***RSWC Adult Intake Packet©***

**Intake Notes:**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BELOW IS FOR STAFF

Time in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time out: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake chart given by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (staff)

Best time to schedule appointment for intake/assessment with therapist:

Notes:

|  |  |  |
| --- | --- | --- |
| Duty/Action | Date | Initials |
| Add to icanotes |  |  |
| Scanned to icanotes |  |  |
| Billing file created |  |  |
| Master Client List |  |  |
| Emergency Contact List |  |  |
| Client Birthday List |  |  |
| File Made |  |  |
| Added to waiting list |  |  |
| Removed from waiting list |  |  |
| Professional disclosure signed |  |  |

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First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Address: |  | Mailing Address:  | * Address Same as physical
 |
|  |  |  |
| STREET ADDRESS |  | STREET ADDRESS |
|  |  |  |
| CITY STATE ZIP |  | CITY STATE ZIP |
|  |  |  |
| DOB: |  / /  | Age: |  |  | SSN: |  | Gender: M F X |
|  | MONTH | DATE | YEAR |  |  |  |  |  |  |
| Cell Phone: | ( ) - |  | Other Phone: | ( ) - |
| Okay to leave message: Y N  | Text messaging: Y N |  | Okay to leave message: Y N  | Text messaging: Y N |
|  |  |
| ***PLEASE FILL OUT EMERGENCY CONTACT ROI ON THE LAST PAGE SO WE CAN COMMUNICATE WITH EMERGENCY CONTACT.*** |
| **EMERGENCY CONTACT:** | Name: |  |  |
| Relationship:  |  |  |  | Phone:  | ( ) - |  |
| Address:  |  |  |  |  |  |  |  |  |  |
|  | STREET ADDRESS |  | CITY |  | STATE |  | ZIP CODE |  |
|  |
| Ethnicity: |  | Native American Y N | Tribe Affiliation: |  |
|  |  |  |  |  |
| Race: | * Native American
 | * Caucasian
 | * Hispanic
 | * African American
 | * Asian
 | * Other
 |  |
| Do you belong to a church? Y N | If so, which one? |  |
|  |  |  |
| Marital Status: | * Single
 | * Married
 | * Separated
 | * Divorced
 | * Partnered
 |
| Family Size in Home: |  | Number of Children under 18 in your custody: |  |
|  |  |  |  |
| Monthly earned income from work: |  | Monthly unearned income: |  |
| Circle Unearned income source: Power Child Support unemployment work comp SSI SSDI Retirement VA other: |  |
|  |  |
| Insurance: | * Medicaid
 | * Medicare
 | * Tricare
 | * Blue Cross
 | * None
 | * Other
 |  |
|  |  |  |  |  |  |  |  |  |
| INSURANCE CARD NUMBER |  | MEMBER ID NUMBER |  | GROUP NUMBER |  | COPAY |  | PAYER ID |
| Policy holder:  |  |  |  |  |  |
|  | NAME: |  | DATE OF BIRTH: |  | SOCIAL SECURITY NUMBER |
|  |  |  |  |  |  |
| Primary Care Physician: |  |  |  |
|  | NAME: |  | PHONE NUMBER |
|  | Date last exam: |  |
| ADDRESS: |  |  |
| Psychiatrist: |  |  |  |
|  | NAME: |  | PHONE NUMBER |
|  | Date last exam: |  |
| ADDRESS: |  |  |
|  |  |  |
| Children on Medicaid: Y N |
| **CHILD FIRST & LAST NAME** |  | **CHILD DOB** |  | **CHILD MEDICAID CARD NUMBER** |
|  |  |  / /  |  |  |
|  |  |  / /  |  |  |
|  |  |  / /  |  |  |
|  |  |  / /  |  |  |
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|  |  |  / /  |  |  |
|  |  |  / /  |  |  |
|  |  |  / /  |  |  |
| How did you hear about us? |  |
|  |  |

