HIGH PLAINS MENTAL HEALTH CENTER
Patient Information - Adult

Name: _____ Age:_____ Date of Birth:_____

Address: _____ Phone: (H)_____ (W) _____

City, State, Zip_____ (Cell) _____

May we correspond by mail, telephone and voicemail (if applicable) at the above HOME address and phone number? ☐Yes ☐No
May we correspond by telephone and voicemail (if applicable) at the above WORK address and phone number? ☐Yes ☐No
May we correspond by mail, telephone and voicemail (if applicable) at the above CELL phone number? ☐Yes ☐No

If not, where may we contact you? The home address listed above will be used for all correspondence unless an alternate address and phone is given below:
Address _____ Phone _____
_____ Whose address & phone is this?_____

GENDER
☐Male
☐Female
☐Transgender Male to Female
☐Transgender Female to Male

ETHNICITY
☐Hispanic or Latino
☐Not Hispanic or Latino

MARITAL STATUS
☐Never Married
☐Married
☐Divorced
☐Separated
☐Widowed

RACE
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White
☐Other

ELIGIBILITY FOR SSI OR SSDI
☐Not Applicable
☐Eligible and Receiving Payment
☐Eligible but not Receiving Payment
☐Potentially Eligible
☐Determined to be Ineligible by Review and Decision
☐Determination Decision on Appeal

MILITARY STATUS ☐No Service ☐Active Duty ☐Reserves ☐National Guard Are you currently serving? ☐Yes ☐No

BRANCH (Check all that apply) ☐Army ☐Air Force ☐Navy ☐Marines ☐Coast Guard

DO YOU WORK IN ANY AGRICULTURE-RELATED INDUSTRY, SUCH AS FARMING, RANCHING, DAIRY, CUSTOM HARVESTING, FARM SUPPLY OR EQUIPMENT SALES, ETC.? ☐Yes ☐No

TOBACCO/NICOTINE USE ☐Never Used ☐Have Used/Not Current User ☐Occasional User ☐Regular User ☐Use Smokeless Tobacco

PRIMARY LANGUAGE _____

RELIGIOUS/SPIRITUAL AFFILIATION _____

What is your occupation?_____

Highest grade level completed:_____

Recent History of Present Situation

Who referred you to us?_____

Please describe the problems you are concerned about:

_____

_____

_____

How long has this been troubling you?_____

Did you have any psychological/emotional problems growing up? ☐Yes ☐No If yes, explain:

_____

_____

Family history of mental illness? ☐Yes ☐No (e.g. depression, schizophrenia, etc)

If yes, please explain:_____

_____

Family history of substance abuse? ☐Yes ☐No

If yes, explain:_____

_____

Have you experienced any current or past abuse and/or neglect? (Victim or Perpetrator) ☐Yes ☐No
If yes, please explain:_____

_____

Have you experienced any current or past problems with alcohol or other substance use? ☐Yes ☐No

If yes, please explain:_____

_____

Current medications/dosage:_____

_____

Current physical/medical health conditions_____

_____

Please list all **PREVIOUS** (Mental health and/or Substance Abuse) treatment you have received (including all High Plains MHC facilities):

Facility	Location (City, State)	Type of Care (Inpatient, Outpatient, Substance Use)	Dates (if known)

Please list all drug allergies and adverse reactions you have had to medications:

Name of Drug:	Type of Adverse Reaction:

Name of Primary Care Physician/Clinic: _____

In emergency, who can we notify? Name _____ Relationship _____
Street Address _____ Home Phone _____
City _____State _____Zip _____ Business Phone _____

Form Completed by:_____ Date:_____

For Office Use Only:
Reviewed By: _____ Initials for additions:_____ Date: _____

High Plains Mental Health Center
Adult Entry Client Status Report

Name: _____ **DOB:** _____

Current Educational Status:

_____ Attending College (1-6 hours)
_____ Attending College (7 or more hours)
_____ Attending Vocational school or apprenticeship, vocational program, (CNA training)
_____ Basic Educational skills
_____ Working on English as a second language
_____ Working on GED
_____ No educational participation
_____ Other (specify: _____)
_____ Pre-Educational explorations
_____ Avocational Educational involvement

