



# Face Sheet

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