|  |  |
| --- | --- |
| **Describe the problem that brought you here today:** |  |
|  |
|  |
|  |
|  |
| **PREVIOUS MENTAL HEALTH TREATMENT** |
| Type of Treatment | YES | NO | When: | Provider/Program | Reason for Treatment |
| Outpatient Counseling |  |  |  |  |  |
| Residential Treatment |  |  |  |  |  |
| Psychiatric Hospitalization |  |  |  |  |  |
| Psychiatric Treatment |  |  |  |  |  |
| Drug Treatment |  |  |  |  |  |
| Alcohol Treatment |  |  |  |  |  |
| Self-help/Support Groups |  |  |  |  |  |
| Suicidal Thoughts |  |  |  |  |  |
| Suicidal Attempts |  |  |  |  |  |
| Hospitalizations |  |  |  |  |  |
| Are you currently having thoughts of hurting yourself? | Y | N |  |
| If yes, please describe: |  |
| Have you ever had thoughts, made statements, or attempted to hurt yourself? |  | Y | N |  |
| If yes, please describe: |  |
| Have you ever had thoughts, made statements, or attempted to hurt someone else? | Y | N |  |
| If yes, please describe: |  |
| Have you recently been physically hurt or threatened by someone else? |  | Y | N |  |
| If yes, please describe: |  |
|  | Medication | Dosage | Prescribing Physician | Purpose of Medication |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |
| 8. |  |  |  |  |
| 9. |  |  |  |  |
| 10. |  |  |  |  |
| **MEDICATION** Please list all current medications, dosage, and prescribing physicians. |
|  |
| **I understand that it is my responsibility to update my therapist with any changes to my medications.** |
|  |
| Client Signature: |  | Date:  |  / /  |

**MEDICAL INFORMATION**

Have you experienced any of the following medical conditions during your lifetime?

|  |  |  |  |
| --- | --- | --- | --- |
| * Allergies
 | * Chronic pain
 | * Stomach aches
 | * Sexually transmitted disease
 |
| * Asthma
 | * High fevers
 | * Vision problems
 | * Hearing problems
 |
| * Surgery
 | * Meningitis
 | * Miscarriage
 | * Dizziness/fainting
 |
| * Diabetes
 | * Seizures
 | * Head injury
 | * Serious accident
 |
| * Abortion
 | * Headaches
 | * Sleep disorder
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Please list any health concerns: |  |
|  |
|  |

**SUBSTANCE USE HISTORY**

|  |  |  |
| --- | --- | --- |
| Substance type |  Current Use (last 6 months) | Past Use |
|  |  | Frequency | Amount |  | Frequency | Amount |
| Tobacco | Y | N |  |  | Y | N |  |  |
| Caffeine | Y | N |  |  | Y | N |  |  |
| Alcohol | Y | N |  |  | Y | N |  |  |
| Marijuana | Y | N |  |  | Y | N |  |  |
| Cocaine/Crack | Y | N |  |  | Y | N |  |  |
| Ecstasy | Y | N |  |  | Y | N |  |  |
| Heroin | Y | N |  |  | Y | N |  |  |
| Inhalants | Y | N |  |  | Y | N |  |  |
| Methamphetamines | Y | N |  |  | Y | N |  |  |
| Pain Killers | Y | N |  |  | Y | N |  |  |
| PCP/LSD | Y | N |  |  | Y | N |  |  |
| Steroids | Y | N |  |  | Y | N |  |  |
| Tranquilizers | Y | N |  |  | Y | N |  |  |
| Other: | Y | N |  |  | Y | N |  |  |
| Have you had withdrawal symptoms when trying to stop using any substances? | Y | N |  |  |
| If yes, please describe: |  |
|  |
|  |
| Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? | Y | N |  |
|  |
|  |

**FAMILY AND DEVELOPMMENTAL HISTORY**

|  |  |  |
| --- | --- | --- |
| * Parents never married
 | * Mother remarried
 | Number of Times: \_\_\_\_\_\_\_ |
| * Parents legally married or living together
 | * Father remarried
 | Number of Times: \_\_\_\_\_\_\_ |
| * Parents temporarily separated
 | * Parents divorced or permanently separated
 |  |
| **Please check if you have experienced any of the following types of trauma or loss:** |
| * Neglect
 | * Emotional abuse
 | * Lived in a foster home
 |
| * Sexual abuse
 | * Parent illness
 | * Multiple family moves
 |
| * Physical abuse
 | * Homelessness
 | * Parent substance abuse
 |
| * Financial problems
 | * Teen pregnancy
 | * Violence in the home
 |
| * Crime victim
 | * Loss of a loved one
 | * Placed a child for adoption
 |
| Where were you born? Were there any difficulties during pregnancy or birth? |  |
|  |
| Have there been any developmental difficulties noted? Include speech, learning, visual, hearing. |  |
|  |
| Describe your relationship with each parent. Include step parents if applicable. |  |
|  |

**INTERPERSONAL/SOCIAL/CULTURAL INFORMATION**

Circle any of the following words that you believe describe you:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Active | Impulsive | Easy-going | Leader | Religious/Spiritual | Ambitious |
| Moody | Shy | Hard-boiled | Busy | Self-Confident | Often-blue |
| Submissive | Persistent | Excitable | Introvert | Sensitive | Nervous |
| Imaginative | Extrovert | Self-conscious | Hardworking | Calm | Likeable |
| Lonely | Impatient | Serious | Quiet | Good Natured |  |

