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 Central Access 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 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.

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.

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

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 AllHealth Network Representative	Date

#150 / Consent to treatment/ Legal

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

Preferred Pronoun:
☐ He ☐ She
☐ Xe ☐ They

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			

First Name: _____ **Date:** _____ **Client ID:** _____

Complete if 18 yrs. or older	**Healthy Days**			
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 any 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 recreations?				
Number of Days: _____ (0-30 days)				

Complete if age 5-17	**Pediatric Global Health**			
Who is answering this form? **(Circle One)**		**Parent/Guardian**	**Child**	
In general, would you say your/your child's health is: (Circle one)				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
In general, would you say your/your child's quality of life is: (Circle one)				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
In general, how would you rate your/your child's physical health : (Circle one)				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
In general, how would you rate your/your child's mental health, including their mood and their ability to think? (Circle one)				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
How often do you/your child feel sad? (Circle one)				
Never	**Rarely**	**Sometimes**	**Often**	**Always**
How often do you/your child have fun with friends? (Circle one)				
Never	**Rarely**	**Sometimes**	**Often**	**Always**
How often do your parents listen to your ideas/you listen to your child's ideas? (Circle one)				
Never	**Rarely**	**Sometimes**	**Often**	**Always**

First Name: _____ **Date:** _____

Complete if 13 yrs. or older	**PHQ-9**			
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not At All**	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Feeling tired or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down?				
7. Trouble concentrating on things, such as reading the newspaper or watching television?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way? Client ID: _____				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle One)	**Not Difficult At All**	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**

Complete if 13 yrs. or older	**GAD-7**			
Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several Days**	**Over Half of the Days**	**Nearly Every Day**
1. Feeling nervous, anxious, or on edge?				
2. Not being able to stop or control worrying?				
3. Worrying too much about different things?				
4. Trouble relaxing?				
5. Being so restless that it's hard to sit still?				
6. Becoming easily annoyed or irritable?				
7. Feeling afraid as if something awful might happen?				
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle One)	**Not Difficult At All**	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**

CLIENT MEDICAL HISTORY INFORMATION

Last Name:	First Name:	M.I.	Date of birth:

Please answer the following questions related to your health:

When was your last annual physical exam? ☐ Never ☐ 0-12 Months ☐ 1-5 years ☐ 5+ years ☐ Unknown

When was your last dental appointment? ☐ Never ☐ 0-12 Months ☐ 1-5 years ☐ 5+ years ☐ Unknown

When was your last flu shot? ☐ Never ☐ 0-12 Months ☐ 1-5 years ☐ 5+ years ☐ Unknown

Are you currently pregnant? ☐ No ☐ Yes ☐ Not applicable (N/A)

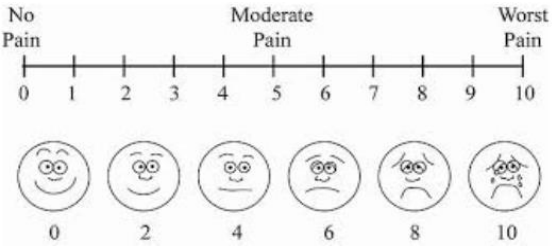
Do you currently experience any pain? ☐ No ☐ Yes

Use this scale to determine your pain level

Pain level _____ Pain location _____

Pain level _____ Pain location _____

Pain level _____ Pain location _____



Please provide us with the following information related to your physical health:

Asthma: ☐ Never present ☐ History of condition ☐ Current – Not receiving treatment ☐ Current - Receiving treatment ☐ Information Unavailable

Diabetes: ☐ Never present ☐ History of condition ☐ Current – Not receiving treatment ☐ Current - Receiving treatment ☐ Information Unavailable

Hypertension: ☐ Never present ☐ History of condition ☐ Current – Not receiving treatment ☐ Current - Receiving treatment ☐ Information Unavailable

Over/Underweight: ☐ Never present ☐ History of condition ☐ Current – Not receiving treatment ☐ Current - Receiving treatment ☐ Information Unavailable

