

## TREATMENT AGREEMENT, CONSENT & ACKNOWLEDGEMENT

### What to expect:

**First appointment:** Your first visit will be with an admissions therapist who will provide a behavioral health assessment. At the end of this assessment, you and the therapist will discuss what services make sense. You will be assigned to a clinical provider who will be your clinical care coordinator. Your next appointment will be scheduled before you leave. You are welcome and encouraged to include friends and/or family at any point in your treatment process (with your written permission).

- **Clinical care coordinator:** This professional could be a therapist, a case manager, or other clinical provider, **based on the level of care you need** and agree to. You will participate in the development of your treatment plan with your clinical care coordinator. This treatment plan is your “map of care” that includes specific goals and milestones that you want to accomplish. This will also include clinical advice on when you can expect treatment to be complete. You will discuss what types of services will help you reach your goals. Your clinical care coordinator may also refer you for an appointment with a psychiatrist or a clinical nurse specialist at AllHealth Network to discuss medication.
- **Medical services:** As a health care agency, AllHealth Network expects frequent coordination with your primary care physician. In addition, if the psychiatrist or advanced practice nurse prescribes medications, there will be close monitoring and communication between you, the clinical care coordinator and our medical staff.
- **Completing treatment:** Our goal is for you to succeed in your treatment. When you and your care team determine that you have met your treatment goals and treatment is no longer indicated, your clinical care coordinator will discharge you from AllHealth Network care and provide referrals for aftercare if needed.
- **Scheduling:** AllHealth Network offers services at various locations and hours. We work to accommodate your scheduling needs to the best of our ability; however, your appointment may be during school or work hours. Please contact 303-730-8858 at least 2 business days in advance if you need to cancel or reschedule an appointment so that we can schedule another client.
- **Missed appointment:** Please call to cancel any appointments you are unable to keep. If you don’t attend a scheduled appointment, we will call you to follow up. We want to know what the situation was that kept you from attending and work with you to solve problems, remove barriers, address your concerns, and attend to your recovery goals quickly and with exceptional care.
- **Exceptional care and staying in touch:** Please notify AllHealth Network of any changes in your telephone number, address, and/or your insurance coverage immediately, by calling 303-730-8858. If you are unhappy with services, please communicate this to any of your providers so we can find solutions to your concerns. You may also call the AllHealth Network Client Representative at 303-347-6405, who will work with you to resolve any concerns that you may have.
- **Client decision to stop treatment:** If you decide to stop treatment before your goals are met, please contact us so we can close your chart. If you stop treatment without contacting us, we will notify you by letter that we are discharging you and provide information about resources outside of AllHealth Network. With your written permission, we will send your records to a new provider. If you are being prescribed medications, we can provide a plan for safely stopping medications. You may contact us to request a limited prescription (generally 30 days) while you find another provider. Your primary care physician may be able to continue to provide you with medication services. Discharging from AllHealth Network means you will not be able to receive any further behavioral health treatment or medication. If you would like to start treatment again please call our Admissions Department at 303-730-8858.

# Advance Directives

## What is an Advance Directive?

According to CMS-2104-F, Section 438.6(i)(1) and Colorado State law CRS 15-18.101-113, every competent adult has the right to make determinations on medical treatments, including the right to accept or refuse medical care and to exercise an Advance Directive. Advance directives are instructions written by you that inform your physician of your preferred treatment in the event of your incapacitation. It also allows you to designate a medical decision maker to make choices for you in the event that you are unable.

These laws require us to ask if you have an Advance Directive. While we are not able to assist you with completing advance directives, we will provide you with information and resources to support your decision making process.

## Colorado Recognizes These Advance Directives:

**Living will** – (also known as Declaration as to Medical Treatment) This document tells your doctor how to proceed with life sustaining measures if you have a terminal illness or are in a persistent vegetative state and are unable to communicate your wishes. A living will also allow you to designate organ donation and the designation of your remains in the event of your passing.

**CPR Directive** –Allows for you to make your wishes known as to which methods, if any, you would like performed in the event your heart or breathing stops.

**Medical Durable Power of Attorney** – Allows for you to appoint a decision maker in the event you are terminally ill and unable to make your wishes known. The appointed decision maker would be designated as your “agent” and is expected to make decisions about your care when you are no longer able.

**Proxy Decision Maker** – Allows for the appointment of a designated decision maker if one has not already been appointed in the event you are unable to make decisions for yourself.

## AllHealth Network and Advance Directives

Advance directives are not a requirement for you to receive care at AllHealth Network. It is your responsibility to provide your advance directive to AllHealth Network. If you provide us with your advance directive, AllHealth Network will provide care according to your written wishes, except as recognized in the Colorado Medical Treatment Decision Act (C.R.S. 15-18-102). You may amend or revoke an advance directive by informing the AllHealth Network privacy officer in writing to 155 Inverness Drive West, Englewood CO 80221.

## If your provider refuses to honor your advance directives you can:

- Call BHI about your concerns at: (303) 361 – 8100
- Call the Colorado Department of Public Health and Environment at: (303) 692-2980
- Or write to: Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver CO 80246-1530 or go to this website: <http://www.colorado.gov/cs/Satellite/CDPHE-EM/CBON/1251589738636>

This document is for your information only. It is not legal advice about advance directives. If you have questions, please consult an attorney who has experience with advance directives. You can visit [www.coloradoadvancedirectives.com](http://www.coloradoadvancedirectives.com) for additional information on creating advance directives.



