Adult and Child Mental Health Center ***Behavioral Health Registration Form***	**Client #:**	**Date:**	**Time:** ☐ am ☐ pm

Name: (Last) (First) (Middle Name) **Previous Names Used:**

Reason for today's visit:

Who referred you to us or how did you hear about us:

Referral Source: ☐ Individual/Self ☐ Alcohol/Drug Care Provider ☐ Health Care, other
☐ School/Educational ☐ Employer/Employee Assistance Program
☐ Other Community Referral ☐ Court/Criminal Justice
☐ Referral from Child Welfare/DCS ☐ Transfer/Referral from CMHC
☐ Transfer Referral from PCP InNetwork ☐ Transfer/Referral from PCP Out of Network

Date of Birth: **Age:** **Social Security #:** **Biological Sex:** ☐ Male ☐ Female
Gender Expression: ☐ Male ☐ Female

Address: **City:** **State:** **Zip:**

County of Residence: **May we mail to this address:** ☐ Yes ☐ No **If No, what is your mailing address?**

	May we call this #:	**May we text this #:**	**Leave message on voicemail:**	**Leave message with someone:**
Home Phone#	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Work Phone#	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cell Phone#	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Email: **May we send information to this email:** ☐ Yes ☐ No

Employment Status:
☐ Full-time(35 or more hrs/wk)
☐ Part-time _____ # of hrs/wk (list hours)
☐ Jobless, looking for work
☐ Jobless, not in labor force
☐ Unknown

Client's Employer:

If unemployed, interest in working with employment support specialist? ☐ Yes ☐ No ☐ NA

Marital Status:
☐ Single ☐ Married/living together
☐ Divorced ☐ Separated
☐ Widowed ☐ Unknown

Name of Spouse: **Spouse Employed?** ☐ Yes ☐ No **Spouse's Employer:**

Emergency Contact Name: **Emergency Contact Relationship:** **Emergency Contact Phone #'s:**

Responsible Party Name: **Responsible Party Address:** **Responsible Party Phone #** **Responsible Party Relationship:**

Do you have insurance (including Medicare or Medicaid) that may assist with the cost of services received? ☐ Yes ☐ No **Responsible Party SS#:**

Primary Insurance: **Secondary Insurance:**

Have you applied for TANF benefits: ☐ **Yes** ☐ **No**

Do you receive Food Stamps assistance: ☐ **Yes** ☐ **No**

Do you live in Supportive Housing: ☐ **Yes** ☐ **No**

Military Veteran:
☐ Yes
☐ Yes, served in combat
☐ No

Do you receive Supplemental Security Insurance (SSI): ☐ **Yes** ☐ **No**
Do you receive Social Security Disability Income (SSDI): ☐ **Yes** ☐ **No**

Highest Grade Completed: ☐ No Formal schooling completed/No follow up evaluation

Grade School (1 2 3 4 5 6 7 8) High School (9 10 11 12) College (1 2 3) ☐ High School Graduate/GED ☐ Bachelors Degree
☐ Masters Degree ☐ Trade/Business School ☐ Associates Degree ☐ Doctorate Degree ☐ Unknown

Living Arrangement: ☐ Independent Living (Own or rent home; if under 18 living with family) ☐ Unknown ☐ Homeless ☐ Residential Facility ☐ Correctional Order or Facility ☐ Supported Living ☐ Foster Care/Home ☐ Inpatient Hospital ☐ Inpatient State Operated Facility ☐ PRTF (Psych Res Tx Facility) ☐ Crisis Stabilization & Sub Acute Stabilization Facility ☐ Nursing Home ☐ Shelter Facility

FOR OFFICE USE ONLY
☐ Client received crisis information

☐ FFSP ☐ RRSP ☐ Insured

Adult and Child – registration form Page 2 Client ID:_____

1. FINANCIAL AGREEMENT:
I agree to pay in full for all services and supplies received by me or the designated client from Adult and Child. I agree to pay at the time of the services or supplies, unless special arrangements are made by me, the managed care organization, or the insurance carrier.

