OneEighty Client Intake Form

Client Name: ____ Date of Birth ____________________

Address ____

City/State/Zip:____ Phone Number _______________________

County: ____________________________ Social Security Number: ______________________________

Emergency Contact: __________________________________ Emergency Phone: ______________________

Can we leave a message at emergency contact #: Yes or No   Name of your employer: ________________________

Client Signature: ____ Date: ___________________________

We receive funding from United Way to provide our services. In turn, we need to report to United Way annually the total number (not individual names) of clients that received services who are employed or have family members employed by the following companies. Please check if your employer and any family members employers are listed below.

	RITTMAN AREA	44	Hawkins Market	89	Wayne Co. Govt.
1	City of Rittman	45	Holmes Co Govt.	90	Wayne County Public Library
2	Gross Lumber	46	International Paper	91	Wayne Metro Housing
3	Luke Engineering	47	JC Penney	92	Wayne Savings
4	Morton Salt	48	Kmart	93	Wayne-Dalton
5	Rittman Paper Board	49	Lowes	94	WCNB
6	Rittman Schools	50	Luk	95	Webb Atlas
7	Wad-Rittman Hospital	51	Magni-Power	96	Western Reserve
8	Rittman Nursing Home	52	Maverick	97	Whitaker Myers Ins.
9	Waynebanc Corp.	53	Metals USA	98	Wooster Brush
	WOOSTER AREA	54	Metro-Media Tech	99	Wooster City Schools
10	A.C.D.C.	55	N. Central Local	100	Wooster Clinic
11	Akro Inc.	56	Northwestern Local Schools	101	Wooster Eye Center
12	Akron Brass Co.	57	OARDC	102	Wooster Glass
13	Albright Welding	58	ODOT	103	Wooster Hospital
14	American Elec Power	59	OSU-ATI	104	Wooster Iron & Metal
15	Apple Creek Bank	60	Pallotta Ford & Chrysler	105	Wooster Motor Ways
16	Artiflex	61	Post Office - Wooster	106	Wooster Office Plus
17	Bank One	62	Premium Bldg.	107	Wooster Products
18	Bauer Corp.	63	ProQuest (formerly Bell & Howell)		
19	Becker McDowell	64	Rayco		**ORRVILLE AREA**
20	Bogner Construction	65	RBB Systems	108	American Weatherseal
21	Bosche Rexroth	66	Reed Warehouse	109	AmeriSteel Bright Bar
22	Buckeye Container	67	Rubbermaid	110	Buckeye Nutrition
23	Buehler's	68	Savings Bank & Trust	111	Caraustar
24	Campbell Construction	69	Scot Hyponex	112	City of Orrville
25	Cargill	70	Scot Industires	113	Contours Ltd.
26	Cats Meow Village(FJ Design)	71	Sealand Tech	114	Dalton Local Schools
27	Certified Angus Beef	72	Seaman Corp.	115	Dunlap Hospital
28	Christian Children's Home	73	Southeast Local	116	Ferro Corporation
29	City of Wooster Govt.	74	Sprenger Enterprises	117	Flo-Tork, Inc.
30	College of Wooster	75	Sprint	118	J. Horst Manufacturing
31	Comm/Saving Bank	76	Stahl	119	Marshallville Pkg.
32	Community Action	77	Steiner Insurance	120	Orrville City Schools
33	D&S Distribution	78	Timken	121	Quality Castings
34	Daily Record	79	Tri-County Ed Ctr	122	Rosemount Analytical
35	Dominion East Ohio Gas	80	Tring	123	Schantz Organ Co.
36	Elder-Beerman	81	Triway Local	124	Smith Dairy Products
37	Felsted	82	United Titanium	125	Smucker's
38	Ferro-Diamonite	83	UnizAn Bank	126	Technocast
39	First Merit	84	UPS	127	Wayne College
40	Frito-Lay	85	USA Waste	128	Wayne-Dalton Rolling Door
41	G&S Titanium	86	Wal-Mart Millersburg	129	Wenger Excavating
42	Green Local	87	Wal-Mart Wooster	130	Wenger Pipeline
43	Hawkins Cafeteria	88	Wayne Co Career Center	131	Will-Burt Co.

OneEighty
Client Financial Intake and Fee Agreement
(You are responsible for informing us of any financial changes)

Client Name: ____ **Date**:______________________

Client Payment Type (please check all that apply):

_____Insurance (We need a copy of your insurance card)
_____Medicaid (If Medicaid only, proceed to bottom signature and we need a copy of your Medicaid card)
_____Medicare
_____ Self-Pay (If you are 100% self-pay only - no Medicaid/Ins/Sliding Fee - proceed to bottom signature)
_____Other (specify)____

You will be charged 100% of the Fee Schedule until we receive copies of the following checked items:

❒ 2 most recent paystubs ❒ Insurance Card ❒ Medicaid Card
❒ Other: ____

Fill out this section if you have insurance and provide us with a copy of your card.