**Please describe your social support network (Check all that apply):**

|  |  |  |  |
| --- | --- | --- | --- |
| * Family
* Friends
 | * Students
* Neighbors
 | * Co-workers
* Community Group
 | * Support/Self-help Group
* Religious/Spiritual Center (which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 |

|  |  |
| --- | --- |
| To which cultural or ethnic group do you belong? |  |
| If you are experiencing any difficulties due to cultural or ethnic issues, please describe: |  |
|  |  |
| How important are spiritual matters to you ? | Not at all | Little | Somewhat | Very much |
| Would you like spiritual/religious beliefs to be incorporated into your counseling? |  Y N |
| Please list your STRENGTHS: |  |
|  |  |
| Please list your WEAKNESSES: |  |
|  |  |
| Describe any special areas of interest or hobbies (art, books, physical fitness, etc.: |  |
|  |  |

**MISCELLANEOUS INFORMATION**

|  |
| --- |
|  |
| **Employment** |
| Employer: |  | Position: |  |
|  |  |  |  |
| Employer address: |  | Employer Telephone # |  |
|  |  |  |  |
| Contact Employer? | * Yes
 | * No
 | Leave message with Employer?  | * Yes
 | * No
 |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Number of Hours you work per day: |  | Per week: |  | Per month: |  |
|  |  |  |  |  |  |
| Length of time in this position: |  | Job Duties: |  |
|  |  |  |  |
| Stress level of this position: | * Low
 | * Medium
 | * High
 |
|  |  |  |  |  |  |  |  |  |  |
| Do you get along with other employees? | * Yes
 | * No
 |
|  |  |
| Comments regarding getting along with other employees: |  |
|  |  |
|  |
| Do you get along with your employer/boss? | * Yes
 | * No
 |  |
| Comments regarding getting along with your boss: |  |
|  |
|  |
| Other jobs you have held: |  |
|  |
|  |
| The best things about my jobs are: |  |
|  |
|  |
| The worst things about my jobs are: |  |
|  |
|  |
| **Education** |
| Are you currently attending school? | * Yes
 | * No
 | Highest Grade Completed: |  |
|  |  |  |  |  |  |
| High School Graduate: | * Yes
 | * No
 | Year: |  | GED: | * Yes
 | * No
 | Year: |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| College Degree:  | * Yes
 | * No
 | Year: |  | Major area of study: |  |
|  |  |  |  |  |  |  |  |  |
|  |
| **Legal** |
| Have you ever been convicted of a misdemeanor or felony?  | * Yes
 | * No
 |  |
|  |  |  |  |
| If yes, please explain: |  |
|  |
|  |
| Are you currently involved in any divorce or child custody proceedings?  | * Yes
 | * No
 |  |
|  |  |  |  |  |  |
| If yes, please explain: |  |
|  |

