Welcome to WMMHC!

Please answer these questions as they apply to the person receiving services. Make sure to print clearly.

Name: _____

First Middle Last (Maiden)

Preferred Name: _____ Suffix: _____

Date: _____ Social Security Number: _____

Legal Guardian (if applicable):_____

Birthdate: _____ Gender: Male / Female / Other (Circle One)

Contact Preference: work/home/cell*/other _____ Contact Phone: _____

Work Telephone: _____ Cell Phone Number*: _____

Email Address*: _____

****We will use your Contact Preference to do Appointment Reminders unless you select otherwise****

Mailing Address: _____

City, State: _____ Zip Code: _____

Physical Address (if different): _____

City of Residence: _____ County of Residence: _____

Prior County of Residence: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Language Preference: _____

Health Insurance Plan: _____

HEALTH INSURANCE

☐ I DO NOT have any health insurance coverage (i.e. Medicaid, Medicare, Private Insurance, etc.)

☐ I DO have health insurance coverage.

Fill out the section below <u>only</u> if you are insured. If you are a tribal member, include enrollment number and address of the IHS office.

Policyholder's Name & Birthdate	Policy Number	Group Number	Insurance Company Name	Who in the household is covered?
Primary:				
Secondary:				

What are your goals for treatment? _____

1. What is your race?

□ White/Caucasian □ Black/African American □ American Indian/Alaskan Native
□ Non-Hispanic □ Asian □ Native Hawaiian/Pacific Islander
□ Hispanic: Check One ⬇ □ More than one race □ Unknown
□ Mexican □ Puerto Rican □ Cuban □ Other

2. What is your marital status? □ Single-Unmarried □ Divorced □ Separated
□ N/A (client is a minor) □ Married □ Widowed □ Other/Unknown

3. Have you ever served in the military? □ YES □ NO Active Combat? □ YES □ NO

Branch: _____ Type of Discharge? _____

Are you eligible for Veteran's assistance? □ YES □ NO

4. Do you receive Social Security?

□ SSI Due to Mental Illness □ SSDI Due to Mental Illness □ None
□ SSI Not Due to Mental Illness □ SSDI Not Due to Mental Illness

5. What is your legal status?

□ Self/None □ Dept. of Child & Family Services □ Guardian
□ Dept. of Corrections □ Parent or Grandparent □ Other
□ Youth Court □ Youth Treatment Court □ Unknown

6. What is your employment status?

□ Full Time □ Retired □ Homemaker/Caregiver
□ Part Time □ Disabled/Unable to work □ Volunteer/unpaid
□ Unemployed but able □ Supported/Sheltered □ No interest in work
□ Student □ Transitional □ Other: _____

7. Are you <u>currently</u> in school?

□ Not in school □ Public K-12 □ Home School
□ Adult Ed/GED □ Vocational School □ Private K-12
□ College Full Time □ College Part Time □ Other: _____

8. How many years of education have you completed?

□ Completed____ Grade □ Completed High School/GED
□ HS Plus 1 Yr College □ HS Plus 2 Yrs College
□ HS Plus 3 Yrs College □ Bachelor's Degree □ Graduate Degree

9. Who referred you here? (Select one)

□ Self □ Hospital Inpatient/ER □ Friend
□ Native American Agency □ Shelter □ Family
□ Non-Psychiatric Physician □ Police □ School
□ Veteran's Administration □ Clergy □ MT State Hospital
□ Treatment Center □ EAP □ Crisis Center
□ Agency for the Elderly □ DDA □ Court
□ Other Mental Health Provider □ Residential Facility □ Agency for Children
□ Physician Name _____ □ Other Mental Health Center
□ Other _____