**ALLHEALTH NETWORK CONSENT**

\_\_\_\_\_ Yes \_\_\_\_\_ No **Consent for treatment:** I voluntarily consent to evaluation and treatment for myself, or my minor child or ward, by qualified health care providers at AllHealth Network. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment. I understand that I have the right to consent to, or refuse to consent to, a proposed treatment and have the right to a second opinion regarding my diagnoses and my individualized course of treatment.

\_\_\_\_\_ Yes \_\_\_\_\_ No **Consent for follow-up contact:** I grant permission to the staff of AllHealth Network to contact me after my discharge from your services to obtain information for follow-up purposes only. All information obtained by AllHealth Network will be confidential, as defined by state and federal laws and regulations.

\_\_\_\_\_ Yes \_\_\_\_\_ No **Consent for telepsychiatry services:** Should I need psychiatric services at an AllHealth Network site where a prescriber is not at the same location, I grant permission to the staff at AllHealth Network to utilize telepsychiatry services. Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the client are not in the same physical location. The interactive electronic systems used in telepsychiatry incorporate network and software security to protect the confidentiality of client information and audio and visual data. I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry. I understand that the technology used by the prescriber is encrypted to prevent the unauthorized access to my private medical information. I understand that my withdrawal of consent will not affect any future care or treatment. I understand that the prescriber has the right to withhold or withdraw their consent for the use of telepsychiatry during the course of my care at any time as well.

\_\_\_\_\_ Yes \_\_\_\_\_ No **Do you have an advance directive?** Advance directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. If you wish, we can put a copy of your advance directives into your medical file. If you do not, you are welcome to talk with your primary care provider or call your insurance or Medicaid organization.

**By initialing below I am acknowledging that I have been given/offered a copy of the following:**

- \_\_\_\_\_ AllHealth Network Welcome Letter and copies of all signed documents
- \_\_\_\_\_ Treatment Agreement, Consent & Acknowledgement
- \_\_\_\_\_ Notice of Privacy Rights, including Confidentiality of Alcohol and Drug Use
- \_\_\_\_\_ Client Financial Information and Policy

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Client Date of Birth

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness of Arapahoe/Douglas Mental Health Network

\_\_\_\_\_  
Date



## DEMOGRAPHICS FORM

<b>Client name:</b> _____		<b>Date of birth:</b> ____/____/____	
<b>Race</b> (select all that apply): <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Declined		<b>Hispanic Ethnicity:</b> <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Declined <input type="checkbox"/> Not Applicable	
<b>Marital Status:</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Married, separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<b>Gender</b> that the client identifies with: <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Living Arrangement:</b> <input type="checkbox"/> Alone <input type="checkbox"/> With mother <input type="checkbox"/> With relatives <input type="checkbox"/> With partner/significant other <input type="checkbox"/> With father <input type="checkbox"/> With guardian <input type="checkbox"/> With spouse <input type="checkbox"/> With sibling(s) <input type="checkbox"/> With unrelated person(s) <input type="checkbox"/> With children <input type="checkbox"/> Foster parent(s)		<b>Sexual Orientation:</b> <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> Declined	
<b>Family Members in the Home</b> <b>Name(s):</b> _____ _____ _____ _____ _____		<b>DOB or Age</b> _____ _____ _____ _____ _____	(circle) <b>M or F</b> _____ <b>M or F</b> _____ <b>M or F</b> _____ <b>M or F</b> _____ <b>M or F</b> _____
<b>Emergency Contact:</b> <i>(You must also complete a Release of Information form)</i> _____ Name		_____ Relationship	<b>Phone:</b> _____ _____
<b>Medical Decision-Making Authority for minors</b> _____ Name _____ Name		_____ Relationship _____ Relationship	
<b>Place of Residence:</b> <input type="checkbox"/> Independent living <input type="checkbox"/> Inpatient <input type="checkbox"/> Halfway house <input type="checkbox"/> Boarding home (adult) <input type="checkbox"/> Foster home (youth) <input type="checkbox"/> Residential facility (MH adult)		<input type="checkbox"/> Correctional facility <input type="checkbox"/> Supported housing <input type="checkbox"/> Residential treatment/group <input type="checkbox"/> Homeless <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted Living	
<b>Current Primary Role</b> <input type="checkbox"/> Employed (Full time 35+ hours/week) <input type="checkbox"/> Employed (part time ≤ 35 hours/week) <input type="checkbox"/> Unemployed <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Supported Employment		<input type="checkbox"/> Student (applies to age 0-18 only) <input type="checkbox"/> Volunteer <input type="checkbox"/> Homemaker <input type="checkbox"/> Disabled <input type="checkbox"/> Inmate <i>*Please note that these are state designated categories</i>	
		<b>Disabilities:</b> (choose all that apply) <input type="checkbox"/> None <input type="checkbox"/> Deaf/severe hearing loss <input type="checkbox"/> Blind/severe vision loss <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Learning disability <input type="checkbox"/> Developmental disability	

