SIOUXLAND MENTAL HEALTH CENTER
NEW CLIENT INFORMATION
Child

Date: _____ Account #_____

Name: _____

Male/Female Date of Birth: _____ SSN: _____
Race:_____ Preferred language:_____

Address: _____

City: _____State:_____ Zip Code: _____

Parent/Guardian's name(s): _____

Guardian's DOB:_____ Guardian's SS#:_____

Primary Phone #: _____ Home___ Cell ____ Work____
Is it okay to leave a voice mail message? Y/N

Email Address:_____ Secondary phone:_____

Please list additional Parents/Guardians and the relationship to the child:

Name: _____ Relationship:_____ PH:_____

Type of Insurance: Primary:_____ Secondary:_____

Referred by: _____

Do you have any family members seeing a provider here? Y/N

If yes, how are they related? _____

If yes, who are they seeing? Doctor? _____

Therapist? _____

Emergency contact: _____ Phone #:_____

Patient's relationship to emergency contact:_____

Employee initials:_____

ASSESSMENT QUESTIONAIRE

Please check any of the statements that apply to your child today. This information will be shared with our therapist or nurse, if needed, so we can better serve you.

_____ My child has been making statements about hurting him/herself.

_____ My child has been hurting him/herself by cutting their body, hitting their head or in other ways.

_____ My child has attempted suicide in the past.

_____ My child has recently made statements about dying or suicide.

_____ My child has specifically stated that he/she wants to kill him/herself. If so, when did they say this? _____

_____ My child has been violent to other people recently.

_____ My child has been threatening to harm other people recently.

_____ My child has recently been a victim of sexual/physical abuse.

_____ I want my child to see a therapist ("talk therapy"). (Therapy is the process of treating mental health disorders and/or emotional distress. A therapist will help the client work through specific or general problems and deal with life stressors.)

_____ I want my child to see a doctor for mental health medications.

If your child has been diagnosed with any mental illness, please list the diagnosis here:_____

_____

Please explain any statements checked above or add any comments:_____

_____

_____

_____

_____

_____ _____

Print name of client Signature of client/guardian

Date:_____ Chart:_____

CLIENT'S INFORMED CONSENT

I have voluntarily chosen to receive treatment services by Siouxland Mental Health Center. I understand that I may terminate services at any time.

I understand that psychotherapy is a cooperative effort between me and my provider and I will work with my provider in a cooperative manner to resolve my issues.

I understand that during the course of my treatment material may be discussed which may be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will remain confidential and will only be released with a signed consent form in accordance with state laws regarding confidentiality.

I understand that my records may be released in accordance with state and local laws in cases in which a danger to self or others exists.

I understand that I may be contacted by Siouxland Mental Health to ensure continuity and quality of my treatment and/or after the completion of, to assess the outcome of treatment. I have read and understand the basic rights of individuals as seen at Siouxland Mental Health. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision on whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my provider, insurance representatives, and my primary care physician may exchange any and all information pertaining to my services, including retrieval of my medication history, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after discharge of treatment.

Client Acknowledgement and Consent to Privacy Notice

I have received an orientation to the Center, which has explained the policies and procedures and I consent to Siouxland Mental Health Center privacy notice, a copy of which has also been made available to me.
I have read and understand the above.

_____ _____

Print name of client Signature of client/guardian

Date:_____ Chart:_____

INSURANCE

Primary Insurance:

Name of insurance company:_____

Cardholder's Name:_____Patient's relationship to cardholder:_____

Gender of cardholder: M/F Cardholder's date of birth:_____

Certificate (ID) #:_____ Group #:_____

Cardholder's social security #:_____- _____-_____ Place of employment:_____

Secondary Insurance:

Name of insurance company:_____

Cardholder's Name:_____Patient's relationship to cardholder:_____

Gender of cardholder: M/F Cardholder's date of birth:_____

Certificate (ID) #:_____ Group #:_____

Cardholder's social security #:_____- _____-_____ Place of employment:_____

You are required to provide Siouxland Mental Health Center with any changes to your insurance coverage as they occur. If this is not provided, you will be financially responsible for the services that were provided to you. In the event that your insurance company pays you directly, you are responsible to reimburse Siouxland Mental Health Center for the amount that your insurance company pays you. All payments made to Siouxland Mental Health Center must be by cash or check.

I understand that this will become a part of my service record; information accumulated in the record may be confidentially reviewed by the accrediting agency for Siouxland Mental Health Center. *I authorize Siouxland Mental Health Center to file an insurance claim and receive the payment for services rendered on my behalf.* Some insurance coverage requires copayment and/or a deductible portion, which is due at the time of service.

