Behavioral Health Registration

Please fill out the following information for the person who will be receiving Mental Health or Addiction Services. If you require assistance completing any of the forms please let an office staff know. Thank you!

WHAT SERVICES ARE YOU SEEKING?

☐ Mental Health Counseling ☐ Alcohol & Drug Treatment ☐ Problem Gambling Counseling ☐ Other___________

CLIENT INFORMATION:

Last Name First Name MI	Social Security No.	Date of Birth	☐Male ☐Female
Street Address City State Zip Code			Home Phone
Mailing Address (if different from above) City State Zip Code			Cell Phone
ODL/Oregon DMV# (*required* for DUII Program)	May we send you a detailed reminder of your upcoming appointments? ☐YES ☐NO ☐Text ☐Voice Message ☐Email:Á		

CLIENT INSURANCE INFORMATION:

OREGON HEALTH PLAN ID #	Name of Mental Health Plan (if applicable)		Name of Medical Health Plan (if applicable)	
MEDICARE ID #	Coverage: ☐Part A ☐Part B ☐Part D			
SECONDARY INSURANCE COMPANY	Group No.	ID#	Insurance Phone Number:	
Responsible Party (if different than insured)	Relationship	Date of Birth	Social Security No.	Phone Number
Is secondary insurance through: ☐Employer ☐Self-purchased ☐Absent Parent ☐Other				

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

_______I agree to be financially responsible and pay for the services provided to me by Polk County Behavioral Health if the services are not covered or fully paid by insurance. I understand that the law allows Polk County Behavioral Health to collect from me the amount owing. If I have health insurance, I hereby authorize Polk County Behavioral Health to furnish all applicable information required by the insurance company(ies) for payment of claims. I hereby assign Polk County Behavioral Health all monies to which I am entitled from insurance, for expense related to the services received from Polk County Behavioral Health.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

_______I have been given written information concerning Polk County Behavioral Health's Privacy Practices. I have had a chance to ask questions about how my information will be used.

ACKNOWLEDGEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

_______I have been given written information concerning my Rights and Responsibilities while enrolled with Polk County Behavioral Health. I have had a chance to discuss any questions or concerns about this document with a Polk County Behavioral Health staff member.

CLIENT CONSENT

My initials beside the statements above indicate my understanding and agreement. I hereby consent authorize Polk County Behavioral Health to provide services for myself, or the named child/person for whom I am legal guardian for. I consent to evaluation and treatment which will be thoroughly discussed with me during the assessment. I understand that I have the right to ask questions of my provider about my treatment services at any time.

_______________________________ _______________________ __________

Client or Legal Guardian Signature Relationship Date

MEDICAL INFORMATION

INDICATE SERVICES YOU HAVE RECEIVED IN THE PAST *Please indicate if we may request these records?*

Service	Provided By	ROI for Records Request:
☐ Mental Health Counseling	Provided By: ______	☐YES ☐NO
☐ Med. Management	Provided By: ______	☐YES ☐NO
☐ A&D Treatment	Provided By: ______	☐YES ☐NO
☐ Gambling Treatment	Provided By: ______	☐YES ☐NO

PRIMARY CARE PROVIDER (PCP) Do you have a Primary Care Provider? ☐YES ☐NO

Dr. Name: ______ Clinic Name/ Location: ______

MEDICATIONS / ALLERGIES

Do you have any Allergies to Medication? ☐YES ☐NO

If yes, please list: ______

If you are currently being prescribed any of the following medications, please mark all that apply:

Medication	Prescriber
☐Abilify/aripiprazole	______
☐Clozaril, Fazalco/clozapine	______
☐Geodon/ziprasidone	______
☐Haldol/haloperidol	______
☐Invega/pallperidone	______
☐Risperdal/risperidone	______
☐Seroquel/quetiapine	______
☐Zyprexa/olanzapine	______

Medication	Prescriber
BENZODIAZAPINES:	
☐Ativan/loraepam	______
☐Klonopin/clonazepam	______
☐Valium/diazepam	______
☐Xanax/alpraolam	______
☐Librium/chlordiazepoxide	______

Medication	Prescriber
STIMULANT DRUGS:	
☐Adderall	______
☐Adderall XR	______
☐Concerta	______
☐Dexedrine	______
☐Dexedrine spansule	______
☐Daytrana	______
☐Metadate CD	______
☐Metadate ER	______
☐Methylin ER	______
☐Ritalin	______
☐Ritalin LA	______
☐Ritalin SR	______
☐Vyvanse	______
☐Quillivant XR	______

