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

DOES ANY PORTION OF YOUR HOUSEHOLD INCOME COME FROM 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 _____

Are you currently employed? ☐Yes ☐No
If yes, what is your occupation?_____
If no, are you interested in working/seeking employment? ☐Yes ☐No
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
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 Progress Reports/Consultations
☐ Medical History, Lab Results, X-Ray
☐ Medications
☐ All of my Substance Use Disorder Records
☐ Insurance/Billing
☐ Documentation of Diagnosis
☐ Other _____
_____
☐ Verbal or written notes/reports re: Medication Evaluations/Reviews
☐ Notification letter of the date of my admission into and discharge from services.

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.

Patient 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.

Patient 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

ID:

HIGH PLAINS MENTAL HEALTH CENTER

Supplemental Integrated Healthcare Patient Information Form for Individuals 12 and up

HPMHC provides integrated healthcare and primary care screening services to CCBHC clients. Our goal is to assist our clients in improving overall health and wellness. Please take a minute to answer the questions below to provide us a preliminary assessment of risk for a variety of factors such as diabetes, heart disease, HIV, and tuberculosis. Your overall health and wellness is important to us!

Name: _____ Date of Birth: _____

Date Form Completed: _____

1. Do you have either of the following conditions?

☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Heart Problems (examples include heart attack, stroke, congestive heart failure, rhythm abnormalities, high blood pressure)

2. Please mark yes or no to the following questions:

☐ Yes ☐ No ☐ N/A	Have you or your sexual partner (s) had other sexual partners in the past year?
☐ Yes ☐ No ☐ N/A	Have you ever had a sexually transmitted disease?
☐ Yes ☐ No ☐ N/A	Are you pregnant or considering becoming pregnant?
☐ Yes ☐ No ☐ N/A	Have you or your sexual partner (s) injected drugs or other substances and/or shared needles with another person?
☐ Yes ☐ No ☐ N/A	Have you ever had sex with a male partner who has had sex with another male?
☐ Yes ☐ No ☐ N/A	Have you ever had sex with a person who is infected with HIV, Hep A, Hep B, or Hep C?
☐ Yes ☐ No ☐ N/A	Have you ever been paid for sex and/or had sex with a prostitute/sex worker?
☐ Yes ☐ No ☐ N/A	Have you shared a toothbrush, razor, or any other item that might have blood on it (visible or not) with a person who has HIV, Hep A, Hep B, or Hep C?
☐ Yes ☐ No ☐ N/A	Have you engaged in behavior resulting in blood to blood contact (e.g. S&M, tattooing, piercing)?
☐ Yes ☐ No ☐ N/A	Have you or your sexual partner(s) received a blood transfusion or blood products before 1985?
☐ Yes ☐ No ☐ N/A	Have you been a victim of rape, date rape or sexual abuse?
☐ Yes ☐ No ☐ N/A	Have you had a temporary or permanent residence of greater than 1 month in a country with a high TB rate?
☐ Yes ☐ No ☐ N/A	Do you have a current or planned immunosuppression?

ID:

☐ Yes ☐ No ☐ N/A	Are you a close contact with someone who has had infectious TB disease since the last TB test?
☐ Yes ☐ No ☐ N/A	Have you ever injected illegal drugs, including those who injected once or a few times many years ago and do not consider themselves drug users?
☐ Yes ☐ No ☐ N/A	Have you received clotting factor concentrates produced before 1987?
☐ Yes ☐ No ☐ N/A	Have you received blood or organs before July 1992?
☐ Yes ☐ No ☐ N/A	Have you been notified that you received blood from a donor who later tested positive for HCV infection?
☐ Yes ☐ No ☐ N/A	Have you ever been on chronic hemodialysis?
☐ Yes ☐ No ☐ N/A	Have you had a persistently abnormal alanine aminotransferase (ALT) level?
☐ Yes ☐ No ☐ N/A	Were you born to an HCV-positive mother?
☐ Yes ☐ No ☐ N/A	Do you have human immunodeficiency virus (HIV) infection?
☐ Yes ☐ No ☐ N/A	Have you had a needle-stick injury or mucosal exposure to HCV-positive blood?