Current Vocational Status:

_____ No Vocational Activity
_____ Prevocational Activity
_____ Screening & Evaluation of vocational interests & abilities
_____ Active Job Search
_____ Participating in a Sheltered work program/sheltered employment
_____ Employed in Transitional Employment
_____ Participating in ongoing volunteer activity
_____ Any person who remains home to take care of children or others
_____ Any job or set of jobs requiring LESS than 30 hours per week
_____ Any jobs or set of jobs requiring MORE than 30 hours per week
_____ Other (Specify: _____)
_____ Retired

Current Residential Arrangement:

_____ Nursing Home
_____ NFMH
_____ Group Home
_____ Boarding Home
_____ Lives w/ relatives – DEPENDENT
_____ Lives w/ relatives – INDEPENDENT
_____ Supervised Housing Program
_____ Independent Living
_____ Other (Specify: _____)
_____ Precariously Housed
_____ Homeless

Form Completed by:_____ Date:_____

HIGH PLAINS MENTAL HEALTH CENTER
TREATMENT PLAN SIGNATURE PAGE

Patient Name: _____ Date of Birth:_____

My signature below indicates that the treatment plan dated _____has been discussed with me and that I have been involved in developing it.

_____ _____
Signature of Patient or Representative Date

HIGH PLAINS MENTAL HEALTH CENTER
FEE AND PAYMENT AGREEMENT
INSURANCE AUTHORIZATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Patient Name _____DOB _____Soc. Sec. #* _____ Entry Date _____
Patient Address _____ City _____ State _____ Zip _____
Responsible Person _____Relationship_____ DOB _____ Soc. Sec. #*_____
Mailing Address _____City _____ State _____ Zip _____
Cell Phone _____Home Phone _____Work Phone_____
Please list any payers including but not limited to **Insurance, Medicaid, EAPs**. List name of policy holder and DOB if other than patient.
Payer Name _____ Policy Holder Name and DOB _____
Payer Name _____ Policy Holder Name and DOB _____
Payer Name _____ Policy Holder Name and DOB _____

I request that payment be made on my behalf to High Plains Mental Health Center for services provided, under the medical direction of Center physicians, during the treatment period that commenced on the above date. I authorize High Plains Mental Health Center to release to the above listed entities or their agents, and every insurance plan that I have coverage under during the course of treatment, any information needed to determine these benefits or the benefits payable for related services. I understand that the purpose of this disclosure is to determine eligibility and payment for services. I understand I may revoke this consent at any time except for information that has already been sent. Unless I revoke it earlier, this consent will expire when claims for all services provided to me have been settled. *Denotes optional field

Kansas Medical Assistance Program: I understand that I am responsible for non-covered services which may include but not limited to: -services provided when consumer was not eligible for Medicaid; the consumer was eligible when services were provided, however, did not inform the provider of his/her Kansas Medical Assistance Program eligibility timely; services Medicaid does not cover such as court appearances, telephone conferences/therapy, services in excess of Medicaid allowed benefits, and psychotherapy for patients whose only diagnosis is mental retardation.

CHECK ONE: COMPLETE THIS SECTION EVEN WHEN YOU HAVE INSURANCE OR A MEDICAL CARD

☐ I do NOT LIVE in the 20 county area served by High Plains Mental Health Center and understand I am not eligible for a sliding scale fee.
☐ I live in _____county and wish to apply for a sliding scale fee based on financial information which I have provided below.
☐ I live in _____county and do not wish to apply for the sliding scale fee. I am willing to pay the usual and customary fee for services.

Total Family Income per year (Gross Pay before taxes and other deductions) $_____
If self employed, how much did you use for all family expenses during the year? $_____
How many people are supported by your family income? _____

High Plains Mental Health Center is supported by patient fees and funds from state and local government. Your fee is based upon financial information certified by you. The Percent of Reduction will be applied to charges on the account. Failure to provide required information on insurance coverage will void the Percent of Reduction and charges will become payable at the Center's usual and customary charge. The Center reserves the right to adjust its usual and customary charge. Your Percent of Reduction will expire upon discharge. High Plains provides services throughout the 20 county area. All statements are mailed from the Hays Office.