Sleep Problems: ☐ Never present ☐ History of condition ☐ Current – Not receiving treatment ☐ Current - Receiving treatment ☐ Information Unavailable

Please list medications you are currently taking:

Name	Dosage	Frequency	Prescribed By

Primary Care Physician (PCP) and preferred pharmacy Information

Name of Primary Care Physician:_____

Phone Number of Primary Care Physician**:** _____

Preferred Pharmacy Name:_____

Preferred Pharmacy Phone Number:_____

How well do you hear <u>without</u> hearing aids? ☐ Adequate ☐ Minimal issues ☐ Moderate issues
☐ Severe issues ☐ Decline to answer
How well do you see <u>without</u> visual aids? ☐ Adequate ☐ Minimal issues ☐ Moderate issues
☐ Severe issues ☐ Decline to answer

Without wanting to, have you lost or gained a significant amount of weight in the last 6 months? ☐ Yes ☐ No
Has your physician ever informed you that you have, or at risk for, disease because of your weight? ☐ Yes ☐ No
Have you ever been hospitalized for an eating disorder? ☐ Yes ☐ No
Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Do you need help controlling use of illicit substances (alcohol, marijuana, opiates, stimulants, hallucinogenic, etc.)? ☐ Yes ☐ No

Has anyone told you that you may have a problem with drugs or alcohol? ☐ Yes ☐ No

X_____
Client Signature or Parent/Legal Guardian Signature Date

Below is for internal use only)

_____
Reviewed by: (Clinical Assessment Specialist) Date

Referred to Be Well: ☐ Yes ☐ No If not, why not?: _____

Client ID# _____

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.)

- **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.

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.

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I understand that responsibility for payment of services for myself and my dependents is mine; due and payable at the time services are rendered, unless financial arrangements have been pre-made.

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.

You are responsible to know what services your insurance covers. You understand that should your insurance not cover specific services you may be responsible for the cost of those services.

Financial assistance is available for qualified clients who are lawfully present in the United States and who can provide current proof of income, dependent(s) and address. A list of appropriate documents is available upon request.

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, address and telephone number along with your 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.

AllHealth Network is authorized to receive direct payment from your insurance carrier for any behavioral health and/or medical benefit services being rendered.

AllHealth Network reserves the right to charge a $35.00 Insufficient Funds Fee for any returned items (checks and/or credit/debit card transactions).

AllHealth Network reserves the right to charge a $30.00 No-Show Fee for all appointments cancelled without 24 hours advanced notice

AllHealth Network reserves the right to add up to 25% of the total delinquent amount if your account is to be sent to an outside collection agency. You understand that you are responsible for all costs of collection including attorney fees, collection fees of 30%, and any additional court costs.

Review of this financial policy and the completion of a financial intake are required annually.

Consent

I understand that by signing this fee agreement, I agree to treatment and commit 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 to missed appointments or late cancellations in 90 days, failure to pay required co-payments or any combination thereof, could 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. I have been offered a copy of this agreement for my records.

_____	_____	_____	_____
Client Signature	Date	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

Notice of Client Rights

As a client at AllHealth Network, you have certain rights. It is important you know what those rights are. If you have questions about these rights, please call 303-347-6405. We want to help you understand your rights. We want to make sure you are being treated fairly.

You have the right to:

