AllHealth NETWORK
Live Better.

AllHealthNetwork.org

Dear friend,

Welcome to AllHealth Network! Thank you for choosing us to partner in your journey to recovery and wellness. We take pride in the quality and range of services we provide, the experience and compassion of our staff, and ability to serve you through a location that is convenient to you.

Your wellness is our top priority. Together, we will address issues that are important to you, create an effective treatment plan, assist with the management of your symptoms, and help you reach your recovery goals.

This packet includes all of the new client forms that are to be completed before your first appointment.
It includes:

- Treatment Agreement, Consent & Acknowledgement
- Notice of Privacy Rights
- New Client Information
- Client Financial Information & Policy
- Medical History Questionnaire

We have been serving our community since 1955. You can trust in the strength of our network and our people as thousands of individuals and families do each year. Thank you for being here.

Joan DiMaria

Joan DiMaria, MSN, CACIII
Executive Director, CEO

# DEMOGRAPHICS FORM

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**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** $ _____<br>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<br>☐ Kindergarten<br>☐ Grade 1<br>☐ Grade 2<br>☐ Grade 3<br>☐ Grade 4<br>☐ Grade 5 | ☐ Grade 6<br>☐ Grade 7<br>☐ Grade 8<br>☐ Grade 9<br>☐ Grade 10<br>☐ Grade 11<br>☐ Grade 12 or GED | ☐ Some college<br>☐ College degree<br>☐ Master's degree<br>☐ Doctoral degree |
|---|---|---|---|

**School Information** (if currently in school)

_____

Name of school

_____

School Address City State Zip

| **Tobacco Status:** | |
|---|---|
| ☐ Current smoker/tobacco user—every day | ☐ Former smoker/tobacco user |
| ☐ Current smoker/tobacco user—periodically | ☐ Never a smoker/tobacco user |
| ☐ Smoker/tobacco user—current status unknown | ☐ Unknown if ever smoked/used |

| **Presence of mental health problem** (select one): | **Previous or Current Services** (check all that apply): |
|---|---|
| ☐ Longer than 1 year | ☐ Juvenile Justice |
| ☐ One year or less | ☐ Adult Corrections |
| **History of Mental Health Services** (check all that apply): | ☐ Developmental Disabilities |
| ☐ Inpatient | ☐ Special Education |
| Number of prior psychiatric hospitalizations: _____ | ☐ Child Welfare |
| ☐ Other 24-hour | ☐ Substance Abuse |
| ☐ Partial Care | ☐ None |
| ☐ 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

# MEDICAL HISTORY QUESTIONNAIRE

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_____ _____ _____/_____/_____
Client I.D # Last Name First Name MI Date

_____/_____/_____ _____
Date of birth Location

**Height _____ft. _____in. Weight _____lbs.**

**Blood Pressure _____/_____ Pulse _____**

**MEDICAL HISTORY**

| Yes | No | Please check YES or NO for each item listed | If YES, furnish details including date and names of physicians |
|---|---|---|---|
| | | 1. During the past 5 years have you:<br>A. Been treated for any medical condition or had surgery? | |
| | | B. Had an x-ray, electrocardiogram or laboratory test? | |
| | | C. Been advised to have an operation? | |
| | | D. Received prescription medication?<br>If YES, give name and dosage. | |
| | | 2. Are you presently taking any prescription medications?<br>If YES, give name and dosage. | |
| | | 3. Are you presently taking any non-prescription medications or herbal supplements?<br>If YES, give name and dosage. | |
| | | 4. Do you have any allergies?<br>If YES, give name and type of reactions. | |
| | | 5. Have you ever had an allergy or bad reaction to any medications?<br>If YES, give name and type. | |
| | | 6. Has anyone in your family had or been treated for an emotional problem? | |
| | | 7. Do you drink coffee/tea/soda? If YES, how much? | |
| | | 8. Do you smoke/use tobacco? If YES, how much? | |
| | | 9. Do you drink alcohol? If YES, how much? | |
| | | 10. Except as prescribed by a physician, have you ever taken:<br>A. Morphine, barbiturates, other narcotics? | |
| | | B. Heroin, cocaine, hashish, marijuana, amphetamines? | |
| | | C. Other drugs? | |

Family physician: _____ _____
MD Name/Clinic Name Address Phone

Other physicians you currently see: _____

_____

Number of medical visits last month: _____ Number of emergency room visits last month: _____