**PRESENTING PROBLEMS AND CONCERNS**

Use the following 1 to 9 scale to rate your current (within the last 3 weeks) problem severity for each domain listed below. Place your rating number on the line to the right of the domain. Also, place an “x” next to the adjectives or phrases that describe your symptoms or assets.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| **No Problem** | **Less than Slight** | **Slight Problem** | **Slight to Moderate** | **Moderate Problem** | **Moderate to Severe** | **Severe Problem** | **Severe to Extreme** | **Extreme Problem** |
| Depression \_\_\_\_\_\_\_ | Anxiety \_\_\_\_\_\_\_ |
| Depressed Mood | Worthlessness | Lonely | Anxious | Calm | Guilt |
| Anhedonic | Hopeless | Sleep problems | Tense | Fearful | Anti-Anxiety Meds |
| Sad | Happy | Anti-Depression Meds | Obsessive | Panic |  |
|  |
| Hyper Affect \_\_\_\_\_\_\_ | Thought Process \_\_\_\_\_\_\_ |
| Manic | Elevated Mood | Agitated | Illogical | Delusional | Hallucinations |
| Sleep Deficit | Overactive | Mood Swings | Paranoid | Ruminative | Intact |
| Pressured Speech | Relaxed | Anti-Manic Meds | Derailed Thinking | Loose Associations | Anti-Psych. Med |
|  |
| Cognitive Performance \_\_\_\_\_\_\_ | Medical / Physical \_\_\_\_\_\_\_ |
| Poor Memory | Low Self-Awareness | Impaired Judgement | Acute Illness | Handicap or Perm. Disability | Good Health |
| Short Attention | Developmental Disability | Slow Processing | CNS Disorder | Chronic Illness | Need Health Care |
| Insightful | Por Concentration | Oriented Times 4 | Pregnant | Poor Nutrition | Enuretic/Encopretic |
| Not Oriented to Person | Not oriented to Place | Eating Disorder | Seizures | Stress-Related Illness |
| Not Oriented to Time | Not Oriented to Circumstance |  |
|  |
| Traumatic Stress \_\_\_\_\_\_\_ | Substance Use \_\_\_\_\_\_\_ |
| Acute | Upsetting Memories | Repression/Amnesia | Alcohol | Recovery | Abstinent | Cravings/Urges |
| Chronic | Dreams/Nightmares |  | Abuse | Drug(s) | Interfere w/Duties | Med. Control |
| Avoidance | Detached |  | DUI | Family History | Dependence | I.V. Drugs |
|  |
| Interpersonal Relationships \_\_\_\_\_\_\_ | Family Relationships \_\_\_\_\_\_\_ |
| Problems w/Friends | Diff. Estab./Maintain Relationships | No Contact w/ Family | Poor parenting skills | Supportive Family |
| Poor Social Skills | Difficulty Maintaining Relationships | Difficulty with partner | Acting Out | No Family |
| Adequate Social Skills | Supportive Relationships | Conflict w/Relative | Difficulty with Child | Difficulty with Parent |
|  |
| Family Environments \_\_\_\_\_\_\_ | Socio-Legal \_\_\_\_\_\_\_ |
| Family Instability | Separation | Custody | Disregards Rules | Probation | Pending Charges |
| Family Legal Problems | Stable Home | Divorce | Dishonesty | Uses or Cons Other(s) | Reliable |
| Single Parent | Birth in Family | Death in family | Offense/Property | Offense/Person |  |
|  |
| Select one or both: Work\_\_\_\_\_/School \_\_\_\_\_\_\_ | ADL Functioning \_\_\_\_\_\_\_ |
| Absenteeism | Disabled | Doesn’t Read/Write | Seeking Job | Money Management Problems | Meal Preparation Difficulties |
| Dropped Out | Poor Performance | Not Employed | Tardiness | Personal Hygiene Problems | Transportation Problems |
| Employed | Learning Disabilities | Attends School |  | Problem Obtain/Maintain Job | Problem Obtain/Maintain Housing |
|  |
| Ability to Care for Self \_\_\_\_\_\_\_ | Danger to Self \_\_\_\_\_\_\_ |
| Able to Care fo Slef | Risk of Harm | Suicidal Ideation | Self-Injury |
| Suffers From Neglect | Refuses to Care for Self  | Past Attempt | Recent Attempt |
| Not Able to Survive without Help | Alternative Care not Available | Current Plan | Self-Mutilation |
|  |
| Danger to Others \_\_\_\_\_\_\_ | Security / Management Needs \_\_\_\_\_\_\_ |
| Violent Temper | Assaultive | Homicidal Ideation | Home w/o Supervision | Restraint | Run/Escape Risk |
| Physical Abuser | Doesn’t Appear Dangerous to others | Behavioral Contract | Suicide Watch |  |
| Homicidal Threats | Hostile | Threatens Others | Involuntary Exam/Commitment | Protection from others |
| Homicidal Attempt |  |  | Locked Unit | Home w/Supervision | Seclusion |

**Please check any of the following items that you are seeking help with:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Unemployed, reduced employment skills, poor employment history | Unemployment, unspecified |  |
| Other physical and mental strain related to work |  |
| Stressful work schedule |  |
| Other problems related to employment |  |
| Illiteracy and low-level literacy |  |
| Other problems related to education and literacy |  |
| 2. | Public Assistance, unable to get on assistance without help | Encounter for disability determination |  |
| Problems related to education and literacy, unspecified |  |
| Homelessness |  |
| Inadequate housing |  |
| Extreme poverty |  |
| Low income |  |
| Insufficient social insurance and welfare support |  |
| 3. | Difficulty establishing or maintaining social support system | Social exclusion and rejection |  |
| Problems related to living alone |  |
| Problems in relationship with spouse or partner |  |
| Problem related to social environment, unspecified |  |
| Other specified problems related to upbringing |  |
| Other absence of family member |  |
| Alcoholism and drug addiction in family |  |
| 4. | Requires assistance in basic living skills; such as personal hygiene, food preparation, money management | problems related to life management difficulty |  |
| Problems related to education and literacy unspecified |  |
| Illiteracy and low-level literacy |  |
| Extreme poverty |  |
| Low income |  |
| absence of family member |  |
| Need for assistance with personal care |  |
| problems related to housing and economic circumstances |  |
| Problems related to living alone |  |
| Other upbringing away from parents |  |
| Personal history of neglect in childhood |  |
| Other stressful life events affecting family and household |  |
| Inappropriate diet and eating habits |  |
| Other problems related to lifestyle |  |
| Limitation of activities due to disability |  |
| 5. | Shows inappropriate behavior that results in intervention by the mental health or judicial system. | Unavailability and inaccessibility of health-care facilities |  |
| Inadequate social skills |  |
| Adult antisocial behavior |  |
| Other problems related to lifestyle |  |
| Problems related to other legal circumstances |  |
| Imprisonment and other incarceration |  |
| Victim of crime and terrorism |  |
| Counseling for family member of drug abuser/alcoholism in family |  |
| Personal history of self-harm |  |
| Other personal history of psychological trauma |  |

