stable Finances | <input type="checkbox"/> Available Transportation |
| <input type="checkbox"/> Intelligence | <input type="checkbox"/> Good Health | <input type="checkbox"/> Other: _____ |

You possess many different **abilities** that can be utilized to help overcome your problems. What are **six (6)** of your abilities that may be most useful in your treatment? I . . .

- | | | |
|---|--|--|
| <input type="checkbox"/> take medication | <input type="checkbox"/> am assertive | <input type="checkbox"/> express thoughts and feelings |
| <input type="checkbox"/> work cooperatively with others | <input type="checkbox"/> provide leadership | <input type="checkbox"/> abstain from alcohol/drugs |
| <input type="checkbox"/> request help from others | <input type="checkbox"/> resolve conflicts | <input type="checkbox"/> analyze problems |
| <input type="checkbox"/> use self-help materials | <input type="checkbox"/> keep appointments | <input type="checkbox"/> develop solutions to problems |
| <input type="checkbox"/> follow directions | <input type="checkbox"/> complete tasks assigned | <input type="checkbox"/> manage time effectively |
| <input type="checkbox"/> maintain consistent behavior | <input type="checkbox"/> other: _____ | <input type="checkbox"/> other: _____ |

DAILY ACTIVITIES²		Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank
1. Personal Care	Present self as generally clean, e.g., bathes, showers, brushes teeth.	
2. Grooming	Care for general appearance, hair, hands, makeup, shaves.	
3. Dress	Wear clean clothes, in good repair, comfortable for the weather, activity.	
4. Household Stability	Contribute to and maintain stable housing; organize possessions, clean, comply with house rules if living with others.	
5. Physical & Mental Health	Manage or assist with health issues, known health problems, medical appointments, medications as prescribed, weight, mood changes.	
6. Communicates	Listen & respond to people; express feelings, especially anger effectively	
7. Safety within environment	Focus attention: safe vision, hearing, & adequate memory; avoid high-risk places, misuse of knives, matches, razors, appliances, dangerous household substances.	
8. Managing Time	Rarely tardy or absent for work, appointments, adequate task management, follow regular sleep periods, mealtimes.	
9. Managing Money	Manage money wisely, control spending habits and responsible with money; e.g., no thefts, no shoplifting, assists or pays bills on time, etc.	
10. Nutrition	Eat at least 2 nutritious meals, good snacks	
11. Problem Solving	Make decisions; resolve basic problems of daily living; clarify instructions, ask questions for clarity, setting expectations.	
12. Family Relationships	Get along with family, significant others; contribute to positive relationships with spouse, parent, sibling, child, significant other/ family	
13. Alcohol, Drug Use	Avoid misuse or, where prescribed, abstain from alcohol, beer, taking illegal drugs, high risk mix of multiple substances and cigarettes.	
14. Leisure Entertainment	Enjoy a variety of activities with others & alone; e.g., watch & play sports, TV, books, magazines, arts, crafts, movies, board games, music, dance, and radio.	
15. Community Resources	Use community or public assistance services: self-help groups, religious organizations, shops/stores, MARTA bus/trains, library, job help lines.	
16. Peers/Social	Get along with friends, neighbors, co-workers, peers of like age.	
17. Sexual Behavior	Exhibit appropriate behavior towards others such as respects self and peers' sexual privacy; no sexually harassing, exploiting behaviors.	
18. Productivity and work	Independently work or volunteer, complete homemaking, childcare responsibilities, participate in school, learn skills for financial self-support.	
19. Coping Skills	Know diagnosis/symptoms of illness; use different options for coping, feel ok about self; regain self control reasonably well under stress.	
20. Behavior Norms	Exhibit self-control over verbal or physical anger, abusive, threatening, anti-social, dangerous, violent, nuisance or bizarre behaviors. Law-abiding.	

²Adapted from Daily Living Activities Scale, Will Pressmanes, with permission

What **problems** or **needs** do you have that might hinder your treatment or ability to reach your desired goals?