<b>Gross annual household income</b> \$ _____ Number of individuals supported by income: _____		Number of <b>dependent children</b> : _____	
Does the client receive <b>SSI</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the client receive <b>SSDI</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Highest Education Level Completed</b>	<input type="checkbox"/> Pre-kindergarten <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1 <input type="checkbox"/> Grade 2 <input type="checkbox"/> Grade 3 <input type="checkbox"/> Grade 4 <input type="checkbox"/> Grade 5	<input type="checkbox"/> Grade 6 <input type="checkbox"/> Grade 7 <input type="checkbox"/> Grade 8 <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 or GED	<input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree
	<b>School Information</b> (if currently in school)		
Name of school _____			
School Address _____		City _____	State _____
<b>Tobacco Status:</b> <input type="checkbox"/> Current smoker/tobacco user—every day <input type="checkbox"/> Current smoker/tobacco user—periodically <input type="checkbox"/> Smoker/tobacco user—current status unknown		<input type="checkbox"/> Former smoker/tobacco user <input type="checkbox"/> Never a smoker/tobacco user <input type="checkbox"/> Unknown if ever smoked/used	
<b>Presence of mental health problem</b> (select one): <input type="checkbox"/> Longer than 1 year <input type="checkbox"/> One year or less		<b>Previous or Current Services</b> (check all that apply): <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Adult Corrections <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Special Education <input type="checkbox"/> Child Welfare <input type="checkbox"/> Substance Abuse <input type="checkbox"/> None	
<b>History of Mental Health Services</b> (check all that apply): <input type="checkbox"/> Inpatient Number of prior psychiatric hospitalizations: _____ <input type="checkbox"/> Other 24-hour <input type="checkbox"/> Partial Care <input type="checkbox"/> Outpatient <input type="checkbox"/> None			
<b>Number of arrests in past 30 days:</b> _____			
<b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Does the client have a history of trauma?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			



# Healthy Days Questionnaire

First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Would you say that in general your health is: **(Circle one)**

Excellent

Very Good

Good

Fair

Poor

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health NOT good?

**Number of Days:** \_\_\_\_\_ **(0-30 days)**

Now thinking about your mental health which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

**Number of Days:** \_\_\_\_\_ **(0-30 days)**

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

**Number of Days:** \_\_\_\_\_ **(0-30 days)**

Provider Use Only

Client ID: \_\_\_\_\_ RU: \_\_\_\_\_ Check here if this is the client's baseline assessment

*Return all forms to QIC*

AllHealth Network  
**MEDICAL HISTORY QUESTIONNAIRE**

Location (circle one)  
 Castle Rock  
 Inverness  
 Parker  
 Southwood  
 Sycamore

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client Last Name \_\_\_\_\_ Client First Name \_\_\_\_\_ Client Middle Initial \_\_\_\_\_

Client's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ What is your height? \_\_\_\_ FT \_\_\_\_ IN What is your weight? \_\_\_\_ LBS

**YOUR MEDICAL HISTORY**

Circle One		Please check YES or NO for each item listed to identify if you have been diagnosed or had difficulties with these items.	If YES, please provide details including date and names of physicians
YES	NO	Cancer	
YES	NO	Diabetes	
YES	NO	Fainting	
YES	NO	Frequent headaches	
YES	NO	Head injury	
YES	NO	Heart disease	
YES	NO	Hepatitis	
YES	NO	High cholesterol	
YES	NO	Hypertension	
YES	NO	Seizures	
YES	NO	Stroke	
YES	NO	<i>Females only:</i> Are you pregnant or planning to get pregnant?	
YES	NO	Do you use tobacco?	If yes, what kind?
			If yes, how much/how often?
YES	NO	Do you have any allergies?	List name and type of reactions:

**YOUR FAMILY HISTORY**

Circle One		Please check YES or NO for each item listed to identify if a member of your immediate family has been diagnosed or had difficulties with these items.	If YES, please identify relationship of family member to you (i.e., mother, grandfather, brother, etc.)
YES	NO	Cancer	
YES	NO	Diabetes	
YES	NO	Heart disease	
YES	NO	High cholesterol	
YES	NO	Hypertension	
YES	NO	Sudden cardiac death before age 50	
YES	NO	Suicide	

**YOUR MEDICATIONS**

Do you take any of the following medications?	Circle One		List who is prescribing the medication
Aripiprazole (Abilify)	YES	NO	
Asenapine Maleate (Saphris)	YES	NO	
Clozapine (Clozaril)	YES	NO	
Iloperidone (Fanapt)	YES	NO	
Lurasidone (Latuda)	YES	NO	
Olanzapine (Zyprexa)	YES	NO	
Olanzapine/Fluoxetine (Symbyax)	YES	NO	
Paliperidone (Invega)	YES	NO	
Quetiapine (Seroquel)	YES	NO	
Risperidone (Risperdal)	YES	NO	
Ziprasidone (Geodon)	YES	NO	

**YOUR MEDICATIONS CONTINUED**

List all other medications you are currently taking (including over the counter medications)

List who is prescribing the medication

**Pre-Diabetes Self-Assessment Screening**

Answer the following 7 questions – for each “Yes” answer, add the number of points listed.

Yes No

Do you have a parent with diabetes?