|  |  |  |
| --- | --- | --- |
|  | **ORIENTATION CONFIRMATION STATEMENT** | **Initials indicate agreement** |
| 1. | I acknowledge that I have been provided with a **CLIENT ORIENTATION HANDBOOK** providing extended details of covered information.  |  |
| 2. | **SMOKING POLICY:** I understand that the Rising Sun Wellness is an indoor smoke free facility. I agree to abide by this policy while receiving services.  |  |
| 3. | **WEAPONS POLICY:** I understand that Rising Sun Wellness Center is a weapons free facility. I agree to abide by this policy while receiving services.  |  |
| 4. | **PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I certify that the information given by me in applying for payment is correct. I authorize any holders of medical or other information about me to exchange any information needed for this or a related health insurance or Medicaid claim. I request that payment or authorized benefits be made to RSWC on my behalf.  |  |
| 5. | **STATEMENT OF EMERGENCY MEDICAL PROCEDURES:** I understand that if I am injured/ become ill while receiving services at RSWC, emergency medical personnel will be called.  |  |
| 6. | **STATEMENT OF NON- RESTRAINT:** RSWC has a non-use of seclusion and/or restraint policy.  |  |
| 7. | **ADMISSION INFORMATION:** I acknowledge that I have received, read and understand the following client information. I have had the opportunity to ask questions regarding these issues and they have been explained to me. |  |
|  |  Service Policies and Client Responsibilities |  |
|  |  Client Rights |  |
|  |  Orientation to Rising Sun Wellness Center Facility |  |
|  |  Rising Sun Wellness Center Guidelines & Rules |  |
|  |  Confidentiality |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |

**Billing Authorization and Client Agreement for Payment of Services**

**Missed or Late Appointment Policy**

* To avoid a $10 late cancellation fee, please call 307-674-1668 by *4:30 p.m. the day before* your appointment.
* You will be charged a $20 fee if you miss an appointment or arrive more than 10 minutes late.
* Rising Sun Wellness Center may place a scheduling hold if you fail consecutive appointments or three appointments within six months.

**Questions**

* For questions about our cancellation or late appointment policy, please call 307-674-1668.

**Current Charges for Mental Health Related Services:** As of 01/28/2019,

|  |  |
| --- | --- |
| Individual Therapy / Family (60 minutes) | **$85.00 - $120.00** |
| Group Therapy / Case Mgt. Education | $45.00 - $75.00 |

A one-time charge for the client’s intake fee is $50.00 and must be paid at that scheduled appointment before the intake process can begin. (This fee does not apply to Medicaid qualified clients). The above fees can change at any time to offset costs. A 30-day notice will be sent to all clients should our service fee(s) change.

1. **Payment of Service:** All Clients are responsible for their billing at the time services are rendered.Any balance due after 30 days of the treatment date will be charged an additional 19% administrative surcharge on the unpaid balance. No further client services may be rendered if any balance exists after 30 days unless satisfactory arrangements are made in advance. In the event that Rising Sun Wellness Center is part of a professional case plan, Rising Sun Wellness Center will advise the following related professional offices that your treatment has ended unsuccessfully should services be terminated for nonpayment.
* **Your physician, if you are required to receive mental health related treatment for medical reasons/ medications.**
* **Your probation or parole officer.**
* **Department of Family Services.**
* **Department of Work Force Services/Vocational Rehab.**
1. **Sliding Fee Discount:** Rising Sun Wellness Center offers clients a sliding fee discount for clients who have a combined household income of $45,000 yearly net income or less and have no medical insurance coverage, providing the client stays current with their balance statements. **If your bill is past due over 90 days and is turned over to Collections, the sliding fee discount will not be honored, and the client is liable for the full amount of the services at our standard rate.**
2. **Medical Insurance:** Payment for services rendered is the responsibility of the client. It is also the client’s responsibility to contact his/her Insurance Company to make sure that Mental Health/Substance Abuse Treatment is covered under your policy and to what degree the Insurance Company will cover your costs. Rising Sun Wellness Center will send statements to your insurance company for process and payment on your behalf.