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center?

FAMILY OF ORIGIN

You were raised by? parents parent/step-parent single parent Other _____

List any developmental problems you recall experiencing such as premature birth, bedwetting, slow physical development, speech problems, delayed sexual development.

What do you think about how you were raised? _____

What kind of relationship do you have today with those who raised you? _____

How many brothers or sisters do you have? _____

What kind of relationship did do you have with your brothers and sisters? _____

Did those who raised you, or your brothers/sisters have mental health or drug/alcohol problems? What about extended family?

What problems did you have as a child or adolescent? (mental health, drug/alcohol, neglect, abuse, etc.)

What significant issues about your childhood would you add to this information?

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education? yes no

Have you engaged in sexual behavior? yes no

Were you prepared to enter into a sexual relationship? yes no

Have you ever been forced to have sexual contact? yes no When? _____

Have you ever contracted a sexually transmitted disease? yes no

Have you participated in High-Risk behavior for HIV? yes no

(multiple sexual partners, or a partner with multiple sexual partners, shared needles, homosexual behavior)

What other significant sexually oriented problems do you wish to discuss?

EDUCATIONAL HISTORY

What is the last grade you completed? 6th or less 7 8 9 10 11 12 GED

College: freshman sophomore junior senior masters doctorate

Any specialized or technical training (i.e., cosmetology, welding, etc.)? _____

Are you currently pursuing your education? yes no What field of study? _____

What was your average grade during your last three years of schooling? A B C D F

What problems with learning did you have? _____

Did you have testing to assess for learning disabilities or ADHD problems? _____

Were you in resource or special education classrooms? _____

How well did you get along with teachers? _____

What other significant education related information do you want to add?

MILITARY SERVICE

Check here if never in the military Which branch did you serve in? _____ For _____ Years

Why did you leave? _____

What problems did you experience in the military? _____

What type of discharge did you receive? _____

What significant military related information do you want to add?

EMPLOYMENT, FINANCES AND LEISURE

Are you currently: employed unemployed laid off on disability How long? _____

Where did you last work (or currently work)? _____

What was/is your position there? _____

Where did you work the longest? _____ How long? _____

How many jobs have you had in the last 5 years? _____

What problems have you had on the job? _____

What problems related to finances do you have? _____

What interests, activities, or hobbies do you pursue in your free time? _____

What significant employment or financial related information do you want to add?

FAMILY AND SIGNIFICANT RELATIONSHIPS

Marital Status? never married married divorced separated widow(er) living as married

How many times have you been married? _____ How long each time? _____

Spouse Name: _____ DOB: _____ Age: _____

Is spouse employed? yes no Employer: _____ Position: _____

Total number of children: ___ his ___ hers ___ ours. If children live with you, please give:

Name: _____ Age _____ Sex _____ his hers ours

Name: _____ Age _____ Sex _____ his hers ours

Name: _____ Age _____ Sex _____ his hers ours

Name: _____ Age _____ Sex _____ his hers ours

With whom do you live? _____

What problems exist in your current intimate relationship? _____

What problems do you have with your children? _____

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____

What significant family or interpersonal relationship information do you want to add?

SPIRITUAL BACKGROUND

With what religion do you identify?

- None Christianity Judaism Islam Buddhism Taoism Native American
 Other: _____

Are you a member of a local religious group? yes no Which one? _____

How active are you? extremely very somewhat not at all

How important is your faith? extremely very somewhat not at all

What problems have you had regarding spiritual issues? _____

How might your faith/spirituality help you overcome your problems? _____

Is there any spiritually related information you would like to add?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Have you ever been arrested or taken to court? yes no

Have you ever been placed in a correctional institution? yes no When? _____ How Long? _____