Insurance Information

Policy Holder: ____SS# __________________________

Policy Holder Date of Birth: ___________________ Relationship to Client: __________________________

By signing below, you are electing to have your insurance company billed first and asking them to pay us directly. This does not release you from financial responsibility for the services received. If your insurance company sends reimbursement directly to you, you are responsible for paying OneEighty directly. You are ultimately responsible for any portion of the bill not satisfied by your insurance company.

I, the undersigned, hereby authorize/request OneEighty, to disclose/receive information regarding diagnosis, treatment, and/or recommendation to/from my insurance company.

I hereby assign and authorize payment of medical benefits from my insurance company to OneEighty, 104 Spink Street, Wooster OH 44691 for services rendered by OneEighty.

____
Policy Holder Signature Date

Income includes spouse income.

Self-Pay/Sliding Fee Scale Information

We offer a sliding fee scale for individuals who may not have the income or ability to pay the full fee. If you are interested in applying for assistance, please complete the following information and provide verification of income. You will be billed 100% of fees incurred for failure to provide proof of income.

Source of income: (Please check all that apply) ❒ Wages/Salary ❒ Alimony ❒ Savings/Invest ❒ SSI ❒ SSDI ❒ SS Retirement ❒ Child Support ❒ Family or Relative ❒ Disab/wComp ❒ Retirement Pension ❒ Gen Relief/Welfare ❒ Aid for Dep Child ❒ None ❒ Other

Gross Annual Family Income: _________________________ #of people claimed on income tax__________

Your % of the fees will be: ____________%.

If it is determined that you are eligible for Medicaid, your financial scholarship will expire in 90 days at which time you will be responsible for 100% of your fees unless you have enrolled with Medicaid.

1. If I am a self-pay client, I will pay my portion of the fee at the time of service, and if I am an insurance client and my insurance company does not pay 100% of the fee, I will pay the balance.
2. I understand that OneEighty will not refuse services for those who cannot pay, but if it has been determined I can pay, OneEighty will use various means to collect delinquent fees including collection agencies, withholding of recommendations and final discharges, and small claims court.

____
Client Signature Date

____
Responsible Party Signature Date

CONSENT TO RELEASE FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I,____,
[Client's Name]
authorize OneEighty, Inc. and its agents, contractors and affiliates to disclose any and all medical information regarding my treatment, including but not limited to any substance use disorder records to my insurance company ____________________________for the purpose of
[Name of Insurance Company]
payment purposes.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder 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 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

upon termination of my treatment by OneEighty, Inc., after all payment for services has been received, and after the conclusion of any retention periods required by law.

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: __________ ____
Signature of Client

____
Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

CONSENT TO RELEASE FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

Revocation of Consent:

Dated: ____________ ____

Signature of Client

____

Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

Date revoked:________________________ **Staff initials:______**

CONSENT TO RELEASE TO ELECTRONIC HEALTH RECORD PROVIDER AND FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I,____,
[Client's Name]
authorize OneEighty, Inc. and its agents, contractors and affiliates to disclose any and all medical information regarding my treatment, including but not limited to any substance use disorder records to AdvancedMD, Inc. for the purpose of maintaining an electronic health record ("EHR") for me and sending any relevant information to my third-party payer entity, if any, for payment purposes.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder 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 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

upon termination of my treatment by OneEighty, Inc., after all payment for services has been received, and after the conclusion of any retention periods required by law.

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ____________ ____
Signature of Client

____
Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

Revocation of Consent:

Dated: ____________ ____

Signature of Client

____

Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

Date revoked:________________________ Staff initials:______

CONSENT TO RELEASE TO MEDICAL LABORATORY SERVICES AND FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I,____,
[Client's Name]
authorize OneEighty, Inc. and its agents, contractors and affiliates to disclose any and all medical information regarding my treatment, including but not limited to any substance use disorder records to Millenium Health, LLC , Inc. for the purpose of laboratory services and allowing Millenium Health, LLC to send any relevant information to my third-party payer entity, if any, for payment purposes.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder 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 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

upon termination of my treatment by OneEighty, Inc., after all payment for services has been received, and after the conclusion of any retention periods required by law.

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ____________ ____
Signature of Client

____
Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

Revocation of Consent:

Dated: ____________ ____

Signature of Client

____

Signature of person signing form if not Client

Describe authority to sign on behalf of Client ____

____

Date revoked:________________________ Staff initials:______

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION ABOUT PERSONS RECEIVING SERVICES FROM ONEEIGHTY

(Client Name)____authorizes OneEighty to disclose to the Mental Health and Recovery Board of Wayne and Holmes Counties (ADAS/ADAMH Board) from whom I may be seeking funding for services, the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services and/or Job and Family Services ("Departments"), the information necessary to accomplish the following purposes:

- To enroll me in the Multi-Agency Community Services Information System (MACSIS) which is the shared computer payment system used by CMH/ADAS/ADAMH Boards and the Departments.
- To determine my eligibility for publicly-funded services.
- To pay claims for services I receive
- To report information required by the ADAS/ADAMH Board and/or the Departments regarding characteristics of individuals seeking services and the services provided. I understand that the Board and Departments use the information in aggregate form for service planning and evaluation purposes.

I understand that I must authorize disclosure of information necessary for payment purposes in order to receive alcohol and drug addiction services. My treatment or payment for my services cannot be conditioned upon my giving authorization for any purpose other than payment.