2. ASSIGNMENT OF INSURANCE BENEFITS:
For the term of my current treatment episode, I authorize Adult and Child to release all information, **including drug and alcohol or HIV records** necessary for a payer or insurer to process and adjudicate a claim for payment for services rendered to the client or the client's participating representative. I understand also that information may be disclosed to the Indiana Department of Mental Health and Addictions, as it supports Adult and Child as a funding source and regulatory body. I also authorize the release of all clinical information necessary to obtain precertification for necessary services from a payer/insurer. It is my responsibility to notify Adult and Child of any changes to insurance and to supply Adult and Child with any documentation or information necessary to file claims. If my insurance company(s) pays nothing or only a portion of the charge(s), I will be required to pay the balance of the account. While insurance companies' policies differ in paying for services, I am responsible for all fees on services not covered by my insurance policy, including deductibles and co-payments. I authorize payment to Adult and Child for insurance or any other third party benefits payable to me. I also understand that verification of benefits by Adult and Child does not guarantee payment from third party carriers. These benefits will be determined at the time claims are processed by third party carriers. I further understand that this consent for payment may be revoked by me in writing at any time except to the extent that action based upon the release has already been taken.

3. SUBSIDY APPLICATION:
Adult and Child receives partial funding from the Indiana Division of Mental Health to provide some reduced-rate specialized services to Indiana residents who are unable to pay for all of their care. A reduced fee is pending approval of income verification. Income verification must be provided within 30 days to receive subsidy approval. To apply for this subsidy, please complete the following:
ANNUAL INCOME(to nearest $1,000 before tax)_____ **FAMILY SIZE**(# supported by income listed)_____

4. APPOINTMENT AGREEMENT:
I understand that my appointment times are being reserved for me and that efficiency of scheduling often depends on my keeping my appointment as scheduled. I understand that repeated missed appointments may delay my treatment progress and failure to cancel 24 hours before an appointment twice may result in my case being closed.

5. CONFIDENTIAL USE OF PROTECTED HEALTH INFORMATION:
The Adult and Child Notice of Privacy Practices gives an in-depth description of reasons for access to your protected health information, where consent is required and when it is not necessary. Signing below acknowledges receipt of the Adult and Child Notice of Privacy Practices and that the Client Rights and Responsibilities were explained orally and offered in written format.

6. CONSENT FOR MENTAL HEALTH/ADDICTION SERVICES:
I, the undersigned, agree and consent to participate in the mental health/addiction services offered and provided by Adult and Child as defined in Indiana law. I have also received notification of my rights of confidentiality of alcohol and drug abuse patient records. I understand that I am consenting and agreeing only to those mental health/addiction services that my assigned providers are qualified to provide within:

a) the scope of the provider's license, certification, and training; or
b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.

☐ (initial) PERMISSION TO TRANSPORT DEPENDENT: As applicable, in the event I cannot bring my minor child or the person for whom I am legal guardian/custodian to the Program, I give Adult and Child permission to bring the client to the Program and participate in treatment as needed.

☐ (initial) PHOTOGRAPHS: I give my permission for A&C staff to photograph me for internal identification, diagnostic, treatment or educational purposes. I understand that I may rescind this consent at any time. Please initial in the box to confirm agreement.

The undersigned certifies that he/she has read the foregoing, is the client, or the client's parent or guardian, and agrees to and accepts the terms of the above.
* If a minor (under 18 y/o) is receiving substance abuse services, he/she must sign the consent in addition to the parent/guardian.

Client/Guardian Signature:_____ Date

Guardian Relationship:_____

Witness Signature:_____ Date

FOR OFFICE USE ONLY: % of Discount: _____
Income Verified: ☐ Yes ☐ No Approved: ☐ Yes ☐ No
HAP Eligible: Yes No
Expiration Date: _____