To the best of my knowledge, the above information is true and correct. I agree to pay for outpatient services at each visit or, if I have insurance, upon receipt of statement indicating the balance due, and to pay Woodhaven Community Support Services monthly upon receipt of statement indicating the balance due. I further understand that should benefits be denied or fees not be fully covered by my insurance, I am responsible for payment of any balance due in accordance with this agreement. If unable to follow this policy, I am responsible for contacting the Insurance Department (785) 628-2871. The Responsible Person of SMI, SPMI or SED patients may request a special fee agreement beyond the sliding fee reduction when extenuating circumstances exist. If the request is denied the consumer or responsible person may file a complaint with the Manager of Quality Improvement. No one will be denied necessary and appropriate services that the Center is required to provide by K.A.R. 30-60-64, solely because of the patient's inability to pay the fees charged by the center for those services. The Center reserves the right to refer delinquent accounts to a professional collection agency and/or the Center's attorney.

I have read and understand the terms of the Fee and Payment Agreement and agree to pay for services provided by High Plains Mental Health Center to the patient listed above according to these terms.

I have received a copy and a verbal explanation of the Center's Insurance, Billing, and Payment Policies, including treatment service fees.

_____ _____
Date Signature of Responsible Person

OFFICE USE ONLY: Percentage of Reduction_____ Initials _____

*Notice To Whomever Records are Disclosed: These records are protected by Federal Regulations (42 C.F.R. Part 2) and Kansas Statutes. Any further disclosure of this information is PROHIBITED. 01/2022 P112

HIGH PLAINS MENTAL HEALTH CENTER

PATIENT SERVICES AND CONSENT FOR TREATMENT AND EVALUATION

THE FOLLOWING SERVICES ARE AVAILABLE (BASED ON MEDICAL NECESSITY) THROUGH HIGH PLAINS MENTAL HEALTH CENTER

Diagnostic Evaluation	Individual Counseling	Conjoint/Marital Counseling
Family Counseling	Group Counseling	Psychiatric Assessment
Medication Services	Attendant Care	Community Psychiatric Support Treatment
Crisis Intervention	Crisis Stabilization	Psychosocial Rehabilitation – Ind or Group
Targeted Case Management	Respite Care	Screening/Concurrent Utilization Review
Competency to Stand Trial Evaluation	Psychological Testing/Evaluation	Parent Support & Training – Ind or Group
Independent Living Skill Building	Peer Support – Ind or Group	Professional Resource Family Care
Substance Use Assessment	Individual Substance Use Counseling	Group Substance Use Counseling

Language interpretation services are available as required when identified by patient and/or High Plains staff.

CONSENT FOR SERVICES AT HIGH PLAINS MENTAL HEALTH CENTER

Identified Patient: _____ DOB:_____

Knowing my rights and the services available:

ADULT SEEKING SERVICES (Check box and sign below):

☐ I hereby consent to receive treatment or an evaluation at High Plains Mental Health Center.

☐ I am the legal guardian of the above named Identified Patient, who is 18 or older, and I hereby give my permission for him/her to receive treatment or an evaluation at High Plains Mental Health Center. (You must provide HPMHC the appropriate court document.)

CHILD SEEKING SERVICES (Check box and sign below) :

☐ I am the parent or legal guardian of the above named Identified Patient, who is under age 18, and I hereby give my permission for him/her to receive treatment or an evaluation at High Plains Mental Health Center.

IN THE MATTER OF DIVORCE OR OTHER LEGAL ORDERS OF CUSTODY: **(Check One)**

☐ I share joint custody of this child with: Name_____

Address_____

City, State Zip _____

(A letter will be sent to the second parent notifying them of the request for services and an invitation to participate in services.)

☐ I have sole custody of this child.

MINOR CONSENTING FOR HIS/HER OWN SERVICES (Check box and sign below):

☐ I am 14-17 years of age and hereby consent to receive treatment or an evaluation at High Plains Mental Health Center. I understand that, per KSA 59-29b49, I must authorize High Plains Mental Health Center to notify my parent or legal guardian that I have sought services.

Initial and Date on each line below. Please use the full date on each line: MM/DD/YY

_____ __/__/___I have received a copy and verbal explanation of and understand the **Rights and Responsibilities** brochure.