1 0

Do you have a brother or sister with diabetes?

1 0

Are you a woman who has had a baby weighing more than 9 pounds at birth?

1 0

Are you between 45 and 64 years old?

5 0

Are you younger than 65 years old and get little or no physical activity in a typical day?

5 0

Are you 65 years old or older?

5 0

Find your height on the chart below.

Do you weigh as much or more than the weight listed on the chart for your height?

9 0

Height	Weight	Height	Weight	Height	Weight	Height	Weight	Height	Weight
4'10"	129	5'2"	147	5'6"	167	5'10"	188	6'2"	210
4'11"	133	5'3"	152	5'7"	172	5'11"	193	6'3"	216
5'0"	138	5'4"	157	5'8"	177	6'0"	199	6'4"	221
5'1"	143	5'5"	162	5'9"	182	6'1"	204		

Pre-Diabetes Screening Score  
\_\_\_\_\_**Primary Care Physician/Primary Care Clinic and Pharmacy Information**

Physician or Clinic Name

Address

Phone Number

Fax Number

Pharmacy Name

Address

Phone Number

Fax Number

Client Signature OR Parent/Legal Guardian Signature if client is under 15 OR incapacitated

Date

**FOR INTERNAL USE ONLY**

Form reviewed by (Intake Clinician)

Date

If client does not have PCP was a referral made to Be Well Clinic? Yes No

Date of Referral

If no, why not: \_\_\_\_\_



AllHealth Network

155 Inverness Drive West Englewood CO 80221

RELEASE OF INFORMATION OR AUTHORIZATION FOR 42 C.F.R. PART 2

I, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
Consumer's First Name Middle Initial Last Name Consumer's Date of Birth

AllHealth Network to obtain information from, and share information with: My identified health insurance company including Medicaid or Medicare

Information related to Substance Abuse may include:

- Assessment/Diagnosis/Family History
Treatment Summary and Recommendations
Psychological Testing/ Consultation
Medical Information/Medications Prescribed
Drug/ Alcohol History and Treatment
Service Plans

By checking this box I hereby authorize AllHealth Network to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, for the purpose of AllHealth Network submitting claims for payment to my insurance company.

If applicable, I hereby further authorize the Behavioral Health Organization ("BHO") who has received and processed a claim for services delivered to me by AllHealth Network, to re-disclose such information to Colorado Department of Health Care Policy and Financing (Medicaid) for its Medicaid administration purposes as is required by the contract that the BHO has with Medicaid.

I understand that information to be released/authorized may include information regarding the following condition(s):
Drug Abuse, Alcoholism or Alcohol Abuse, Psychiatric Conditions/Treatment, HIV / Auto Immune Deficiency Syndrome (AIDS)
I understand that AllHealth Network may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not.
If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42 C.F.R. Part 2.
I understand that I may revoke this release/authorization at any time by giving verbal or written notice to AllHealth Network, except to the extent that action has already been taken in reliance on it.
I understand that I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

\*A copy/facsimile of this Release / Authorization is as valid as the original.

\*\*If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/authorization.

**OUT-OF-STATE OFFENDER  
CLIENT QUESTIONNAIRE**

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or DMV?  YES  NO

2) Do you have any pending cases in another state?  YES  NO

If yes to 1 or 2, please answer the following questions:

3) What state are you completing treatment for? \_\_\_\_\_

4) Who are you to report the treatment to? \_\_\_\_\_  
(example: court, judge, probation, parole, etc.)

5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado?  YES  NO

6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring your driving privileges as the result of an alcohol or drug related driving offense in another state, but are not under court order to do so?  YES  NO

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your \_\_\_\_\_  
Probation officer, parole officer, judge \_\_\_\_\_  
or diversion officer. \_\_\_\_\_  
\_\_\_\_\_

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

**Staff use only:** If yes to 1 or 2, Contact Rebecca Frazier, Treatment Placement Analyst with the Interstate Office, Colorado Department of Corrections at 303-763-2441 or [rebecca.frazier@state.co.us](mailto:rebecca.frazier@state.co.us) to complete notification of out of state offender placement documents. Form A and Form B must be completed and submitted to the DOC.



## FEE/BILLING POLICY

Thank you for choosing AllHealth Network as your behavioral health care provider. We are committed to providing you with outstanding care at the most affordable cost. In order to achieve these goals, we need your assistance and understanding of our financial policy.

ALL CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES AND/OR NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK AND MAJOR CREDIT CARDS.

**MEDICAID ONLY:** If you have other insurance in addition to Medicaid you must provide that information immediately. Failure to do so is FRAUD. Medicaid is always the insurance payer of last resort.