3. Have you had the following vaccines?

☐ Yes ☐ No ☐ Unsure	COVID-19
☐ Yes ☐ No ☐ Unsure	Flu
☐ Yes ☐ No ☐ Unsure	Pneumonia
☐ Yes ☐ No ☐ Unsure	Hepatitis A
☐ Yes ☐ No ☐ Unsure	Hepatitis B
☐ Yes ☐ No ☐ Unsure	Shingles

4. What pharmacy do you use?

   Name: _____ Location (City): _____

5. Who is your primary care physician? (Where do you go when you are sick?)

   Name: _____ Location (City): _____

_____

Signature of Individual Completing Form

Patient Name: _____ Patient ID: _____

High Plains Mental Health Center
Consent for Outpatient Treatment

Consent for Outpatient Treatment

I hereby consent to an initial assessment and subsequent treatment subject to my ongoing involvement in providing consent. The purpose of the assessment is to determine my current mental health and/or substance use needs and to develop treatment recommendations. I understand that if I wish to accept treatment I have the right to have the risks and benefits of treatment options, including not having any treatment, explained to me.

I understand that I may at any time refuse any intervention in which I do not wish to participate. This consent is voluntary and I can withdraw my consent to treatment at any time.

Consent to Participate in Telemedicine Services

To better serve the needs in the community, some behavioral and substance use health care services are now available by interactive video communications, often referred to as "telemedicine". Limited services may also be available by telephone. Using telemedicine, you may be evaluated and treated by a provider from a distant location.

- The provider at the distant location is licensed in the state of Kansas, and you will be informed as to what type of license they have.
- You will be informed if any additional personnel are present at the distant location and will have a chance to request that they not be present.
- Health care providers will have access to your mental health and substance use records, and will document your service just as when you are seen for a face-to-face service.
- Your privacy and confidentiality will be protected. There are potential risks to telemedicine technology, including interruptions, unauthorized access and technical difficulties. High Plains has taken precautions to secure those communications and minimize the risks.
- Charges for services using televideo conferencing or telephone technology will be billed to you in the same manner as if the services were delivered face-to-face. Charges 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.

Your participation in telemedicine is voluntary, and you may refuse to participate or decide to stop participation at any time. If you refuse to participate or decide to stop participation, you may seek traditional behavioral health care services through High Plains Mental Health Center (if available) or another provider of your choice. This could result in delays in service, need to travel, or the risks associated with having a delay in behavioral health care services.

_____ I consent to the use of telemedicine.

Notifications

_____ I have been given a verbal explanation and copy of High Plains Mental Health Center's Rights and Responsibilities Brochure, and understand the Grievance Procedure as outlined in the brochure.

_____ I have been given a verbal explanation and copy of High Plains Mental Health Center's Notice of Information and Privacy Practices.

_____ I have been given a copy of High Plains Mental Health Center's Billing, Insurance and Payment Policies which includes treatment service fees.

Patient Name: _____ Patient ID: _____

ADULT SEEKING SERVICES (Initial and sign below):

_____ I hereby consent to an initial assessment and subsequent treatment at High Plains Mental Health Center.

_____ I am the legal guardian of the Identified Patient, who is 18 or older, and I hereby give my permission for him/her to receive an initial assessment and subsequent treatment at High Plains Mental Health Center. (Please provide HPMHC the appropriate court document.)

CHILD SEEKING SERVICES (Initial and sign below):

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

IN THE MATTER OF DIVORCE OR OTHER LEGAL ORDERS OF CUSTODY: **(Initial 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 (Initial and sign below):

_____ I am 14-17 years of age and hereby consent to receive an initial assessment and subsequent treatment 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.

Printed Name of Patient **OR** Printed Name of Representative Relationship to Patient

Signature of Patient Date

Signature of Representative Date

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 KSA 59-2949, I have determined that (s)he/they has/have the capacity to make the decision for treatment.

Signature of HPMHC Representative

Date