Date of last physical: Month _____Year _____ If never, write NONE_____

Results and recommendations: _____

Date of last medical hospitalization: Month _____Year _____ If never, write NONE _____

Reason for hospitalization: _____

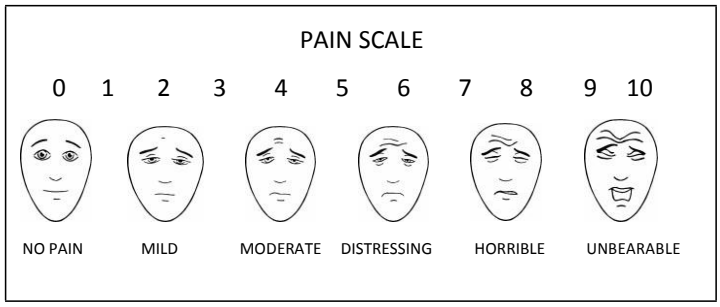
## REVIEW OF SYMPTOMS

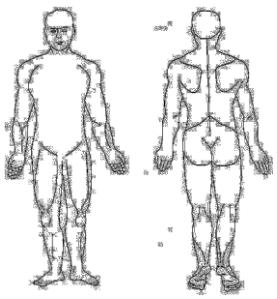
Have you or someone in your immediate family ever had, or been told you/they have the following?
(If "have now" and "had in past," check Y for "yes")

| Self | Family | Check one for each symptom | Self | Family | Check one for each symptom |
|---|---|---|---|---|---|
| ☐ Y☐ N | ☐ Y☐ N | obesity | ☐Y ☐N | ☐ Y☐ N | thyroid trouble |
| ☐ Y☐ N | ☐ Y☐ N | high blood pressure | ☐Y ☐N | ☐ Y☐ N | asthma or shortness of breath |
| ☐ Y☐ N | ☐ Y☐ N | diabetes | ☐Y ☐N | ☐ Y☐ N | recent gain/loss of weight (circle gain or loss) |
| ☐ Y☐ N | ☐ Y☐ N | high cholesterol/triglycerides | ☐Y ☐N | ☐ Y☐ N | epilepsy or seizures |
| ☐ Y☐ N | ☐ Y☐ N | cardiovascular disease-heart trouble | ☐Y ☐N | ☐ Y☐ N | jaundice or liver disease |
| ☐ Y☐ N | ☐ Y☐ N | frequent or severe headaches | ☐Y ☐N | ☐ Y☐ N | kidney disease |
| ☐ Y☐ N | ☐ Y☐ N | dizziness or fainting spells | ☐Y ☐N | ☐ Y☐ N | stroke |
| ☐ Y☐ N | ☐ Y☐ N | eye problems including glaucoma | ☐Y ☐N | ☐ Y☐ N | **MALES** - prostate trouble |
| ☐ Y☐ N | ☐ Y☐ N | head injury | ☐Y ☐N | ☐ Y☐ N | **FEMALES** - Are you currently pregnant or planning a pregnancy in the near future? |

**PAIN EVALUATION:** Do you have pain? ___Yes ___ No

Use the scale below to rate your pain from 0 =none to 10 =extreme:



If you are experiencing pain, please mark the area(s) affected.

Which pain medications: _____

Who prescribes: _____

_____ _____

Client's Signature OR Signature of Parent OR Legal Guardian if Client is under age 15 OR incapacitated Date

Reviewed by: _____ _____

Primary Therapist Date

Reviewed by: _____ _____

Medical Person Date

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# 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.

# NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION – PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, AllHealth Network will obtain, record, and use mental health and medical information about you that is protected health information (PHI). This information is confidential and will not be used or disclosed without your written authorization, except as described below.