- AllHealth Network is authorized to receive direct payment from your insurance carrier for any behavioral health and/or medical benefit services being rendered.
- ALL non-covered services must be paid for at the time of service. These services and their associated fee will be discussed with you prior to providing the service.
- As a courtesy, upon presentation of your current valid insurance card we will bill your insurance carrier. However, the entire balance is your responsibility whether the insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.
- It is your responsibility to make sure that the insurance card provided is the most current and that all the personal information is correct including your name, date of birth and primary care physician (if applicable).
- In the event that your insurance coverage changes to a plan in which we are a non-participating provider, you are responsible for payment in full at the time service is rendered.
- Financial assistance is available for qualified clients by providing current proof of income, proof of dependent(s) and proof of address. (A list of appropriate documents is available upon request)
- We reserve the right to add 25% of the total delinquent amount if your account is to be sent to an outside collection agency.
- We reserve the right to charge a \$35.00 Insufficient Funds (ISF) Fee for any returned items (checks and/or credit/debit card transactions).
- We reserve the right to charge a \$30.00 No-Show Fee for all appointments cancelled without 24 hours advanced notice.
- Review of this financial policy and the completion of a financial intake are required annually.

I understand that by signing this fee agreement, I agree to treatment and committing to regular on-time attendance for all of my appointments. I understand that attending sessions will help me reach my treatment goals. I further understand and agree that two missed appointments or late cancellations in 90 days, failure to pay required co-payments or any combination thereof, will result in my care being moved to an alternative level of care, outreach attempts, or discharging me as a client if I don't respond. I understand that payment is due at the time of service. I understand that outstanding fees must be paid in order for me to be considered for re-admission. I am welcome to call admissions at 303-730-8858 to be considered for future services.



AllHealth  
NETWORK

## STATEMENT OF INCOME

Client Name \_\_\_\_\_ Client # \_\_\_\_\_ As of this date \_\_\_\_\_

Client is receiving services from AllHealth Network. They have indicated the following information to us.

I do not have any source of income or insurance at the present time.

Or

I have limited finances and am requesting assistance.

Annual household income

Total # of Individuals in household \_\_\_\_\_

Client has agreed to notify AllHealth Network when their situation changes in regards to their income, dependents or insurance eligibility. Client understands the fee is based on total household income and number of dependents.

\_\_\_\_\_  
Printed Name of AllHealth Network representative

\_\_\_\_\_  
Signature of AllHealth Network representative

\_\_\_\_\_  
Date



# CLIENT FINANCIAL INFORMATION AND FEE AGREEMENT FORM

Check One:  New Insurance  Same Policy/Different Copay  Lost Insurance  No Change

Client I.D. # ____-____-____-____	Client's Last Name	First Name	M.I.	Client's Date of Birth
Client's Social Security #: _____-____-____	Policy Effective Date:			

## PERSON FINANCIALLY RESPONSIBLE for CLIENT

Relationship to Client: (Please Circle Your Answer) 1) Self    2) Spouse    3) Dependent    4) Parent/Guardian    5) Other _____				Responsible SSN ____-____-____
Last Name	First Name	M.I.	Responsible Party's DOB	
Street Address		City	State	Zip Code
Home Phone		Work Phone & Ext.	Place of Employment	

## PRIMARY INSURANCE POLICY HOLDER

Policy Holder's Last Name	First Name	M.I.	Policy Holders SSN
Insurance Company Name			Policy Holder's DOB
Policy Holder's Employer			Insurance Co. Phone #
Policy #	Group #	Insurance Type: (Please Circle)    I = Individual    F = Family    O = Other	

## SECONDARY INSURANCE (ONLY COMPLETE IF YOU HAVE A SECOND INSURANCE PLAN)

Policy Holder's Last Name	First Name	M.I.	Policy Holder' SSN
Insurance Company Name			Policy Holder's DOB
Policy Holder's Employer			Insurance Co. Phone #:
Policy #	Group #	Insurance Type: (Please Circle)    I = Individual    F = Family    O = Other	

### *To Be Completed By AllHealth Network*

Gross Annual Income	<u>SLIDING SCALE DOCUMENTATION</u>		
# Of Dependents <i>(include self)</i>	PROOF OF INCOME TYPE		PERCENTAGE OF CHARGES TO PAY
# Of Dependent Children	PROOF OF DEPENDENTS TYPE		MEDICAID APPLICATION OUTCOME
ADDRESS VERIFICATION DOCUMENTATION TYPE			

I have reviewed the Fee/Billing Policy on the reverse side. I understand that co-pays and deductibles are an estimate based on the information AllHealth Network has received from my insurance company and are subject to change. I have completed the requested information completely and to the best of my knowledge. I have received a copy of the form. **I agree to assume responsibility and pay the Network the assigned Fee(s)/Insurance Fee(s).**

I authorize AllHealth Network to release my information for all claims and payment purposes, as may be required by my insurance company or any third party payer, and release AllHealth Network from any liability related to such release of information.

I assign all benefits and rights to payment for services provided by Arapahoe/Douglas Mental Health Network, and authorize payment to be made directly to Arapahoe/Douglas Mental Health Network by any third party payer that provides benefits or payment for such services.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
AllHealth Network Representative

\_\_\_\_\_  
Date

# ADDICTION SEVERITY INDEX

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

ST \_\_\_\_\_

ZIP \_\_\_\_\_

Phone number \_\_\_\_\_

**Use the column on the right to record your answers.**

<b>G14</b>	How long have you lived at this address? _____	_____ Years    Months
<b>G16</b>	Date of birth: _____/_____/_____	(month/day/year)
<b>G17</b>	Of what race do you consider yourself? 1. White (not Hisp) 2. Black (not Hisp) 3. American Indian 4. Alaskan Native 5. Asian/Pacific 6. Hispanic – Mexican 7. Hispanic - Puerto Rican 8. Hispanic - Cuban 9. Other Hispanic	
<b>G18</b>	Do you have a religious preference? 1. Protestant            3. Jewish            5. Other 2. Catholic            4. Islamic            6. None	
<b>G19</b>	Have you been in a controlled environment in the past 30 days? 1. No                            4. Medical Treatment 2. Jail                            5. Psychiatric Treatment 3. Alcohol/Drug Treat    6. Other: _____ A place, theoretically, without access to drugs/alcohol.	
<b>G20</b>	How many days? "NN" if Question G19 is No. Refers to <u>total</u> number of days detained in the past 30 days.	