Juvenile arrests? _____

Adult arrests? _____

What are your current legal issues or problems? _____

MEDICAL HISTORY

Have you had any of the following symptoms in the past 60 days?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Penile Discharge | <input type="checkbox"/> Urination Difficulty |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Pulse Irregularity | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Cramps | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Shakiness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mole/Wart Changes | <input type="checkbox"/> Tremor | <input type="checkbox"/> Falling | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hair Change | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Confusion | <input type="checkbox"/> Gait Unsteadiness | <input type="checkbox"/> Sweats (Night) |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sweats (Other) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tingling in Arms & Legs | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Rash | <input type="checkbox"/> Bleeding gums |

Pregnant? yes no If yes, expected delivery date _____

Hospitalized in last three (3) years? yes no If yes, where and why _____

Allergies/Drug Sensitivity: None Food _____

Medication _____ Other _____

Weight Change in last year by more than five (5) pounds? yes no If yes, how much (+/-) _____

Any of the following:

Problem	Now	Past	Never	Medical Treatment Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (High or Low)				
Bone/Joint problems				
Cancer				
Cirrhosis / Liver Disease				
Diabetes				
Epilepsy / Seizures				
Eye Disease / Blindness				
Fibromyalgia / Muscle Pain				
Glaucoma				
Headaches				
Head Injury / Brain Tumor				
Hearing Problems / Deafness				
Heart Disease				
Hepatitis / Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/ Dental				
Stomach / Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexual Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity / ADD				
Schizophrenia				
Sexual Problem				
Sleep Disorder				
Suicide Attempts / Thoughts				

ALCOHOL & DRUG USE AND TREATMENT (You may choose not to answer any of the following questions.)

CATEGORY	AGE STARTED	AGE STOPPED OR CURRENT	AVERAGE FREQUENCY IN PAST YEAR	AVERAGE AMOUNT USED EACH TIME	COMMENTS
ALCOHOL (beer, wine, liquor)					
CAFFEINE (coffee, tea, soda, "No-Doze," etc.)					
NICOTINE (cigarettes, chew, snuff, cigars, pipe)					
STIMULANTS (cocaine, crack, crank, speed, amphetamines, methamphetamine, pseudoephedrine, ephedrine)					
CANNABIS (marijuana, hashish, hash oil)					
SEDATIVE HYPNOTICS (barbiturates, ie, Seconal, Phenobarbital; benzodiazepines, ie, Valium, Xanax, sleeping pills; Quaalude, Doriden)					
HALLUCINOGENS (LSD, PCP, mushrooms, ketamine, ecstasy, MDMA)					
INHALANTS (glue, paint, solvents, rush, gasoline, white out)					
OPIOIDS (opium, morphine, heroin, codeine, methadone)					
OTHER (dextromethorphan, steroids, etc.)					

What treatment have you had for Alcohol/Drug related problems? none AA/NA
 outpatient treatment residential treatment detoxification hospitalization

Where? _____

Other substance use related information you would like to add?

MENTAL HEALTH HISTORY & TREATMENT

Check here if you have never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

***Thank you for taking the time to complete this background information.
Please place this in the envelope provided, put your name on the outside and
seal envelope to insure privacy.
Bring to your appointment.***



CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

304 N. Jefferson
PO Box 807
Iola, KS 66749

402 S. Kansas
Chanute, KS 66720

519 S. Elm
Garnett, KS 66032

212 State St.
Fort Scott, KS 66701

505 W. 15th
Pleasanton, KS 66075

1106 S. 9th
Humboldt, KS 66748

204 S. Main
Yates Center, KS
66783

Client Name	Client Case #
Client Address	
Date of Birth	Phone #

<p>I hereby authorize the Southeast Kansas Mental Health Center to <input type="checkbox"/> release to <input type="checkbox"/> obtain from</p> <hr/> <p><i>Organization/Individual Name/Relationship</i></p> <p><i>Address</i></p> <p><i>Telephone/Fax</i></p> <hr/> <p>The purpose or need is to:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Assist in the provision of services</td> <td><input type="checkbox"/> Legal/Court ordered</td> </tr> <tr> <td><input type="checkbox"/> Personal use</td> <td><input type="checkbox"/> School</td> </tr> <tr> <td><input type="checkbox"/> Criminal Justice</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Coordination of Treatment</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Assist in the provision of services	<input type="checkbox"/> Legal/Court ordered	<input type="checkbox"/> Personal use	<input type="checkbox"/> School	<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Coordination of Treatment		<input type="checkbox"/> Other: _____		<p>the following information: From: _____ To _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Admission Evaluation Report <input type="checkbox"/> Diagnosis Only <input type="checkbox"/> Treatment Plan(s) <input type="checkbox"/> Psychiatric Consultation Report <input type="checkbox"/> Psychological Evaluation Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Progress Review(s) <input type="checkbox"/> Alcohol and Drug Treatment information <input type="checkbox"/> Hospitalization Screening <input type="checkbox"/> Progress Notes: FROM _____ TO _____ <input type="checkbox"/> MHC Treatment Report Form <input type="checkbox"/> Medical Report <input type="checkbox"/> Legal Reports <input type="checkbox"/> Education Reports <input type="checkbox"/> Medications <input type="checkbox"/> Labs <input type="checkbox"/> Appointments <input type="checkbox"/> Other _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> Assist in the provision of services	<input type="checkbox"/> Legal/Court ordered										
<input type="checkbox"/> Personal use	<input type="checkbox"/> School										
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Other: _____										
<input type="checkbox"/> Coordination of Treatment											
<input type="checkbox"/> Other: _____											

Expiration			
<p>This authorization shall remain in effect until _____ at which time this authorization expires, but no later than one year (month/day/year)</p> <p>from the date listed below. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Southeast Kansas Mental Health Center. I understand that fees may be charged for preparing and sending copies of records.</p> <p>I acknowledge that I am aware that certain information that I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and I am aware of the specific protections afforded or am waiving my rights to being informed of the specific provisions of these laws, Statute 42 CFR – Part 2. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.</p> <p>I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization.</p>			
Client/Patient Signature		Date	
Parent/Guardian/Legal Representative		Date	
Relationship to Client			
Witness Signature		Date	

Televideo Mental Health/Chemical Abuse Consent Form

I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The potential benefit of Southeast Kansas Mental Health Center televideo mental health/chemical abuse services is that I will be able to talk with mental health/chemical abuse staff or providers from this local setting for an evaluation of my needs.
3. The potential risk of Southeast Kansas Mental Health Center televideo mental health/chemical abuse services is that there could be a partial or complete failure of the equipment being used which could result in the inability of the mental health/chemical abuse staff or provider to complete the evaluation, mental health /chemical abuse services, and/or prescription process.
4. No video or voice recording is made or preserved of any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.
5. All existing or applicable protections for confidentiality apply to any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.
6. All existing laws regarding client access to mental health/chemical abuse information and copies of mental health/chemical abuse records apply to any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.

I consent to Southeast Kansas Mental Health Center televideo mental health/chemical abuse services in circumstances in which mental health/chemical abuse staff or providers appropriate to my needs are not immediately available at my site. My mental health/chemical abuse care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

Signature of Client

Date

Signature of Responsible Adult

Relationship to Client Date

Signature of Witness/Interpreter

Date

Electronic Communication Consent

Client Name: _____

DOB: _____

SSN: _____

Purpose: Consent to allow SEKMHC staff to correspond by e-mail/text message to myself. These can be used for scheduling, appointment reminders, billing, and other forms of client communication/information. I am responsible for providing SEKMHC with current email address and cell phone number.

Cell Phone/Text Number: _____ Email address: _____

Cell Phone/Text Number: _____ Email address: _____

E-Mail and Text Messaging Risk Factors and Responsibilities

Risks:

- Emails can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email or text messages can be sent out and received by many recipients, some or all of whom may be sent the message accidentally.
- Emails/text messages are not always encrypted and could be read by someone with the skills to do so.
- Email or text messages senders could misaddress a message.
- Emails or text messages are easier to falsify than handwritten or signed documents.
- Even if someone deleted an email or text message, there may still be a backup copy.
- Employers and on-line services may have a right to archive or inspect emails/text messages transmitted.
- Email/text messages can be intercepted, altered, forwarded or used without authorization or detection.
- Emails or text messages are a part of the client's file and therefore can be used as evidence in court.
- Emails or text messages can be used to introduce viruses into computer systems.