## I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

### A. General Uses and Disclosures Not Requiring the Client's Consent

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1) ***Treatment.*** Refers to coordination and management of your medical and mental health care and related services by any provider. AllHealth Network staff involved with your care may use your information to plan your treatment to make sure the most appropriate methods are being used to help you.
2) ***Payment.*** Activities we conduct to obtain or provide reimbursement related to your mental health and medical care. We will use your information for AllHealth Network financial purposes which may include information that identifies you and details of your treatment for bills we send to you and claims we send to your insurance company, other payer, or the State of Colorado Medicaid program.
3) ***Health care operations***. Refers to activities by AllHealth Network having to do with regular administrative functions. We may use your health information to monitor service quality, staff training, medical chart reviews, audits, licensing, and other purposes directly related to how we run our business.
4) ***Contacting the client.*** AllHealth Network may contact you to remind you of appointments and tell you about other treatments and services that may help you.
5) ***Required by law.*** AllHealth Network will disclose PHI when required by law in any of the following situations (but not limited to):
    a) Reporting child abuse or neglect
    b) Court ordered
    c) Legal duty to warn or take action regarding imminent danger to others
    d) When client is a danger to self or others or gravely disabled
    e) When required to report certain communicable diseases and certain injuries
    f) When a coroner is investigating the client's death
6) ***Health oversight activities***. AllHealth Network will disclose PHI to health oversight agencies as authorized by law and necessary for the oversight of any of the following:
    a) The health care system (*insurers, doctors, hospitals, pharmacies, etc.)*
    b) Government health care benefit programs *(Medicare, Medicaid, etc.)*
    c) Regulatory programs *(Drug Enforcement Agency, State Medical Licensing, etc.)*
    d) To determine compliance with program standards
7) ***Crimes on the premises or observed by staff.*** Crimes that are observed by AllHealth Network staff, directed towards staff, or that occur on the Network's premises, will be reported to law enforcement.
8) ***Business associates.*** Some of the functions of AllHealth Network are provided by contracts we have with other businesses. PHI will be provided to these businesses to perform tasks directly related to AllHealth Network client treatment. These businesses who work with AllHealth Network must enter into an agreement with AllHealth Network that they will maintain the privacy of your PHI.

9) ***Research.*** The Network may use or disclose PHI for research purposes.
10) ***Involuntary clients***. To provide and coordinate the care of clients being treated involuntarily, PHI will be shared with other providers, legal offices, and others as the law allows.
11) ***Family members***. Except for certain minors, incompetent or involuntary clients, PHI cannot be disclosed to family members without the client's consent. If family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, PHI may be disclosed in the course of that discussion. However, if the client objects, PHI will not be disclosed. Both parents of divorced children, regardless of awarded decision making, will have access to the child's record unless this action is specifically barred by a court order.
12) ***Fundraising***. AllHealth Network may contact clients as part of its fundraising activities.
13) ***Emergencies.*** In life threatening emergencies, AllHealth Network staff will disclose PHI necessary to avoid serious harm or death.
14) **CORHIO Participation.** AllHealth Network endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. More information about CORHIO can be found at www.CORHIO.org

**B.** **Client Authorization or Release of Information**. AllHealth Network may not use or disclose your PHI in any way, other than those allowable by law, without a signed authorization or release of information from you. The authorization or release may be revoked by written request or documented verbal communication with you. The revocation will apply upon receipt of notice in writing unless AllHealth Network has already taken action on a verbal order.

## II. YOUR RIGHTS AS A CLIENT

**A.** **Access to Protected Health Information (PHI)**. Subject to certain limitations, you have the right to inspect and obtain a copy of PHI contained in your legal medical record. Those limitations will be explained to you at the time of your request. To make a request, ask AllHealth Network staff for the appropriate form.

**B.** **Amendment of Your Record.** You have the right to request that AllHealth Network amend (revise/correct) your PHI. It is not required to amend PHI if it is determined that the record is accurate and complete. There are other exceptions. Additional information will be provided to you at the time of your request, along with information about the appeal process available to you. To make a request, ask AllHealth Network staff for the appropriate form.

**C.** **Accounting of Disclosures**. You have the right to receive a list of disclosures AllHealth Network has made regarding your PHI in the 6 years prior to the date of the request. It does not include disclosures for the following:

1) Treatment
2) Payment
3) Health care operations
4) Disclosures made pursuant to a HIPAA-compliant authorization
5) Disclosures made before April 14, 2003.

There may be other exceptions that will be provided to you should you request an accounting,

by asking AllHealth Network staff for a request form.

D. **Additional restrictions.** You have the right to request additional restrictions regarding the use or disclosure of your PHI. However, AllHealth Network does not have to agree with the request. There are certain limits to any restriction. These can be explained to you at the time of your request. To make a request, ask AllHealth Network staff for the appropriate form.

E. **Alternative Means of Receiving Confidential Communications.** You have the right to request that you receive communication of PHI from AllHealth Network by other means or at other locations. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask AllHealth Network staff for the appropriate form.