_____ __/__/___I have received a copy and verbal explanation of the Notice of Information and Privacy Practices, and I consent to the use and disclosure of protected health information as described in the **Notice of Information and Privacy Practices**.

_____ __/__/___I have received a copy and verbal explanation of and understand the Grievance Procedure as outlined in the **Rights and Responsibilities** brochure and the Notice of Information Privacy Practices.

SIGN HERE: _____ Relationship: _____ Date: _____

Printed Name of Person Authorized to Sign _____

Internal Use Only:

The above signed has stated that (s)he/they has/have an understanding of their rights and meet the signature requirements. Per K.S.A. 59-2949, I have determined that (s)he/they has/have the capacity to make the decision for treatment.

Therapist: _____ Date: _____

HIGH PLAINS MENTAL HEALTH CENTER
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

High Plains Mental Health Center Attn: Medical Records 208 E 7th Street Hays, KS 67601 Ph (785) 628-2871 Fax (785) 628-0330

Type of Release (please mark either or both): ☐ Release To ☐ Obtain From

Name _____

Address _____

_____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

I hereby authorize the disclosure of information checked below from the records of:

Name: _____ DOB: _____ SSN (last 4 digits): _____

The type and amount of information to be used or disclosed is as follows:

☐ Entry/Admission Report
☐ Discharge Report
☐ Psychological Evaluation
☐ Treatment Plan
☐ Verbal or written notes/reports re: Medication Evaluations/Reviews
☐ Notification letter of the date of my admission into and discharge from services.
☐ Verbal or Written Progress Reports/Consultations
☐ Medical History, Lab Results, X-Ray
☐ Medications
☐ All of my Substance Use Disorder Records
☐ Insurance/Billing
☐ Documentation of Diagnosis
☐ Other _____

All of the records authorized above may be released unless actual dates of treatment are specified here: _____

It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Payment ☐ Legal ☐ Continuity of Care
☐ Other (specify)_____

* I understand my records may include information regarding alcohol or drug treatment, HIV testing, HIV status, or AIDS.
* I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization will automatically expire ninety days following termination of services unless otherwise specified: _____
* I understand that information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by federal privacy laws.
* I understand that High Plains Mental Health Center will not condition treatment on my signing this authorization.

Signature of Patient _____ Date _____

Signature of Legal Representative _____ Date _____

Printed Name of Signee Relationship

* Notice To Whomever Records are Disclosed: These records are protected by Federal Regulations (42 C.F.R. Part 2) and Kansas Statutes. Any further disclose of this information is PROHIBITED.

HIGH PLAINS MENTAL HEALTH CENTER
CONSENT FOR TELEVIDEO CONFERENCING SERVICES

INTRODUCTION TO TELEVIDEO CONFERENCING
PATIENT INFORMATION

Welcome to High Plains Mental Health Center's televideo conferencing services. You will be participating in a live interview between you and a provider of services using the interactive video system. This system allows patients and providers to see and talk with each other much as if we were in the same room.

There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. High Plains has taken precautions to secure these communications and minimize the risks. You or the High Plains provider can discontinue the televideo conference if it is felt that the videoconferencing connections are not adequate for the situation. Nothing is recorded unless we obtain your separate consent.

From time to time you may notice the camera make noise or move from side to side. This camera activity is normal. The provider on the other end may be adjusting the camera to get a different view of you.

If the psychiatrist or nurse practitioner decides you need a prescription or prescription refill, it will be submitted to the pharmacy of your choice. If the prescription is a controlled substance and cannot be called in by telephone or electronically submitted, a written prescription will be mailed to you, to the pharmacy, or to the High Plains office where you are using the system. The provider will work out the details which best fit your needs at the time the decision is made.

A progress note describing the interview will be written just as it is when you are seen face-to-face by the provider. This note will be placed in your medical record.

Charges for services using televideo conferencing technology will be billed to you in the same manner as if the services were delivered face-to-face by the provider. Charges for services will be billed to you at our usual and customary rate and your sliding scale fee reduction will be applied. If you have insurance, we will bill your insurance carrier first and then apply your sliding scale fee rate to any balance that is not paid for by insurance.

