

PHOENIX CENTER BEHAVIORAL HEALTH SERVICES APPLICATION

L I E N T I N F O	Last Name:		Suffix:	First Name:	Middle Name:	Maiden Name:
	Street Address:			City:	County:	Zip Code:
	Date of Birth:	Age:	Home Phone:	Work Phone:	Cell Phone:	SS#:
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Method of Payment: <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicaid #: <input type="checkbox"/> Medicare #: <input type="checkbox"/> Insurance #:				
	Religious Preference:			What is the highest grade you completed in school?		
	Race/Ethnicity: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Single Race <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown					
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Other:					
F A M I L Y I N F	Legal/Guardian Information					
	Name:		Relationship: <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Guardian			
	CSP Only: <input type="checkbox"/> Guardian (Ad Litem) <input type="checkbox"/> 1 st Representative <input type="checkbox"/> 2 nd Representative <input type="checkbox"/> Other:					
	Address (If Different from Above):					Home Phone:
	Mother's Name (If Under 18 or as needed):		Address (If different):			Home Phone:
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Separated <input type="checkbox"/> Other:					
	Father's Name (If Under 18 or as needed):		Address (If different):			Home Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Separated <input type="checkbox"/> Other:						

Please review or complete this **Initial Contact Information**.

If we previously received this information from you, please let the Front Staff know if anything has changed.

Please let us know who referred you to Phoenix Center.

Please describe the problems that led you to call or come to Phoenix Center today.

Has the adult/child seeking services injured themselves or others in the past 72 hours? Yes No

Has the adult/child seeking services threatened to harm themselves or others in the past 72 hours? Yes No

Has the adult/child seeking services been hospitalized for mental health or alcohol/drugs in the past 72 hours?
 Yes No

Is the adult/child seeking services currently experiencing any bizarre/unusual behaviors which are causing concern for the family? Yes No

FOR OFFICE STAFF ONLY

Emergency (w/in 3 hrs) Urgent (w/in 24 hrs) Routine (MH w/in 5 days/SA (w/in 3 days))

Consumer Preference Appointment time & Date: _____ With: _____

For CSP Only: Involuntary Voluntary For Department of Juvenile Justice: MH SA

Front Desk Staff who received data print name:	Front Desk Staff who received data signature:	Date:
--	---	-------

Application to Phoenix Center Behavioral Health Services	Client Name: ID# :
---	-------------------------------------

PLEASE PROVIDE THE FOLLOWING INFORMATION SO THAT WE MAY BETTER SERVE YOUR NEEDS.

Were you accompanied by anyone today? No Yes If yes, by whom?

Please list the name of a family member or friend we may contact in the case of an emergency.
Name: _____ **Address:** _____
Phone: _____

Have you ever been a client at Phoenix Center before: No Yes If yes, when:

Physical Disabilities: No Problems Vision Problems Hearing Problems Vision and Hearing Problems Wheelchair Bound Speech Problems Other:

Allergies: No Known Allergies Yes If yes, please list allergies:

Please list any medications that the adult or child client seeking service is currently taking?

Please let us know who your Primary Care Doctor is;	Address:
	Phone #:

Please let us know which Pharmacy you prefer to use:	Address:
	Phone #:

Please let us know which Hospital you prefer to use:	Address:
	Phone #:

I have received a copy of the Phoenix Center Orientation Handbook which explains the, Availability of Services, Confidentiality, Non-Discrimination Policy, Client Rights & Responsibilities, Staff Code of Ethics, Grievance Policy, Purpose of Satisfaction Survey (CSQ-8) etc. I understand that if I have any questions my case manager will explain further.

Consent for Treatment: I hereby apply for services and give my permission to Phoenix Center Behavioral Health Services to provide Medical and psychiatric services as may be indicated for my care and well-being. This permission includes follow-up care by Center staff after my discharge. I understand that I may withdraw this consent at any time.

I authorize the release of any medical information necessary to process claims on my behalf. I also authorize payment of medical benefits to PHOENIX CENTER BEHAVIORAL HEALTH SERVICES for services rendered

Print name of Applicant/Responsible Person:	Signature of Applicant/Responsible Person:	Date:
Print name of Admissions Staff:	Signature of Admissions Staff:	Date:

Application to Phoenix Center Behavioral Health Services	Client Name: ID# :
---	-------------------------------------

Phoenix Center Behavioral Health Services
CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information (“protected health information”) by Phoenix Center BHS (“Center”) in order to carry out treatment, payment, or health care operations. I have been given an opportunity to receive a copy of the full NOTICE of PRIVACY PRACTICES for PROTECTED HEALTH INFORMATION as required by Federal Law.

The Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Center does change the terms of its Notice of Privacy Practices, I will receive a copy of the revised Notice at the next appointment.

I retain the right to request that the Center further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Center is not required to agree to such requested restrictions; however, if the Center does agree to my requested restriction(s), such restrictions are then binding on the Center.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Center in writing. The revocation shall be effective *except* to the extent that the Center has already taken action in reliance on the Consent.

