JOHNSON COUNTY KANSAS Mental Health

# Client Registration

ClientFirst Name: _____MI:_____ Last Name: _____ SS#_____

Maiden Name:_____ Previous name:_____ Date of Birth: _____ Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Phone#:_____

**Relationship Status:** Single/Never married ☐ Married ☐ Separated ☐ Divorced ☐
Widowed ☐ Living together ☐

**Name of person (other than client) completing the form:** _____

**If not client, is the client with you?** Yes ☐ No ☐

**Relationship to client:** Spouse ☐ Parent ☐ Non-custodial Parent ☐ Legal guardian ☐
Step Parent ☐ Family member ☐ Foster Parent ☐ Case manager ☐ Other (describe): _____

| **Spouse or Parent 1** | **Parent 2** |
|---|---|
| Name: _____ | Name: _____ |
| Maiden or Alias: _____ | Maiden or Alias: _____ |
| Social Security #: _____ DOB: _____ | Social Security #: _____ DOB: _____ |
| Address (if different): _____ | Address (if different):_____ |
| City: _____ State: _____ Zip: _____ | City: _____ State: _____ Zip: _____ |
| Phone # _____ Employer: _____ | Phone # _____ Employer: _____ |
| Client lives with this parent? Yes ☐ No ☐ | Client lives with this parent? Yes ☐ No ☐ |

**Emergency Contact Name:** _____ **Emergency Contact Phone** _____

**Relationship to ER Contact:** _____ **Reside with ER Contact:** Yes ☐ No ☐

**Client Education: (indicate the highest grade completed)**

School grade _____ High school graduate _____ GED _____ Vocational training beyond high school _____

Some college (indicate # of year's) _____ College degree _____ Graduate work, no degree _____

Master's degree _____ JD _____ Doctorate degree _____

**Employment status:** Student ☐ Unemployed ☐ Self-Employed ☐ Part-time ☐
Full-time ☐ Retired ☐ Disabled ☐

**Military Status:**

Have you (client) ever served in the military? Yes ☐ No ☐

Has your parent/guardian ever served in the military? (only if client is a child) Yes ☐ No ☐

**Client Ethnicity:** Asian ☐ Black/African American ☐ Pacific Islander ☐ Native American ☐
White/Caucasian ☐ Other (describe): _____ Are you of Latin or Hispanic ethnicity? Yes ☐ No ☐

**Is client a smoker?** Yes ☐ No ☐

**Insurance**: Yes ☐ No ☐ If yes, what Insurance Carrier? _____

**Previous Client of JCMHC?** Yes ☐ No ☐ **Client #**_____

**JOHNSON COUNTY MENTAL HEALTH CENTER**
**APPLICATION FOR REDUCED FEE**

The Mental Health Center is supported by client fees, insurance, and county and state funds. If you live in Johnson County, you may qualify for a reduced fee. No resident of Johnson County will be denied service because of an inability to pay. Services may be limited or delayed because of refusal to pay.

This form is used to determine how much assistance an individual or family may qualify for in paying for services at the Center. We will help you complete this form if you need assistance. Proof of income is required.

☐ I prefer not to give the following information and will pay the full charge.

Signature: _____ Date: _____

**PERSONAL INFORMATION**

Person receiving services _____ County of Residence_____

List people in your household, including you, who are dependent on this income (do not include children for whom you make child support payments):

| Name: | Relationship: | Age: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**HOUSEHOLD INCOME**

**Copies of supporting documentation are required.** Income should reflect the gross amount paid to or on behalf of any member of the household, before any deductions are taken out. Other Income includes but is not limited to income from savings, dividends, trusts, and estates.