Medicaid and Blue Cross/Blue Shield have indicated they will cover services delivered utilizing televideo conferencing technology in the same manner as if those services were delivered face-to-face. Medicare covers individual psychotherapy, pharmacologic management and psychiatric diagnostic interviews delivered through the use of televideo conferencing technology as long as a qualified provider is providing the service. Other third party insurance carriers may or may not cover services delivered over the interactive video system depending on the particular insurance carrier and the specific insurance plan. We would be glad to contact your insurance carrier upon your request to determine what coverage you may have regarding televideo conferencing services.

You do have the option to refuse televideo conferencing services and retain the option of receiving face-to-face care based on available resources.

Your comments or feedback about the televideo conferencing system are welcome. Should you have any comments, please share them with your therapist or a receptionist.

----------Consent for Services over the Televideo Conferencing System----------

By signing this form, I consent for me, my child or my ward to receive services via the televideo conferencing system at High Plains Mental Health Center. I also affirm by signing this form that I will be responsible for payment of any balance due for services delivered using the interactive system and agree to pay the Center's current rate for the service that I receive.

Printed Patient Name:_____ DOB:_____

Signed: _____ Date: _____

Staff Signature: _____ Date: _____

Client Name: ID:

High Plains Mental Health Center
E-Mail/Electronic Communication Consent

High Plains Mental Health Center (HPMHC) discourages the use of email and text messaging to communicate about your medical matters because it is not a secure method of communication, information could potentially be sent to the wrong person, it may not be the timeliest method of communication and it is dependent on technology which may or may not work all of the time. However, there are instances where email and text communication are permissible.

Email

With your consent, email can be used:

- For HPMHC to provide forms to me, and for me to return completed forms,
- To provide resources to me to assist in my treatment,
- To submit necessary business office documents (such as insurance paperwork, copies of insurance cards, etc).

Text Messaging

Text messaging is used by HPMHC to send next day appointment confirmations. If you do not want to receive text message appointment confirmations you will be able to "opt out" of this service by responding to the first text message confirmation you receive.

With your consent, text messaging is also allowed for:

- Scheduling and canceling appointment times with community-based service providers,
- Surveys,
- To reduce communication barriers in pre-approved, specific situations.

I understand that email communication should not be used for emergencies or for communicating time sensitive information. In the event of an emergency I should call HPMHC at (800) 432-0333 or (785) 628-2871 or dial 911. To communicate emergent or time sensitive information I should directly contact the office of my healthcare provider.

I further understand that email communication and text communication should not be used for any additional purposes not described above. Communication should occur by phone, in writing, or by talking to my healthcare provider during a scheduled session.

I understand that due to situations outside of the control of HPMHC, internet and email service may be interrupted or not work at any given time. HPMHC is not responsible for technical failures.

I will not share, distribute, release or sell my healthcare provider's e-mail address to anyone.

I understand that email communication is not a substitute for medical care and evaluation. I must arrange for an office appointment to assure appropriate care.

Client Name: ID:

I understand that I am to provide my full name and contact phone number in all e-mails.

I understand and accept that my provider may route my e-mail to other members of the staff of HPMHC for informational purposes or for expediting a response. I authorize my provider to send and designate staff within HPMHC to receive and read my e-mail.

I acknowledge that commonly used e-mail services are not secure and fall outside the security requirement of set forth by the Health Insurance Portability and Accountability Act for the transmission of protected information. Therefore, I understand there is a risk that my health information may be obtained by others not affiliated with my provider. I authorize my provider to communicate with me as described above by email or text messaging even though email and text messaging may not be secure and private and may be subject to loss or exposure.

I acknowledge and accept that my healthcare provider can terminate e-mail or text communication at any time. I understand that I am responsible for notifying HPMHC if I choose to discontinue email or text communication or if my email address or cell phone number has changed.

I ☐ approve ☐ do not approve email as a form of communication for the purposes described above.

If approved, provide email address: _____

I ☐ approve ☐ do not approve text messaging as a form of communication for the purposes described above. (If you do not want to receive automated appointment confirmation texts you will be required to opt out of that system upon receipt of your first confirmation text.)

If approved, provide cell phone number: _____

Client or Guardian Signature	Date
Print Name	Relationship if other than client