**Regardless of your medical insurance coverage and/or process of payment, it is still the responsibility of the client to keep his/her bill current including any co-pay and/or deductible not covered by insurance.**

**All unpaid balances will be turned over to Collections Agency for any balances that are 90 days past due.**

**I have read and accept financial responsibility for services rendered on my behalf as stated above. I also transfer and release to Rising Sun Wellness Center, all my medical reimbursement benefits under any and all health or medical insurance that is available to me.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

My “Protected Health Information” **PHI**: means health information, including my demographic information, collected from me, created, or received by my physician, another care provider, health plan, my employer or health care clearinghouse. This **PHI** relates to my past, present, future physical, mental health, or condition & identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review the **RSWC** Notice of Privacy Practices prior to signing this document.***[\_\_\_\_] Initial***

The Notice of Privacy Practices **NPP** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **RSWC.** The **NPP** for RSWC is also provided at 151 W. Brundage St, Sheridan, Wyoming 82801. **NPP** also describes my rights & duties of RSWC with respect to my protected health information.RSWC reserves the right to change the privacy practices that are described in the **NPP**.I may obtain a revised **NPP** by accessing the RSWC’s website, calling the office & requesting a revised copy be sent in the mail or asking for one at the time of my next appointment ***[\_\_\_\_] Initial***

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right-hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

I have been informed of **RSWC’s** Notice of Privacy Practices and acknowledge my right to a paper copy and/or electronic copy. ***[\_\_\_\_] Initial***

I authorize **RSWC** to use and disclose the health and medical information for the purposes of Treatment, Payment and Health Care Operations\* ***[\_\_\_\_] Initial***

**\*Treatment** includes activities performed by a health care provider, nurse, office staff, therapists, case managers, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician. ***[\_\_\_\_] Initial***

**\*Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization. ***[\_\_\_\_] Initial***

**\*Health Care Operations** includes the necessary administrative and business functions of our office.

I consent to the use or disclosure of my protected health information by **RSWC** for diagnosing, treating, obtaining payment for my health care bills or to conduct health care operations of RSWC. ***[\_\_\_\_] Initial***

I understand that diagnosis or treatment of me by **RSWC** may be conditioned upon my consent as evidenced by my signature on this document. ***[\_\_\_\_] Initial***

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operation of the practice. RSWC is not required to agree to the restriction that I may request. However, if **RSWC** agrees to a restriction that I request, the restriction is binding on **RSWC. *[\_\_\_\_] Initial***

I have the right to revoke this consent, in writing, at any time, except to the extent **RSWC** has taken action in reliance on this

***[\_\_\_\_] Initial***

**I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsity information is grounds for refusing services or for discharge.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |

**Policies and Procedures**

**2.G.1 Notice Of Practices: This Notice describes how the Rising Sun Wellness Center (RSWC) uses and discloses your protected health information (PHI) and describes how you can obtain access to your individual health related records, as required by the Health Insurance Portability Act of 1996 (HIPAA).**

At RSWC we are committed to keeping your PHI private. We also follow the state and federal laws that pertain to PHI. We realize that these laws can be complicated and subject to change over time. Therefore, RSWC reserves the right to revise this Notice as it becomes necessary. Your past PHI will be affected by any new revision to our Notice effective immediately as well as any new PHI that we obtain in the future.

RSWC will post the most current revision of the Notice of Privacy Practices and a copy will be available to you at any given time during office hours. Please feel free to contact our staff with any concerns or questions.

**RSWC may use and disclose your PHI as follows:**

1. Treatment: RSWC keeps record of diagnosis, treatment and contact information that allow our staff to provide quality health care to you. Your PHI will be shared with other RSWC staff on a need to know basis so that we may utilize our staff expertise as it applies to you and your prescribed treatment. PHI for children and minors will be disclosed to their parents/guardian.
2. Payment: RSWC may disclose PHI for billing and payment to health insurance companies and/or state and federal assistance programs such as Medicare, or credit collections for non-payment.
3. Administration and Operations: RSWC may disclose information to evaluate: quality of care, effectiveness, cost management, business planning, and accreditation/licensure and requirements mandated by local, state and federal laws.
4. Appointment reminder: RSWC will call you to remind you of your next appointment. At your request we will not leave voice mail messages or leave messages with another person if you do not want others to know about your appointments.
5. Disclosure required by law: when RSWC is presented with proper legal warrants, we are required to release PHI to federal, state and local authorities.