Medication	Prescriber
OTHER:	
☐Vicodin	______
☐Oxycontin	______
☐Fentanyl/Duragesic,/Fentora	______
☐Lorcet/Lortab/Norco	______
☐Hydromorphone/ Dilaudid	______
☐Meperidine/Demerol	______
☐Methadone/Dolophine	______
☐Morphine/ MS Contin	______
☐Oxycodone	______
☐Oxyfast/Roxicodone	______
☐Targiniq ER	______
☐Percocet	______
☐Tramadal	______
☐Suboxone	______

Other prescribed drugs not on this list: ______

______

______

Are you Pregnant? ☐YES ☐ NO

Do you use Tobacco? ☐YES ☐ NO

Do you now or have you ever used IV Drugs? ☐YES ☐ NO

Have you used non-prescribed drugs or alcohol in the past 90 days? ☐YES ☐ NO

DEMOGRAPHIC INFORMATION Because we are a Medicaid provider, we are required to ask the following questions.

1. Client last name at birth?______________________________

2. Do you need an interpreter? ☐YES ☐ NO ☐Hearing Impaired? ☐Primary Language:____________________

3. Is the client a veteran? ☐YES ☐NO

4. What is client's legal status?
☐None ☐DUII Diversion ☐DUII Conviction ☐Parole Probation ☐Child Welfare Guardianship ☐Court Guardianship (non-DHS)

5. What is the highest grade completed by client?_______ If currently a student, what school do you attend?__________________

6. What is client's county of residence? ☐Polk ☐Marion Other: __________________

7. What is client's marital status? (*If Living as Married – Please check married)*
☐Never Married ☐Married ☐Divorced ☐Separated ☐Widowed

8. What is client's employment?
☐Full Time ☐Part Time ☐Unemployed ☐Disabled ☐Not in Labor Force
☐Student ☐Homemaker ☐Retired ☐Other: ___________________

9. What is the primary source of income/support for client or parent of client?
☐Wages/Salary ☐Public Assistance ☐Disability/SSDI ☐Retirement/Pension/SSI
☐Other ☐None

10. Estimated Gross Monthly Household Income: ______________ ☐No Income ☐Refuse to Answer
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Á**11. What is the client's living arrangement**?
☐ Live Alone ☐ Live w/Significant other ☐ Live w/parent ☐ÁFoster Home
☐ Jail ☐ Oxford Home ☐ Residential Facility ☐ Room and Board
☐ Supported Housing ☐ Homeless ☐ Other ____________________

12. Please list the number of: ÁÖWQÁArrests in the past month ÁÁÁÁÁÁÁÁÁÁÁÁÁÖWQÁArrests in ˆ[˘ ¦ lifetime _______
ÁÁŒrests in the past month ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁŒrests in your lifetime _______

13. Which of the following best describes client's:

Race?
Mark all that apply
☐ White ☐ Alaska Native ☐American Indian ☐Black or African American
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐Other Single Race

Ethnicity?
☐ Not of Hispanic Origin ☐Cuban ☐Mexican ☐Puerto Rican
☐ Other Specific Hispanic ________________________

Tribal Affiliation ?
☐ Not Applicable ☐Burns Paiute ☐Conf Tribe Coos, Lower Ump & Siuslaw
☐ Conf Tribe of Grand Ronde ☐Conf Tribe of Siletz ☐Conf Tribe of Umatilla
☐ Conf Tribe of Warm Springs ☐Coquille Indian Tribe ☐Cow Creek / Ump Indians
☐ Klamath Tribes ☐Other_______________

14. Who Referred You To Us?

☐Self
☐Family/Friend
☐Doctor, Nurse or Physician
☐Crisis Helpline
☐Media, Internet
☐Advocacy Group
☐School
☐DD Services
☐Aging & Disability
☐ADES

☐ Police or Sheriff
☐ Parole
☐ Probation
☐ Employer
☐ Employment Services
☐ Vocational Rehab
☐ Attorney
☐ Child Welfare
☐ Health Plan / CCO
☐ Jail

☐State Prison
☐Federal Prison
☐State Psychiatric Facility
☐PSRB Board
☐Municipal Court
☐Justice Court
☐Circuit Court
☐Federal Court
☐None
☐Other ________________

FOR OFFICE USE ONLY

RECEIVED BY: ____ CLIENT ID# _______________

FORM # BH R001 (4/15)