Some of the questions in this questionnaire ask for you to rate the severity of a particular issue. For those questions, please use the following rating scale:

**0 = Not at all**    **1 = Slightly**    **2 = Moderately**    **3 = Considerably**    **4 = Extremely**

If you have any questions about how to answer a question, please feel free to ask. Thank you.

## MEDICAL STATUS

## COMMENTS

(Include question number with your notes)

<b>M1</b>	How many times in your life have you been hospitalized for medical problems? Include ODs and DTs. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of overnight hospitalizations for medical problems.	
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<b>M3</b>	Do you have any chronic medical problems which continue to interfere with your life? <b>0=No 1=Yes</b> If Yes, specify in comments. A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of your abilities.	
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<b>M4</b>	Are you taking any prescribed medication on a regular basis for a physical problem? <b>0 = No 1 = Yes</b> If Yes, specify in comments. Medication prescribed by a MD for medical conditions; not psychiatric medicines. Include medicines prescribed whether or not you are currently taking them. The intent is to verify chronic medical problems.	
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<b>M5</b>	Do you receive a pension for a physical disability? <b>0 = No 1 = Yes</b> If Yes, specify in comments. Include workers' compensation, exclude psychiatric disability.	
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<b>M6</b>	How many days have you experienced medical problems in the past 30 days? Do not include ailments directly caused by drugs/alcohol. Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if you were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).	
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Use the rating scale above.

<b>M7</b>	How troubled or bothered have you been by these medical problems in the past 30 days? Restrict response to problem days Question M6.	
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<b>M8</b>	How important to you <u>now</u> is treatment for these medical problems? Refers to your need for new or additional medical treatment.	
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Rating Scale: **0 = Not at all**    **1 = Slightly**    **2 = Moderately**    **3 = Considerably**    **4 = Extremely**

### EMPLOYMENT/SUPPORT STATUS

### COMMENTS

(Include question number with your notes)

<b>E1</b>	<b>Education completed:</b> GED = 12 years, note in comments. Include formal education only.	_____ Years	_____ Months	
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<b>E2</b>	<b>Training or technical education completed:</b> Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics or computers.	_____ Years	_____ Months	
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<b>E4</b>	<b>Do you have a valid driver's license?</b> <b>0 = No 1 = Yes</b> Valid license; not suspended/revoked. <u>If NO, skip to Question E6</u>	
<b>E5</b>	<b>Do you have an automobile available?</b> <b>0 = No 1 = Yes</b> If E4 = No, then E5 = No. Does not require ownership, only requires availability on a regular basis.	

<b>E6</b>	<b>How long was your longest full time job?</b> Full time = 35+ hours weekly; Does not necessarily mean most recent job.	_____ Years	_____ Months	
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<b>E7</b>	<b>Usual (or last) occupation? (Specify)</b> _____
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<b>E9</b>	<b>Does someone contribute to the majority of your support?</b> <b>0 = No 1 = Yes</b>	
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<b>E10</b>	<b>Usual employment pattern, past three years? _____</b> 1. Full time (35+ hours)                      5. Service 2. Part time (regular hrs)                  6. Retired/Disability 3. Part time (irregular hrs)                7. Unemployed 4. Student                                        8. In controlled environment Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.
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<b>E11</b>	<b>How many days were paid for working in the past 30 days?</b> Include "under the table" work, paid sick days and vacation.	
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Rating Scale: **0 = Not at all**    **1 = Slightly**    **2 = Moderately**    **3 = Considerably**    **4 = Extremely**

**How much money did you receive from the following sources in the past 30 days?**

<b>E12</b>	Employment? \$ _____ Net or "take home" pay, include any "under the table" money.
<b>E13</b>	Unemployment compensation? \$ _____
<b>E14</b>	Welfare? \$ _____ Include food stamps, transportation money provided by an agency to go to and from treatment.
<b>E15</b>	Pensions, benefits or Social Security? \$ _____ Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.
<b>E16</b>	Mate, family or friends? \$ _____ Money for personal expenses, (i.e. clothing), include unreliable sources of income (e.g., gambling). Record cash payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.).
<b>E17</b>	Illegal? \$ _____ <i>Cash</i> obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. <b>Do Not</b> convert drugs exchanged to a dollar value.

<b>E18</b>	How many people depend on you for the majority of their food, shelter, etc.? Must be regularly depending on client, do include alimony/child support, do not include yourself or self-supporting spouse, etc.	
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<b>E19</b>	How many days have you experienced employment problems in the past 30? Include inability to find work, if actively looking for work, or problems with present job in which that job is jeopardized.	
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Use the rating scale above.

