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 for additional information on creating advance directives.

DNS_AdvanceDirectivesFlyer_2/2016

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

Client name: _____

Date of birth: ____/_____/_____

Race (select all that apply):
☐ American Indian/Alaskan
☐ Asian
☐ Black/African-American
☐ Caucasian
☐ Native Hawaiian/Pacific Islander
☐ Declined

Hispanic Ethnicity:
☐ Cuban
☐ Mexican
☐ Puerto Rican
☐ Other Hispanic
☐ Declined
☐ Not Applicable

Gender that the client identifies with:
☐ Female
☐ Male

Marital Status:
☐ Never Married ☐ Married ☐ Married, separated ☐ Divorced ☐ Widowed

Living Arrangement:
☐ Alone
☐ With partner/significant other
☐ With spouse
☐ With children
☐ With mother
☐ With father
☐ With sibling(s)
☐ Foster parent(s)
☐ With relatives
☐ With guardian
☐ With unrelated person(s)

Sexual Orientation:
☐ Bisexual
☐ Gay/Lesbian
☐ Heterosexual
☐ Other
☐ Declined

Family Members in the Home *Name(s):*	**DOB or Age**	(circle)	**Relationship to client:**
_____	_____	**M** or **F**	_____
_____	_____	**M** or **F**	_____
_____	_____	**M** or **F**	_____
_____	_____	**M** or **F**	_____
_____	_____	**M** or **F**	_____

Emergency Contact: (*You must also complete a Release of Information form)*
_____ Name
_____ Relationship
Phone: _____ _____

Medical Decision-Making Authority for minors
_____ Name _____ Relationship
_____ Name _____ Relationship

Place of Residence:
☐Independent living
☐ Inpatient
☐ Halfway house
☐ Boarding home (adult)
☐ Foster home (youth)
☐ Residential facility (MH adult)
☐ Correctional facility
☐ Supported housing
☐ Residential treatment/group
☐ Homeless
☐ Nursing home
☐ Assisted Living
☐ ATU (adults only)
☐ Sober living
☐ Group home (adult)
☐ Other residential facility

Current Primary Role
☐ Employed (Full time 35+ hours/week)
☐ Employed (part time ≤ 35 hours/week
☐ Unemployed
☐ Military
☐ Retired
☐ Supported Employment
☐ Student (applies to age 0-18 only)
☐ Volunteer
☐ Homemaker
☐ Disabled
☐ Inmate
**Please note that these are state designated categories*

Disabilities:
(choose all that apply)
☐ None
☐ Deaf/severe hearing loss
☐ Blind/severe vision loss
☐ Traumatic Brain Injury
☐ Learning disability
☐ Developmental disability

Gross annual household income $ _____ Number of individuals supported by income: _____			Number of **dependent children**: _____
Does the client receive **SSI**? ☐ Yes ☐ No		Does the client receive **SSDI**? ☐ Yes ☐ No	
Highest Education Level Completed	☐ Pre-kindergarten ☐ Kindergarten ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Grade 5	☐ Grade 6 ☐ Grade 7 ☐ Grade 8 ☐ Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 or GED	☐ Some college ☐ College degree ☐ Master's degree ☐ Doctoral degree
School Information (if currently in school) Name of school School Address City State Zip			
Tobacco Status: ☐ Current smoker/tobacco user—every day ☐ Current smoker/tobacco user—periodically ☐ Smoker/tobacco user—current status unknown		☐ Former smoker/tobacco user ☐ Never a smoker/tobacco user ☐ Unknown if ever smoked/used	
Presence of mental health problem (select one): ☐ Longer than 1 year ☐ One year or less		**Previous or Current Services** (check all that apply): ☐ Juvenile Justice ☐ Adult Corrections ☐ Developmental Disabilities ☐ Special Education ☐ Child Welfare ☐ Substance Abuse ☐ None	
History of Mental Health Services (check all that apply): ☐ Inpatient Number of prior psychiatric hospitalizations: _____ ☐ Other 24-hour ☐ Partial Care ☐ Outpatient ☐ None			
Number of arrests in past 30 days: _____			
Pregnant? ☐ Yes ☐ No			
Veteran? ☐ Yes ☐ No			
Does the client have a history of trauma? ☐ Yes ☐ 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	*Females only:* 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/Fluexetine (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. (Services may not be conditioned or refused if consumer refuses to sign.)
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. **BHOs Authorized to Receive and Re-Disclose Information**: Access Behavioral Care; Behavioral Healthcare, Inc.; Colorado Health Partnerships; Foothills Behavioral Health Partners, LLC; Northeast Behavioral Health Partnership.

- **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. Without such revocation, this release/authorization will expire on _____/_____/ _____ , or if left blank, two years from the date of my**

  signature, or as of the action or event of _____ .
- **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.**

_____ _____

Signature of Consumer/Parent/Legal Representative Relationship to Consumer

_____

Date Witness

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 general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
**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 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.

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		**SLIDING SCALE DOCUMENTATION**		
# Of Dependents ***(include self)***		**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