- Be treated with respect and due consideration for your dignity and privacy
- Be treated equally without discrimination based on race, color, national origin, religion, age, sex, gender, financial status, political affiliation, sexual orientation, or disability
- Get culturally appropriate and competent services from AllHealth Network providers
- Get services from a provider who speaks your language or get interpretation services in any language needed
- Get information in a way that you can easily understand
- Be a part of discussions about what you need and make decisions about your care with your providers
- Have an individual plan for services and be a part of developing it.
- Get a full explanation from us about:
  - You or your child's diagnosis and condition,
  - Different kinds of treatment that may be available,
  - What treatment and/or medication might work best, and
  - What you can expect
- Be free from any form of restraint or seclusion used as a means of convincing you to do something you may not want to do, as a punishment, or for convenience of staff
- Know about any fees you may be charged
- To request a change in the people providing your care.
- Be notified quickly of any changes in services or providers
- Get written information on advance medical directives
- Get a second opinion if you have a question or disagreement about your treatment
- Make a grievance (complaint) about your treatment to AllHealth Network without retaliation. You may choose someone else to represent you when you make a complaint.
- Get information about and help with grievances and appeals
- Have an independent advocate help with any questions, problems, or concerns about the mental health system
- Express an opinion about AllHealth Network services to state agencies, legislative bodies, or the media without your services being affected
- Exercise your rights without any change in the way AllHealth Network providers treat you
- Have your privacy respected. Your personal information can only be released to others when you give your permission or when allowed by law. There are exceptions to this that can be found in the Notice of Privacy Practices.
- Know about the records kept on you while you are in treatment and who may have access to your records
- Get copies of your treatment records and service plans and ask AllHealth Network to change your records if you believe they are incorrect or incomplete
- To know the names, professional status, and experience of the staff that are providing services
- Any other rights guaranteed by statute or regulation (the law)
- To receive services in the least restrictive environment, as allowable
- To know that sexual intimacy in a professional relationship is never appropriate. You should report this to the Department of Regulatory Agencies.
- Have an advance directive and have AllHealth Network comply with it.

Additional Rights

If you are receiving treatment at AllHealth Network's Acute Treatment Unit (ATU) or Crisis Stabilization Unit (CSU), you have these additional rights:

- To receive and send mail; no incoming or outgoing mail will be opened, delayed, held, or censored by AllHealth Network
- To have access to letter writing materials including postage, and to have staff members help write and mail letters
- To have access to a telephone, both to make and receive calls in privacy
- To be able to meet with visitors
- To wear your own clothing that meets safety guidelines for the unit
- To refuse to take psychiatric medications, unless medications are ordered for you by the court or you are an imminent danger to self or others
- To not be fingerprinted unless required by law
- To refuse to be photographed except for facility identification and the administrative purposes of the facility
- To receive 24 hour notice before being transferred to another facility unless there is an emergency, and to have AllHealth Network notify someone of your choosing about the transfer
- To retain and consult with an attorney
- To have the opportunity to vote in primary and general elections

How to Complain about your Services

If you are unhappy with AllHealth Network you can talk to a Client Representative at AllHealth Network. We will try to make things better and help you fix any issues you may have. To file a complaint, please call 303-347-6405. We will call you back within 2 business days. We will work hard to resolve your complaint quickly; you will hear from us again in no more than 15 working days from the date you complained.

To make a complaint in writing, please contact:

AllHealth Network Attn: Client Representative
155 Inverness Dr. W.; Suite 200
Englewood, CO 80112

Other Important Numbers

You have the right to contact people outside AllHealth Network about your concerns. These are some places you may wish to contact.

- Department of Regulatory Agencies (DORA) at 303-894-7855 or 800-886-7675 or www.colorado.gov/dora or at 1560 Broadway Suite 110, Denver, CO 80202
- Signal at 303-639-9320 or 6130 Greenwood Plaza Blvd., Greenwood Village, CO 80111
- Office of Behavioral Health at 303-866-7400 or 3824 W Princeton Cir., Denver, CO 80236
- Access Behavioral Health Care at 303-751-9030 or 1-800-984-9133
- Department of Health Care Policy and Financing (HCPF) by calling (303) 866-3513, toll-free at 1 (800) 221-3943, or at 1570 Grant Street, Denver, Colorado 80203
- Ombudsman for Medicaid Managed Care at (303) 830-3560, toll-free at 1 (877) 435-7123, or TTY at 1 (888) 876-8864
- Your insurance company (often complaints can be accepted online or by calling the member services department)