<b>E20</b>	How troubled or bothered have you been by these employment problems in the past 30 days? Do not mark if incarcerated or detained during the past 30 days.	
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Use the rating scale above.

<b>E21</b>	How important to you <u>now</u> is counseling for these employment problems? Ratings in Questions E20-21 refer to Question E19. Help finding or preparing for a job, not getting a job.	
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## ALCOHOL/DRUGS

## COMMENTS

(Include question number with your notes)

Route of Administration Types:				
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV				
Note the <u>usual</u> or <u>most recent</u> route. For more than one route, choose the most severe. The routes are list from least severe to most severe.				
		Past 30 days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)			
D2	Alcohol (to intoxication)			
D3	Heroin			
D4	Methadone			
D5	Other opiates/analgesics			
D6	Barbiturates			
D7	Sedative/hypnotics/tranquilizers			
D8	Cocaine			
D9	Amphetamines			
D10	Cannabis			
D11	Hallucinogens			
D12	Inhalants			
D12a	Nicotine			
D13	More than 1 substance per day (including alcohol)			

D17	How many times have you had alcohol DTs? <b>Delirium Tremens (DTs):</b> Occur 24-48 hours after last drink, or significant decrease in alcohol intake. Include shaking, severe disorientation, fever, hallucinations, they usually require medical attention.	
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How many times in your life have you been treated for:		
D19	Alcohol use?	
D20	Drug use? Include detoxification, halfway houses, in/outpatient counseling AA or NA (if 3+ meetings within one month period.)	
How many of these were detox only?		
D21	Alcohol?	
D22	Drugs? If D19 = "00", then question D21 is "NN" If D20 = "00", then question D22 is "NN"	
How much money would you say you spent during the past 30 days on:		
D23	Alcohol?	\$ _____
D24	Drugs? Only count actual money spent. What is the financial burden caused by drugs/alcohol?	\$ _____

D25	How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? Include AA/NA	
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Rating Scale: **0 = Not at all**    **1 = Slightly**    **2 = Moderately**    **3 = Considerably**    **4 = Extremely**

Use the rating scale above.

<b>How many days in the past 30 have you experienced:</b>		
<b>D26</b>	Alcohol problems?	
	How troubled or bothered have you been in the past 30 days by these?	
<b>D28</b>	How important to you <u>now</u> is treatment for these?	
<b>How many days in the past 30 have you experienced:</b>		
<b>D27</b>	Drug problems? Include only: craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.	
	How troubled or bothered have you been in the past 30 days by these?	
<b>D29</b>	How important to you <u>now</u> is treatment for these?	

## LEGAL STATUS

<b>L1</b>	Was this admission prompted or suggested by the criminal justice system? Judge, probation/parole officer, etc. <b>0 = No 1 = Yes</b>	
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<b>L2</b>	Are you on parole or probation? Note duration and level in comments. <b>0 = No 1 = Yes</b>	
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## How many times in your life have you been arrested and charged with the following:

Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult. Include formal charges only. Do not include misdemeanor offenses from questions L18-20 below. Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

<b>L3</b>	Shoplift/Vandal	
<b>L4</b>	Parole/Probation	
<b>L5</b>	Drug charges	
<b>L6</b>	Forgery	
<b>L7</b>	Weapons offense	
<b>L8</b>	Burglary/Larceny/B&E	
<b>L9</b>	Robbery	
<b>L10</b>	Assault	
<b>L11</b>	Arson	
<b>L12</b>	Rape	
<b>L13</b>	Homicide/Manslaughter	
<b>L14</b>	Prostitution	
<b>L15</b>	Contempt of court	
<b>L16</b>	Other	
<b>L17</b>	How many of these charges resulted in convictions?	
	If L3-16 = 00, then question L17 = "NN"	

## COMMENTS

(Include question number with your notes)

How many times in your life have you been arrested and charged with the following:		
L18	Disorderly conduct, vagrancy, public intoxication?	
L19	Driving while intoxicated?	
L20	Major driving violations? Moving violations: speeding, reckless driving, no license, etc.	

How many months were you incarcerated in your life?		
L21	If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.	

L24	Are you presently awaiting charges, trial, or sentence? <b>0 = No 1 = Yes</b>	
L25	What for? Use the number of the type of crime committed: L3-16 and L18-20 Refers to question L24. If more than one, choose most severe. Don't include civil cases, unless a criminal offense is involved.	

L26	How many days in the past 30 were you detained or incarcerated? Include being arrested and released on the same day.	
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L27	How many days in the past 30 have you engaged in illegal activities for profit? Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with question E17 under Employment/Support Section.	
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Use the rating scale above.		
L28	How serious to you feel your present legal problems are? Exclude civil problems.	
L29	How important to you <u>now</u> is counseling or referral for these legal problems? You are rating a need for <i>additional</i> referral to legal counsel for defense against criminal charges.	