Conditions for use:

- We can't guarantee that email or texts will be read, received or responded to within a particular time frame.
- No one should use text or email for emergencies or any matter that is time sensitive in nature. Please call 911, the crisis line or go to the nearest ER for care.
- Texting and emails are to be used during business hours and not to be used after hours or during weekends and holidays and we can't guarantee a response during these times.
- All emails or text messages received or sent may be made part of the client record.

- Messages may be forwarded internally via email to staff.
- Messages may be forwarded to independent third parties with signed release on file.
- The center uses Facebook, has a website, and third-party applications that we use to connect with the community and to provide tools to assist with problem solving/learning skills. If you use these sites to connect with us, we can't guarantee confidentiality on these sites.

By signing below, I agree to Electronic Consent Form and request that my provider communicate with me electronically. I can revoke in writing at any time. I understand risks involved and agree to the conditions above. The center may use third party applications, and these will be explained to me at the time. I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized below.

Messages may be communicated to me via email, cell phone and by texting/SMS on my cell phone.

*Client or Client's Parent/Legal Guardian Signature

Date

Printed Name

Print Relationship to client (if other than self)

Signature of Witness

(Print Name)

Date



You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 620 343-2211.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

If you have questions about any part of this notice or if you want more information about our privacy practices, please contact:
Nathan Fawson, Executive Director, 304 N. Jefferson, PO Box 807, Iola, KS 66749, Phone 620/365-8641

WHY WE ARE PROVIDING THIS NOTICE:

Southeast Kansas Mental Health Center compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a designated record set. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice you will be given a revised Notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT MAY BE MADE *WITHOUT YOUR AUTHORIZATION*:

For your treatment. We may share your protected health information with other treatment providers. For example, if you have a heart condition we may use your information to contact a specialist and may send your information to that specialist. We may send your information to other treatment providers, as necessary.

For payment. We may share your protected health information with anyone who may pay for your treatment. For example, we may need to obtain a pre-authorization for treatment or send your health information to an insurance company so it may pay for treatment. However, if you pay full fee out of pocket for your treatment and make a specific request that we not send information to your insurance company for that treatment, we will not send that information to your insurer except under certain circumstances.

1. For our healthcare operations. We may use and disclose your protected health information when it is necessary for us to function as a business. For example, when we contract with other businesses to do specific tasks for us, we may share your protected health information related to those tasks. When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent Southeast Kansas Mental Health Center would be able to do so. These businesses are called Business Associates. Another example is if we want to see how well our staff is doing, we may use your protected health information to review their performance.
2. For appointment reminders. We may use your protected health information to remind you of appointments, including leaving a voicemail message.
3. For Surveys. We may use and disclose your protected health information to contact you to assess your satisfaction with our services.
4. For providing your information on treatment alternatives or other services. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you. In some cases the facility may receive payment for these activities. We will give you the opportunity to let us know if you no longer wish to receive this type of information.
5. To discuss your treatment with other people who are involved with your care. We may disclose your health information to a friend or family member who is involved in your care. We may also disclose your health information to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. Unless you inform us that you do not want any information released, we may tell individuals who ask, your location in the hospital and provide a general statement of your condition.
8. As Required By Law. We will disclose your protected health information when the law requires us to do so.
9. To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
10. Military and Veterans. The protected health information of members of the United States Armed Forces members of a foreign military authority may be disclosed as required by military command authorities.
11. Employers. We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.
12. Workers' Compensation. We may release your protected health information for workers' compensation or similar programs providing you benefits for work-related injuries or illness.
13. Public Health Risks. We may disclose your protected health information for public health activities which include the prevention or control of disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of devices or products; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence.
14. Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.
15. Legal Proceedings. We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.
16. Law Enforcement. When a law enforcement official requests your protected health information, it may be disclosed in response to a court order, subpoena, warrant, summons, or similar process. It may also be disclosed to help law enforcement identify or locate a suspect, fugitive, material witness, or missing person. We may also disclose protected health information about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at Southeast Kansas Mental Health Center; or in an emergency to report a crime, the location of the crime, victims of the crime, or to identify the person who committed the crime.
17. Coroners, Medical Examiners, and Funeral Directors. We may disclose your protected health information to a coroner, medical examiner, or a funeral director.
18. National Security and Intelligence Activities. When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.
19. Protective Services for the President and Others. We may disclose your protected health information to certain federal officials so they may provide protection to the President, other persons, or foreign heads of state, or to conduct special investigations.
20. Inmates or Persons in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.
21. Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