10. What is your current living situation? (Select one)

□ Living With Family or Friend
□ Living independently
□ Nursing Home
□ Transient
□ Hotel
□ Hospitalized
□ Mental Health Group Home
□ Shelter
□ Psychiatric Res. Treatment Facility
□ Personal Care Home
□ Jail
□ Child Foster Home
□ Adult Foster Home
□ Homeless
□ Non Mental Health Group Home
□ Living Independently with others
□ Therapeutic Foster Care
□ Supported Independent Living

How long have you lived here? _____

12. Are you coming here voluntarily or are you required to receive services?

□ Voluntary □ Forced Voluntary □ Involuntary, Civil □ Involuntary, Criminal

13. Are you on Probation? □ YES □ NO **Are you on Parole?** □ YES □ NO

Name/phone of Probation /Parole Officer: _____

14. Do you currently have a pending DUI, MIP, or Dangerous Drug Charge? □ YES □ NO

Thank you for choosing Western Montana Mental Health Center for your behavioral healthcare needs. A staff member will assist you in getting connected with someone from our clinical team.

Consent for Remote Group Sessions

To reduce the exposure of our clients and our staff to infectious disease during this highly unusual circumstance related to the COVID-19 pandemic, the provision of substance use disorder services has moved from an in-person format to a telehealth format.

In addition to one-on-one sessions, group sessions continue to be an important and therapeutic part of your recovery. Western Montana Mental Health Center (WMMHC) will continue to provide group sessions and will need your help to make these sessions confidential for everyone involved. You may choose not to participate in any group sessions and continue to receive one-on-one services only.

We will be able to guarantee a confidential setting on the part of our therapist. We will need to following assurances from you:

- You will find a quiet, confidential and private location to participate in group.
- You will immediately alert the therapist running the group if you are unable to maintain the confidential and private nature of your location.
- You agree to participate in these remote group sessions, understanding that other clients will also be in locations that are not controlled by WMMHC.

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I agree to the three conditions stated above and will not join a group session if I cannot reasonably expect to maintain the confidential and private nature of my location. I will let the therapist running the group session know if I am uncomfortable at any time during the session.

_____

Client's printed name

_____ Date:_____

Client Signature

Western Montana Mental Health Center

CLIENT ACKNOWLEDGMENT CONSENT, RIGHTS, AND BEHAVIOR

Please initial below to indicate you have received, read, and understood the following:

_____ Consent for Treatment

_____ Client Rights in the State of Montana

_____ Grievance Procedure

_____ General Aggressive Behavior Policy

_____ Smoking and Weapons

_____ Notice of Privacy Practices

CLIENT SIGNATURE:_____

CLIENT PRINTED NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN PRINTED NAME:_____

STAFF SIGNATURE:_____

DATE: _____

WESTERN MONTANA
MENTAL HEALTH CENTER

CONTRACT FOR PAYMENT OF SERVICES

Please read this fee agreement carefully and ask for any needed clarification. Please initial at the side of each statement and sign at the bottom.

By initialing each area, I attest that **I UNDERSTAND:**

_____ (initial)
1. I agree to pay any and all costs not paid by a third party payer. These costs may include: my deductible, co-insurance, and/or denial of coverage. If I do not wish to have my services billed to a third party or my insurance becomes inactive during treatment, I will be responsible for **payment in full.**

_____ (initial)
2. If I have Medicaid, I agree to pay any co-pay established by Medicaid. I understand that if my Medicaid becomes inactive during treatment or a service is not covered by Medicaid, I will be responsible for **payment in full.**

_____ (initial)
3. If I have Medicare, I understand that Medicare covers some but not all specific services offered by WMMHC. I agree to pay any co-pay established by Medicare. I understand that, if my Medicare becomes inactive during treatment or a service is not covered by Medicare, I will be responsible for **payment in full.**

_____ (initial)
4. I may qualify for public funding in order to offset a portion of my treatment costs. In order to qualify, I must provide proof of income. **I understand if I do not provide the necessary documentation of eligibility, I will not qualify for public funding and will be responsible for payment in full.**

_____ (initial)
5. In the event I do not qualify for public funding, I may be eligible for sliding scale fee services on the basis of my family income and number of dependents. In order to qualify, I must provide proof of income and complete an application. If I do not wish to provide the necessary documentation, I understand I will not qualify for sliding scale fee services and will be responsible for payment in full.