Rating Scale: **0 = Not at all**    **1 = Slightly**    **2 = Moderately**    **3 = Considerably**    **4 = Extremely**

## FAMILY/SOCIAL RELATIONSHIPS

## COMMENTS

(Include question number with your notes)

<b>F1</b>	<b>Marital Status:</b> 1. Married      3. Widowed      5. Divorced 2. Remarried    4. Separated      6. Never Married Common-law marriage = 1 Specify in comments.	
<b>F3</b>	<b>Are you satisfied with this situation?</b> <b>0 = No    1 = Indifferent    2 = Yes</b> Satisfied = generally liking the situation. Refers to question F1.	

<b>F4</b>	<b>Usual living arrangements (past 3 years):</b> 1. With sexual partner & children 2. With sexual partner alone 3. With children alone 4. With parents 5. With family 6. With friends 7. Alone 8. Controlled environment 9. No stable arrangement Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.	
<b>F6</b>	<b>Are you satisfied with these arrangements?</b> <b>0 = No    1 = Indifferent    2 = Yes</b>	

### Do you live with anyone who:

<b>F7</b>	Has a current alcohol problem? <b>0 = No 1 = Yes</b>	
<b>F8</b>	Uses non-prescribed drugs? <b>0 = No 1 = Yes</b>	

<b>F9</b>	<b>With whom do you spend most of your free time?</b> <b>1 = Family    2 = Friends    3 = Alone</b> If a girlfriend/boyfriend is considered as family, then please refer to them as family throughout this section, not a friend.	
<b>F10</b>	<b>Are you satisfied with spending your free time this way?</b> <b>0 = No    1 = Indifferent    2 = Yes</b> A satisfied response must indicate that you generally like the situation. Referring to question F9.	

**Have you had significant periods in which you have experienced serious problems getting along with:**

"Serious problems" mean those that endangered the relationship.  
A "problem" requires contact of some sort, either by telephone or in person.

<b>0 = No 1 = Yes</b>		Past 30 days	Lifetime
<b>F18</b>	Mother		
<b>F19</b>	Father		
<b>F20</b>	Brother/Sister		
<b>F21</b>	Sexual partner/Spouse		
<b>F22</b>	Children		
<b>F23</b>	Other significant family (Specify in comments)		
<b>F24</b>	Close friends		
<b>F25</b>	Neighbors		
<b>F26</b>	Co-workers		

**Did anyone abuse you?**

		Past 30 days	Lifetime
<b>F28</b>	Physically? <b>0 = No 1 = Yes</b> Caused you physical harm.		
<b>F29</b>	Sexually? <b>0 = No 1 = Yes</b> Forced sexual advances/acts.		

**Rating Scale: 0 = Not at all    1 = Slightly    2 = Moderately    3 = Considerably    4 = Extremely**

<b>F30</b>	How many days in the past 30 have you had serious conflicts: With your family?	
<b>F32</b>	How troubled or bothered have you been in the past 30 days by: Family problems? Use the rating scale above.	
<b>F34</b>	How important to you <u>now</u> is treatment or counseling for these: Family problems? You are rating <u>your</u> need for counseling for family problems, not whether the family would be willing to attend. Use the rating scale above.	
<b>F31</b>	How many days in the past 30 have you had serious conflicts: With other people?(excluding family)	
<b>F33</b>	How troubled or bothered have you been in the past 30 days by: Social problems? Use the rating scale above.	
<b>F35</b>	How important to you <u>now</u> is treatment or counseling for these: Social problems? Include need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Your rating should refer to dissatisfaction, conflicts, or other serious problems. Use the rating scale above.	

## PSYCHIATRIC STATUS

## COMMENTS

(Include question number with your comments.)

How many times have you been treated for any psychological or emotional problems:		
<b>P1</b>	In a hospital or inpatient setting?	
<b>P2</b>	Outpatient/private patient? Do not include substance use, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days. Enter diagnosis in comments if known.	

<b>P3</b>	Do you have a pension for psychiatric disability? <b>0 = No 1 = Yes</b>	
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Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:			
<b>0 = No 1 = Yes</b>		Past 30 days	Lifetime
<b>P4</b>	Experienced serious depression, sadness, hopelessness, loss of interest, difficulty with daily function?		
<b>P5</b>	Experienced serious anxiety/tension, been uptight, unreasonably worried, unable to feel relaxed?		
<b>P6</b>	Experienced hallucinations – saw things or heard voices that were not there?		
<b>P7</b>	Experienced trouble understanding, concentrating, or remembering?		

For items P8-10, you can have been under the influence of alcohol/drugs.			
<b>0 = No 1 = Yes</b>		Past 30 days	Lifetime
<b>P8</b>	Experienced trouble controlling violent behavior including episodes of rage or violence?		
<b>P9</b>	Experienced serious thoughts of suicide? You seriously considered a plan for taking your life.		
<b>P10</b>	Attempted suicide? Include actual suicidal gestures or attempts.		
<b>P11</b>	Been prescribed medication for any psychological or emotional problems? Prescribed by MD. Record "Yes" if a medication was prescribed even if you were not taking it.		

Rating Scale: 0 = Not at all    1 = Slightly    2 = Moderately    3 = Considerably    4 = Extremely

<b>P12</b>	How many days in the past 30 have you experienced these psychological or emotional problems? This refers to problems noted in questions P4-P10.	
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Use the rating scale above.

<b>P13</b>	How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? Refer to question P12	
<b>P14</b>	How important to you <u>now</u> is treatment for these psychological or emotional problems?	