OTHER USES AND DISCLOSURES:

1. Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that constitute a sale of protected health information require your authorization. Psychotherapy notes are a particular type of protected health information. Mental health records generally are not considered psychotherapy notes. Your authorization is necessary for us to disclose psychotherapy notes.
2. There are some circumstances when we directly or indirectly receive a financial (e.g., monetary payment) or non-financial (e.g., in-kind item or service) benefit from a use or disclosure of your protected health information. Your authorization is necessary for us to sell your protected health information. Your authorization is also necessary for some marketing uses of your protected health information.
3. Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may revoke your authorization in writing at any time, provided you notify us. If you revoke your authorization, it will not take back any disclosures we have already made.

YOUR HEALTH INFORMATION RIGHTS:

1. **Right to Access.** You have the right to access, or to inspect and obtain a copy of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form so we have the information we need to process your request. You may request that your records be provided in an electronic format and we can work together to agree on an appropriate electronic format. Or you can receive your records in a paper copy. You may also direct that your protected health information be sent in electronic format to another individual. You may be charged a reasonable fee for access. We can refuse access under certain circumstances. If we refuse access, we will tell you in writing and in some circumstances you may ask that a neutral person review the refusal.
2. **Right to Amend Your Records.** If you feel that your protected health information is incorrect or incomplete, you may ask that we amend your health records. To exercise this right, you must contact the Privacy Officer to complete a specific form stating your reason for the request and other information that we need to process your request. We can refuse your request if we did not create the information, if the information is not part of the information we maintain, if the information is part of information that you were denied access to, or if the information is accurate and complete as written. You will be notified in writing if your request is refused and you will be provided an opportunity to have your request included in your protected health information.
3. **Right to an Accounting.** You have a right to an accounting of disclosures of your protected health information that is maintained in a designated record set. This is a list of persons, government agencies, or businesses who have obtained your health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. There are specific time limits on such requests. You have the right to one accounting per year at no cost.
4. **Right to a Restriction.** You have the right to ask us to restrict disclosures of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. If you self-pay for a service and do not want your health information to go to a third party payer, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payer (e.g., a governmental payer), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.
5. **Right to Communication Accommodation.** You have the right to request that we communicate with you in a certain way or at a specific location. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us the information that we need to process your request.
6. **Breach Notification.** You have the right to be notified if we determine that there has been a breach of your protected health information.
7. **Right to Obtain the Notice of Privacy Practices.** You have the right to have a paper copy of this Notice. You may request a copy from the Privacy Officer.
8. **Right to File a Complaint.** If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights (Regional Office at Kansas City), 601 East 12th Street Room 248, Kansas City MO 64106, 816.426.7277, or through www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be penalized for filing a complaint.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Southeast Kansas Mental Health Center participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO.

If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at <http://www.KanHIT.org> or by completing and mailing a form. This form is available at <http://www.KanHIT.org>. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit <http://www.KanHIT.org> for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our facility. Effective Date: 03/23/2010, Revised 03/13/13, Revised 05/29/15