**RSWC may use and disclose your PHI under unique circumstances:**

1. Public Health Risk: RSWC may release PHI to public health authorities that are authorized by law to collect information for:
	1. Maintaining vital records, such as births and deaths.
	2. Reporting child/elder and any person under the care of a caregiver/guardian regarding abuse/neglect.
	3. Preventing or controlling disease, injury or disability.
	4. Notifying a person of potential exposure to a communicable disease.
2. Health oversight activities: RSWC will disclose PHI to legal authorities for criminal investigation (with proper warrants), inspections, audits, licensure and disciplinary actions.
3. Law Enforcement: RSWC will release your PHI to law enforcement under the following circumstance:
	1. If you are a victim of a crime and we are unable to contact you.
	2. In the event that your death resulted from criminal conduct.
	3. In response to warrants, summons, court order, subpoena or similar legal process.
	4. To identify a suspect, material witness, fugitive or missing person.
	5. In emergency circumstance, and/or to report illegal activity.
4. Serious Threat to Health or Safety: RSWC will release PHI to proper authorities under these circumstances: If you are perceived through your actions/inactions to be a physical threat to:
	1. Yourself
	2. Spouse
	3. Family members or friends
	4. Other RSWC clients
	5. RSWC staff
5. Military: if you are a member of any U.S. military force, including veteran status, the military can request PHI providing they follow proper protocol.
6. National Security: RSWC will release PHI to federal officials who are authorized by law.
7. Inmates: RSWC will release PHI to correctional institutions if you are under their custody for purposes of your own health care or for the safety and security of the institution or other inmates at the institution.

 **Your Rights regarding your Private Health Information (PHI)**

1. Confidential communications: You have the right to receive health care from RSWC in privacy. We will make every reasonable effort to provide you with the level of privacy that you request. We will provide you with a form that states who you want/do not want RSWC to contact or inform. Examples of this would be:
	1. You would not want us to contact you at work.
	2. You do not want others who have access to your phone and/or voicemail.
	3. You must provide this information to us via our RSWC release of information form that is available to you at the reception desk. It is your responsibility to update your privacy information via our Release of Information form should your circumstance change.
2. Right to file a Complaint: If you believe that your PHI was compromised you may file a written complaint to the: ***RSWC Chief of Office Operations, 151 W. Brundage St. Sheridan WY 82801 (307)674-1668.*** RSWC well make every reasonable effort to resolve the issue within 10 working days. If we cannot resolve this issue, we will provide you with the contact information for other state and federal agencies who are responsible for related investigations. You will not be penalized for a complaint.
3. Right to have your PHI shared: At your written request we will provide your PHI to anyone, or any organization or institution that you wish. A release of information form is available to you at the reception desk. You can, at any given time revoke the release of information via an updated and signed release of information form.
4. You have a right to a paper copy of this Notice of Privacy. Copies are available at the reception desk.

**PROGRAM PARTICIPANT’S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT**

RSWC is committed to protecting individual rights & providing services within an environment with by dignity & respect of all persons, & is responsive to the unique needs, abilities, & characteristics of each person served by the organization.

**Program Participant Rights:** As a participant in programming of the RSWC you have the right to:

* Be fully informed about the course of your care and decisions that may affect your treatment
* Revoke your consent for treatment at any time
* Timely and accurate information to assist you in making sound decisions about your treatment
* Be fully involved as an active participant in decisions pertaining to your treatment
* Have an individual identified in writing that will direct and coordinate your treatment
* Request a change in individual directing and coordinating your treatment, if you so desire
* Receive services in an environment that is free of all forms of abuse, including, but not limited to
	+ (a) Financial abuse
	+ (b) physical abuse and punishment
	+ (c) sexual abuse and exploitation
	+ (d) Psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and
	+ (e) all forms of seclusion and restraint
* Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
* File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
* Have family members, friends or others involved in your treatment with your consent and approval
* Receive services that comply with all applicable federal and state laws, rules and regulations
* File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have, or does not adequately address any formal grievance you submit
* To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences
* You may also have additional rights afforded to you based on federal, state, and local regulations. Your service coordinator will advise you of any additional rights that you may have.