_____ _____

Print name of client Signature of client/guardian

Date:_____

NO-CALL NO-SHOW POLICY as of April 09, 2018

New patients (new psych evaluations and new therapy): After one no-call no-show appointment, you will need to attend group at least once to be able to reschedule. You can come in and sit in the lobby and wait for a cancellation to be seen. In order to reschedule you need to attend group.

Established patients (psych and therapy): After two no-call no-show appointments with either psychiatry or therapy, or combined, you will lose your scheduling privileges and will be referred to group. Once you have attended one group session, you will be able to schedule again. You can come in and sit in the lobby and wait for a cancellation to be seen. In order to reschedule you need to attend group.

It is the policy of Siouxland Mental Health Center that if you miss a scheduled psychiatric or therapy appointment, you run the risk of being charged. If it is an initial intake appointment with a therapist or a psychiatric evaluation that is missed without canceling 24 hours in advance, the charge will be $50.00. If it is a medication check or a therapy appointment that is missed without canceling 24 hours in advance, the charge will be $25.00. The patient will be responsible for paying this fee.

If you cannot make your appointment, please give us at least a 24 hour notice and with that notice, this will not be considered a no-call no-show appointment.

_____ _____

Print name of client Signature of client/guardian

Date:_____

CONSUMER RIGHTS AND RESPONSIBILITIES

Consumer Rights Policy: The policy of Siouxland Mental Health Center is that all consumers of the center will receive treatment subject to the following protection:

1. Each consumer has the right to participate in the development of his/her treatment/service plan.
2. Services are made available to all Woodbury County residents on an equal basis.
3. Each consumer has the right to assume that all treatment information will be held in confidence and will not be released to anyone unless one of the following situations exists:
    a. Written request is made by a consumer to release portions of file information.
    b. That a court order requires submission of certain file materials.
    c. That, in the opinion of the professional staff members of the center, a life-threatening situation exists.
4. Each consumer of the Center has the right to be fully informed about any risks that might be entailed in treatment or as the result of research studies.
5. Each consumer of the Center has the right to expect treatment with dignity and respect and without unnecessary invasion of privacy.
6. Each consumer has the right to refuse treatment.
7. Each consumer has the right to treatment with as little delay as possible.
8. Only information that is needed to assist the center's professional staff and their treatment process will be obtained from a consumer/guardian.
9. Each consumer has the right to be treated in the least restrictive setting possible.
10. Each consumer has the right to express his/her opinion concerning the services delivered at the Center.
11. Consumers of Siouxland Mental Health Center, and their guardians, have the right to appeal any policy, procedure, or action of Siouxland Mental Health Center in order to adequately protect the consumer's rights.
12. I have voluntarily chosen to receive treatment services by Siouxland Mental Health Center. I understand that I may terminate services at any time.

Procedure:

a. First, the consumer/guardian should attempt resolution with their primary staff.
b. If the issue is not resolved within fourteen days, written statements from the consumer/guardian and the staff person will be submitted to the staff person's immediate supervisor.
c. If the issue is still not resolved, letters from the consumer/guardian, staff, and supervisor and to the Executive Director will be sent to the Chairperson of the Board of Directors for review by the Executive Committee of the Board. The Executive Committee will review the appeal at the next regularly scheduled Executive Committee meeting. The Chair of the Board of Directors will respond to all parties, in writing, within 30 days of the Executive Committee meeting.

Consumer Responsibilities: I understand that in addition to having the rights listed above, I also agree to abide by the following responsibilities. I understand that failure to do so can result in my discharge from services.

1. I will take my medications as prescribed by the doctor to the best of my ability.
2. I will attend all scheduled appointments with my providers. If I cannot attend, I will call 24 hours in advance to cancel.
3. I will attempt to fulfill the goals I have set in my service plan to the best of my ability or, notify my provider if I feel the goal is no longer appropriate.
4. I will treat my worker respectfully and in the same manner that I would like to be treated.
5. I will refrain from abusing drugs and alcohol to the best of my ability.
6. I will contact my provider on a regular basis.
7. I understand that it will be necessary for me to sign documents in order to continue to receive services with Siouxland Mental Health Center.

_____ _____

Print name of client Signature of client/guardian

Date:_____

PSYCHIATRIC ADVANCE DIRECTIVE NOTIFICATION FORM (ADULTS ONLY)

Do you have a Psychiatric Advance Directive Form or a Durable Power of Attorney for Medical Care Form?

Yes No

If yes, do you wish to provide a copy to Siouxland Mental Health?

Yes No

Copy provided to intake person?

Yes No

PRIMARY CARE PHYSICIAN FORM

NAME OF PHYSICIAN:_____

_____ I want you to contact my Primary Care Physician

_____ I do not want my Primary Care Physician contacted

_____ I do not have a Primary Care Physician

_____ _____

Print name of client Signature of client/guardian

Date:_____