_____ (initial)
6. If my check is returned, I will be charged a returned check fee of $25.00.

_____ (initial)
7. If my income, situation, insurance coverage, address, or phone number changes, I will immediately notify WMMHC.

_____ (initial)
8. In the event I fail to pay fees as agreed upon, my account may be referred to a collection agency and/or law firm. If the event my account is sent to a collection agency and/or law firm, I will be liable for all costs associated with the collections process, including legal and demand costs.

_____ (initial)
9. I understand WMMHC cannot carry patient balances over 12 months from the last date of service. In signing this agreement, I agree to have the balance of my account paid in full within one year unless other arrangements have been made with the Accounts Receivable Department.

_____ (initial)
10. I understand this contract applies to any and all services rendered by WMMHC program and locations.

Client/Guardian Signature: _____ Date:_____

Client/Guardian Printed Name:_____

Staff Signature:_____ Date:_____

WESTERN MONTANA
MENTAL HEALTH CENTER

AUTHORIZATION TO RELEASE INFORMATION - SUD

NAME:_____DOB:_____SSN: _____

Hereby authorizes Recovery Center Missoula to the following (initial all that apply) via the following means:

_____ RELEASE TO_____OBTAIN FROM

_____ ELECTRONIC_____VERBAL _____WRITTEN

Name:_____**Relationship:** _____

Agency:_____

Address: _____

Phone:_____**FAX:** _____ **e-mail**: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

	ACT Records		Discharge Medications		Pre-Sentence Investigation
	Admission/Compliance Status		Discharge Summary		Progress Notes/MD Notes
	Bio-Psych-Social Info.		Family Program Info		Progress Report
	Continued Stay Reviews		History/Physical		Psychiatric Evaluation/Records
	Continuing Care Plan		Intake/Assessment Summary		Treatment Plan
	Demographic Info		Lab Tests (re-release)		Treatment Recommendations
	Diagnostic Impressions		Presence in Treatment		

_____ Re-Release of Records (Specify Record(s): _____

_____ I understand this could include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome Virus), Psychiatric or Mental Health Care, Treatment for alcohol and/or drug abuse.

PURPOSE FOR DISCLOSURE:

_____

_____I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specify the date, event, or condition upon which this consent expires)

_____To revoke this authorization, I must submit a written request to the Clinical Records Department of **Recovery Center Missoula.** I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____I understand that generally **Recovery Center Missoula** may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules.

_____I have received a copy of this authorization and the Privacy Rights Notice

CLIENT SIGNATURE:_____Date: _____

GUARDIAN SIGNATURE:_____Date: _____

WITNESS SIGNATURE:_____Date: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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.

WESTERN MONTANA
MENTAL HEALTH CENTER

AUTHORIZATION TO RELEASE INFORMATION - SUD

NAME:_____DOB:_____SSN: _____

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Name:_____**Relationship:** _____

Agency:_____

Address: _____

Phone:_____**FAX:** _____ **e-mail**: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

	ACT Records		Discharge Medications		Pre-Sentence Investigation
	Admission/Compliance Status		Discharge Summary		Progress Notes/MD Notes
	Bio-Psych-Social Info.		Family Program Info		Progress Report
	Continued Stay Reviews		History/Physical		Psychiatric Evaluation/Records
	Continuing Care Plan		Intake/Assessment Summary		Treatment Plan
	Demographic Info		Lab Tests (re-release)		Treatment Recommendations
	Diagnostic Impressions		Presence in Treatment		

_____ Re-Release of Records (Specify Record(s): _____

_____ I understand this could include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome Virus), Psychiatric or Mental Health Care, Treatment for alcohol and/or drug abuse.

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