☐ I have Medicaid or ☐ Household income is $0.00, explain: _____

| | Self | | Spouse/ Partner/ Other | | **(For Office Use Only) Annual Income** |
|---|---|---|---|---|---|
| ☐ Wages ☐ Salary | $ ____/hr | _____hrs/week | $ ____/hr | _____hrs/week | $ _____ |
| Self-Employment | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Social Security/Retirement | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Unemployment | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Child Support | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Alimony | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Disability/Workers Compensation | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| Other Income: _____ | $ _____ | ☐ week ☐ month | $ _____ | ☐ week ☐ month | $ _____ |
| | | | | **TOTAL ANNUAL INCOME (FOR OFFICE USE ONLY)** | $ _____ |

I certify that the information provided is an accurate and wholly true statement of my gross income and household size.

Signature: _____ Date: _____

Client Name: _____ Client #: _____

# CONFIDENTIAL INFORMATION

JOHNSON COUNTY KANSAS Mental Health

**Client Medical History**
**Substance Use**

**Client Name: _____**

**Adult (18 and over)**

How many time in the past year have you had 5 (men) or 4 (women) more drinks in a day? _____

How many times in the past year have you used illegal drugs or prescription drugs other than how they were prescribed by your physician? _____

**Adolescent (12-18)**

During the past 12 months did you:

Drink any alcohol (more than a few sips?) _____

Smoke any marijuana or hashish? (Include K2) _____

Use anything else to get high? _____

If you responded no to the above questions, have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? YES_____☐_____ NO_____☐_____

**Medications**

**List ALL medication(s) the client is currently taking (both prescribed and over the counter).**

| Medicine | Dose (if known) | For what reason? | Effective |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Allergies (Medication and/or Food)**

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

JOHNSON COUNTY KANSAS
Mental Health

**ASSIGNMENT OF BENEFITS/INSURANCE RELEASE FORM**

**Account #:_____ Client Name: _____ DOB: _____**

**Primary Ins: _____ Effect Date: _____**

**Policy Holder: _____ Date of Birth: _____ SS#: _____**

**Employer: _____Group#: _____ Relationship: _____**

**ID#: _____ Contract #: _____**

**Secondary Ins: _____ Effect Date: _____**

**Policy Holder:_____ Date of Birth: _____ SS#: _____**

**Employer: _____Group#: _____ Relationship: _____**

**ID#: _____ Contract #: _____**

**Medicaid#:_____ Effective: _____**

**Client or Guardian initial:**

_____ I understand that my insurance company will be billed at the full cost for service, and not my ability fee.

_____ I understand that payments from HRA/HSA/FSA and other insurance managed fund accounts will be applied to the full amount of the patient responsibility as determined by my insurance, and not my ability fee.

_____ I understand that the Mental Health Center is subsidizing a portion of the full cost until my insurance company reimburses.

_____ I understand that my authorization below is allowing the Mental Health Center to collect up to the full cost of services.

**_____ Client is not covered under any health care plan.**

**_____ Client has insurance but does not wish services to be billed to them. This constitutes FULL FEE FOR SERVICES.**

## Client or Guardian initial:

### _____ Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Johnson County Mental Health Center (JCMHC) for any charges not covered by health care benefits. It is my responsibility to notify JCMHC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by JCMHC and/or my insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment of services and/or treatment provided.

### ____ Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicaid and Medicare, to Johnson County Mental Health Center (JCMHC) for all covered services provided to me during all courses of treatment and care provided. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by JCMHC, and will constitute a continuing authorization of any insurance policy that is in effect at the time of service, maintained on file with JCMHC, which will authorize and allow for direct payment to JCMHC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, and care provided. This serves as a lifetime consent for Medicare.

### ____ Release of Information

I authorize Johnson County Mental Health Center (JCMHC) to release information from the medical records of the above-mentioned client for the purpose of accessing insurance benefits. This information may include diagnoses and dates and type of treatment received. Additional information may be requested before claim payment is made and may include, but not limited to, items such as the intake report, treatment plan, progress notes, medications prescribed, and discharge report.

_____ _____

**Client or Guardian or Insured (Signature)** **Date of Signature**