F. **Copy of this Notice.** You have a right to obtain another copy of this Notice upon request.

## III. ADDITIONAL INFORMATION

A. **Privacy Laws.** AllHealth Network is required by state and federal law to maintain the privacy of PHI. AllHealth Network is also required by law to provide clients with notice of its legal duties and privacy practices regarding PHI.

B. **Terms of the Notice and Changes to the Notice**. AllHealth Network is required to follow the terms of this Notice and reserves the right to change the terms of its Notice and make the new provisions effective for all PHI that it maintains. When the Notice is revised, it will be posted at AllHealth Network sites and will be available upon request.

C. **Breach Notification.** The Network is required to notify you following an illegal release of your Protected Health Information.

D. **Complaints Regarding Privacy Rights.** If you believe AllHealth Network has violated your privacy rights, you have the right to report this to AllHealth Network management by calling the AllHealth Network Privacy Officer at 720-707-6336. You also have the right to report this to the US Secretary of Health & Human Services by sending your written complaint to:

Office of Civil Rights
US Department of Health & Human Services
999 18th Street, Suite 417
Denver, CO 80202

It is the policy of AllHealth Network that there will be no retaliation if you file a complaint.

E. **Additional Information**. For more information about your privacy rights at AllHealth Network, please call our Privacy Officer at 720-707-6336.

F. **Effective Date**. This notice is effective April 27, 2016.

## IV. CONFIDENTIALITY OF ALCOHOL AND DRUG USE CLIENT INFORMATION

Federal law 42 C.F.R. Part 2 protects the confidentiality of alcohol and drug use client records maintained by AllHealth Network and these records may not be released without your written consent unless:

1) The client consents in writing, OR
2) The disclosure is allowed by a court order, OR
3) The disclosure made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, OR
4) The client commits or threatens to commit a crime either at AllHealth Network or against any person who works for AllHealth Network.

Violation of the federal law and regulations by AllHealth Network is a crime. Suspected violations may be reported to the United States Attorney in the District of Colorado.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under Colorado law to appropriate state or local authorities.

## 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.

# CLIENT FINANCIAL INFORMATION AND FEE AGREEMENT FORM

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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 |

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.

## 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 |
|---|---|

**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, <u>including treatment requirements</u> 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.

AllHealth NETWORK
Live Better.

# COMBINED STATEMENT OF MEDICAL DECISION-MAKING AUTHORITY AND CONSENT FOR TREATMENT FOR A MINOR CHILD OR ADULT WARD

_____ ____/_____/_____ _____
Minor child's or adult ward's name Date of birth Client I.D #

I _____ **state and attest** that I may legally consent to medical, mental health and/or substance use treatment for the above listed minor child/adult ward if deemed necessary, advisable and appropriate by AllHealth Network and its employees, therapists, contractors, etc. I consent under the following authority:

___ **Legal Guardian/Parent**
_____has sole Medical Decision Making Authority.

Medical Decision Making Authority is shared between

_____
Name 1 Name 2

___ **Department of Human Services Representative** - Department has custody of minor and authority to consent to the treatment of same.

___ **Self** – Minor who is at least 15 years old and wishes to consent to services.

___ **Other** - Please provide explanation: _____

I am aware that on (date) _____, an appointment for the minor child/adult ward listed above is scheduled for the purpose of a **mental health and/or substance use assessment** by AllHealth Network. I am also aware that following this assessment, it may be necessary, advisable and appropriate that the minor child/adult ward receives treatment from AllHealth Network. Without the generality of what "treatment" may involve, I understand it may involve individual or family therapy, group therapy, psycho-education, skills building, emergency services, counseling, care coordination, medication or a combination of one or more of these things.

I also authorize (print name) _____to sign any and all papers necessary for the treatment of the minor child/adult ward listed above.

## PARENT OR LEGAL GUARDIAN WITH DECISION-MAKING AUTHORITY SIGN THE FOLLOWING:

_____ ____/_____/_____
Signature Parent or Legal Guardian Date

_____ ____/_____/_____
Signature Parent or Legal Guardian Date

_____ ____/_____/_____
Signature of Witness Date

## VERIFICATION

I, _____, am the DHS Case Worker for the minor child listed above. After reviewing the Court's order of (date) _____ directing this child be placed in the care of_____, I have found nothing inconsistent with the Court's Order and I am in agreement with any and all assessments/treatments by Arapahoe/Douglas Mental Health Network.

_____ ____/_____/_____
Signature of DHS Caseworker Date

_____ ____/_____/_____
Signature of Witness Date

# 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.