**Program Participant Responsibilities:** As a program participant of RSWC you have the responsibility to:

* Refrain from all forms of physical violence or abuse toward other program participants, staff or visitors
* Refrain from abusive language, disruptive behavior or overt sexual conduct
* Refrain from loitering outside the organization’s facilities
* Refrain from bringing any type of weapon into the organization’s facilities or property
* Refrain from bringing any illicit (illegal) drug or alcohol onto the organization’s property
* Refrain from using illicit drugs or alcohol while participating in services provided by the organization
* Use tobacco only in designated areas
* Attend all services required by the organization to meet agreed upon goals
* Notify any outside treatment provider (physician, case worker, counselor, etc.) of participation in services, should your treatment impact, or compromise, the provision of those services
* Treat other program participants, staff and visitors in a respectable manner

**I acknowledge that I have read and understand my rights and responsibilities as a participant in services at the RSWC.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |

***GIVE COPY TO PROGRAM PARTICIPANT***

**Release of Information Consent and/or Disclosure**

|  |  |  |  |
| --- | --- | --- | --- |
| Client’s Name: |  | DOB:  | \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
|  |  |  | Month Day Year |

Authorizes between the following parties:

|  |  |  |
| --- | --- | --- |
| **RISING SUN WELLNESS CENTER** | **And** |  |
|  | First and Last Name |
| **(RSWC)** |  |
|  | Organization |
| 151 W Brundage St |  |
|  | Address |
| Sheridan, Wy 82801 |  |
|  | City, State, Zip |
| 307-674-1668 |  |
|  | Telephone |
| 307-674-1667 |  |
|  | Facsimile |

 **□ Both Send and Receive □ Only Send from RSWC □ Only Receive to RSWC**

\_\_\_\_\_\_ (client initial) I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

\_\_\_\_\_\_ (client initial) I further understand that the information and/or documentation disclosed and/or released may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

\_\_\_\_\_\_ (client initial) I understand that this authorization is voluntary, and after 1 year this consent automatically expires. I may revoke this consent at any time by providing written notice.

\_\_\_\_\_\_ (client initial) I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Any disclosure and/or documentation provided by RSWC is prohibited from being further disclosed without specific consent by RSWC or a representative of RSWC **and** the client. Additionally, any documentation received by RSWC will not be further disclosed or released to a third party.

**Client authorizes: Release and/or Disclosure of the following information and/or documentation**:

|  |  |  |
| --- | --- | --- |
| * Academic testing results
 | * Summary reports
 | * Crisis intervention
 |
| * Psychological testing results
 | * Medical reports
 | * Behavior programs
 |
| * Vocational testing results
 | * Psychological reports
 | * Service/Treatment plans
 |
| * Intelligence testing results
 | * Progress reports
 | * Entire record, except progress notes
 |
| * Case Management
 | * Personality profiles
 | * Other (specify)
 |  |
|  |
| **The information/disclosure will be used for the following purposes:** |
| * Planning appropriate treatment or program
 | * Updating files
 | * Determining eligibility for benefits or program
 |
| * Continuing appropriate treatment or program
 | * Case review
 | * Other (specify)
 |  |

Your relationship to client: \_\_\_\_\_ Self\_\_\_\_\_ Parent/Legal guardian\_\_\_\_\_ Personal Rep\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_ (describe)

**If you are the legal guardian or representative appointed by the court for the client, please attach a copy of legal authorization to sign this Release of Information Consent and/or Disclosure.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |

**Release of Information Consent**

**Emergency Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| Client’s Name: |  | DOB:  | \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
|  | First and Last name |  | Month Day Year |

Authorizes between the following parties:

|  |  |  |
| --- | --- | --- |
| **RISING SUN WELLNESS CENTER**  | **And** |  |
|  | First and Last Name |
| **(RSWC)** |  |
|  | Relationship |
| 151 W Brundage St |  |
|  | Address |
| Sheridan, Wy 82801 |  |
|  | City, State, Zip |
| 307-674-1668 |  |
|  | Telephone |
| 307-674-1667 |  |
|  | Facsimile |

□ Both Send and Receive

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and after 1 year this consent automatically expires. I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

\_\_\_\_\_\_ (client initial) I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

\_\_\_\_\_\_ (client initial) I further understand that the information and/or documentation disclosed and/or released may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

\_\_\_\_\_\_ (client initial) I understand that this authorization is voluntary, and after 1 year this consent automatically expires. I may revoke this consent at any time by providing written notice.

\_\_\_\_\_\_ (client initial) I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

|  |  |  |  |
| --- | --- | --- | --- |
| Your relationship to client: | * Self
 | * Parent/Legal guardian
 | * Personal representative
 |
| * Other (describe)
 |  |

Your relationship to client: \_\_\_\_\_ Self\_\_\_\_\_ Parent/Legal guardian\_\_\_\_\_ Personal Rep\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_ (describe)

**If you are the legal guardian or representative appointed by the court for the client, please attach a copy of legal authorization to receive this protected health information.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date:  |  / /  |
| Witness Signature: |  | Date:  |  / /  |