<u>If I am not receiving funding</u> from the ADAS /ADAMH Board and Departments, I am authorizing OneEighty to only disclose the following information:

- To report information, as required by Ohio law, about reportable incidents that may occur while I am receiving services to the ADAS/ADAMH Board and Department(s).

I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment with OneEighty

I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that OneEighty cannot control the use of this information once it has been disclosed.

____ _________________________

Signature of Individual (Client) **Date**

____ _________________________

Signature of Personal Representative Date

* *

Explanation of efforts to obtain authorization, if signature is declined:

____

____

____ _________________________

Signature of Staff Person attempting to obtain authorization Date

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? ☐ Yes ☐ No **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): ____________
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Medical History Form

Name ____ Birthdate ____________________

Last physical exam:	When:	Doctor:

Please list all medications now being taken:		
Medication	Dose/How long taken	Prescribing Physician

Over-the-counter medications (e.g. vitamins, diet aids, laxatives, etc): ____________________

____

ILLNESS Please indicate if you have, or have ever had, any of the following illnesses. Check the box if the answer is yes. Please indicate the year you had the problem or when it started.

□ Anemia	□ Headaches	□ Sinus Problems
□ Arthritis	□ Heart disease	□ Skin Disease
□ Asthma	□ Hearing Loss	□ Stroke
□ Back Problems	□ Intestinal Problems	□ Thryoid Disease
□ Bronchitis/Emphysema	□ Hepatitis/Liver Dx	□ Tuberculosis
□ Cataracts	□ High Blood Pressure	□ Tumors
□ Cancer	□ Kidney/Renal Dx	□ Ulcers
□ Diabetes	□ Pneumonia	□ Vascular Dx
□ Hay Fever/Allergy	□ Seizures/Epilepsy	□ Vision Problems

Other significant illnesses/date ____

____

Childbirth History:
Currently pregnant □ No □ Yes □ 1st Trimester □ 2nd Trimester □ 3rd Trimester
Childbirth within the last 5 years? □ Yes □ No
Total number of births (live and still)

Signficant weight loss/gain in the last year: □No □ Yes How much change:

Hospitalizations in the last 3 years □ No □ Yes, please complete below:		
Hospital	City/Date	Reason
Emergency Room Visits in the last year □ No □ Yes, please complete below:		
Hospital	City/Date	Reason

over

Please indicate if client uses any of the following:
Cigarettes(Packs per day/# years)_______________________________ Past smoking history?___________
Coffee, tea, cola (circle 1 or more) ________glasses/day___________

Allergies (drug or food):____

Have you ever had a head injury or concussion? If so, when? ______________________________________

Were you treated by a doctor at the time of injury? If yes, who? ____________________________________

Do you have any ongoing problems due to history of head injury? If yes, what symptoms do you experience? ____

Do you have health concerns not listed on this form? If yes, what are they and what treatment do you receive for them? ____

Do you use any Complementary Health Practices such as natural products, yoga, non-traditional healers, etc? If so, which do you use?____

Do you have any difficulties with Activities of Daily Life? (such as bathing, dressing, obtaining meals)________
____

Would you like a consultation from our Medical Services Department? (for example: review medications, health questions or health screening, check blood pressure, etc.) ☐ Yes* ☐ No If yes, what you would like the consultation for?

If Yes is checked, please send a copy of this form to Medical Services Supervisor.

Print Client's Name **Date**

Signature of Person Completing Questionnaire **Date**

Reviewed By **Date**

ACKNOWLEDGEMENT AND TREATMENT CONSENT FORM

Name: ____

I have received (and if appropriate legal guardian/custodian has received) a written packet of <u>all</u> the information as indicated below:

- Informed Consent
- Treatment Consent
- Telehealth Consent
- Electronic Health Record and Billing Consent
- Confidentiality
- Client Rights
- Client Abuse Policy
- Client Fee Policy
- Client Responsibilities
- Policy regarding provision of services to sensory impaired clients
- Client Grievance Procedure
- HIV/AIDS, Hepatitis B/C & Tuberculosis Brochure

My signature below is to confirm that:

- A staff member of OneEighty has been available to explain the information and to answer any questions regarding the above packet.
- I have read and understand the content of each of the above forms, and consent to the same.
- I understand that OneEighty uses security cameras in common areas. I acknowledge and agree that if I am in a common area, I may be recorded for the purpose of maintaining safety on the premises.
- **I understand that OneEighty** is a dynamic, integrated health system providing the following services: Addiction Services, Peer Support, Mental Health Services, Domestic Violence and Sexual Assault Services, Rape Crisis Center Services, Housing and Supportive Services and Prevention and Education Services. **I further understand that the staff members are trained to provide appropriate treatment and/or services as needed in this area.**
- **I agree to treatment or services as offered by OneEighty:**
  _____Myself **_____ My Child (or person for whom I am legal guardian/custodian)**

Client Signature: ____ Date: ______________

(If needed)
Legal Guardian/Custodian: ________________________________ Date: ______________
Staff Signature: ____ Date: ______________

Revised 9-2020