The Center may refuse to provide services if I (or an authorized representative) do not sign this Consent Form (except to the extent that the Center is required by law to treat individuals). If I (or authorized representative) sign this Consent Form and then revoke Consent, the Center has the right to refuse to provide further service as of the time of revocation (except to the extent that the Center is required by law to treat individuals).

I understand that I have the right to request in writing that Phoenix Center communicate with me about my health care only in a certain location or through a certain method.

I hereby authorize Phoenix Center to carry forward an appeal on my behalf, should they so choose, as permitted by law. I understand that this does not obligate or require Phoenix Center to carry forward any such appeal, unless they so choose.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE CONSUMER OR AM AUTHORIZED TO ACT ON BEHALF OF THE CONSUMER TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

If the consumer is a minor for whom a guardian has been appointed, the parent or legal guardian of the consumer must sign this consent, except when exempted by law.

Consumer Signature (if over age 18) Date

Parent/Representative/Legal Signature Date

Witness Signature Date

Please explain Representative's Relationship to Consumer and include a description of Representative's Authority to act on behalf of the Consumer:

Client Name _____

Phoenix Center

CLIENT'S RIGHTS AND RESPONSIBILITIES

Your Rights and Responsibilities include:

The right to receive care suited to your needs
The responsibility to be truthful concerning your needs

The right to receive services that respect your dignity and protect your health and safety
The responsibility to respect the dignity of others and protect their health and safety

The right to participate in planning your own program
The responsibility of working on your individual service plan goals to the best of your ability

The right to refuse services unless a physician or licensed psychologist feels that refusal would be unsafe for you or others.
The responsibility to accept the services offered to you that you need

The right to prompt and confidential services even if you are unable to pay
The responsibility to pay for services, if you are able

The right to review and obtain copies of your records, unless the physician or other authorized staff feels it is not in your best interest.
The responsibility to use the information contained in your records responsibly

The right to exercise all civil, political, personal and property rights to which you are entitled as a citizen.
The responsibility to respect the civil, political, personal and property rights of others

The right to remain free of physical restraints or time-out procedures unless such measures are required for providing effective treatment or protecting the safety of you or others
The responsibility to behave in such a manner that restraints or time-out procedures are not needed

The right to be free of any form of abuse, such as negligence, sexual, psychological, physical, verbal, or financial
The responsibility to not physically or verbally abuse staff or other clients

The right, if you are a residential client, to converse privately, to have reasonable access to a telephone, to receive and send mail, to have visitors and to retain your personal effects and money.
The responsibility of making reasonable requests at reasonable times

The right to file a complaint (without affecting your care at Phoenix Center) if you think any of these rights have been restricted or denied

The right to have/use an advocate in the complaint process
 A client rights advocate will be provided to the client upon request
The responsibility of making truthful complaints

If you want to know more about your rights, a full copy of the Regulations (290-4-9) is available to you upon request. A summary of the Client's Rights Complaint Process is available in your Hand Book.

Client /Guardian Signature	Date
Signature of Reviewing Staff	Date
CLIENT RIGHTS & RESPONSIBILITIES	Client Name:
Page 1 of 1	MHID:

**Phoenix Center Behavioral Health Services
Center Information on Fees and Billing**

1. All services have a standard fee. All clients are responsible for any fees accrued.
2. We expect everyone to pay at time of services rendered. If you need special consideration, please ask and we will work to arrange a reasonable payment plan for you.
3. All active and inactive clients with a balance due will receive a monthly statement. The statement will show either the balance owed or will be an information-only statement. If you have any questions regarding your bill, you may call the number and individual(s) indicated on your statement.
4. For clients who do not have Insurance and/or Mental Health coverage:
The standard fees may be adjusted according to annual household income. This discounted rate may not apply to certain services such as prescriptions, lab tests, and drug screens; therefore, the standard fee is charged for these items. These standard fees are due at the time of service. In order to apply for the discounted rate:
 - a. You must provide evidence of annual household income and information to determine family size.
 - b. Income may be verified using the latest IRS-1040 (A, EZ), W-2(s), pay stubs, or other income documents.
 - c. Without verification of income, your co-payment amount will be the full 100% fee.
5. For clients who do have Insurance and/or Mental Health coverage:
This is including private insurance, Medicaid, and/or Medicare. We will file claims for you. Since in most cases insurance does not pay the entire charge, you are expected to pay the remaining balance. This fee will be due at the time of service. This fee may or may not include your standard co-pay, which is also due at time of service.
 - a. If you have private insurance (including Medicare) you must provide the secretary with a copy of your insurance card and sign an Insurance Authorization Form at your first appointment. You must bring your insurance and/or Medicare card to each and every appointment.
 - b. Should your private insurance decline coverage of any services provided, you will be responsible for the full fee of the service.
 - c. If you have insurance coverage and elect not to use it, you will be charged the full standard fee, which will be due at the time of service.

Client Signature

Date

Guardian Signature

Date

Witness Signature

Date

Information on Fees and Billing	Consumer Name:
Page 1 of 1	Alt ID: