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 Monthly 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

OneEighty

Helping people change direction.

ACKNOWLEDGEMENT AND TREATMENT CONSENT FORM

Name: _____

I have received (and if appropriate legal guardian/custodian has received) a written packet of all 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

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:**_____

MY DOCTORS CAN NOW SHARE MY MEDICAL RECORDS ELECTRONICALLY!

Automatic Consent

You are automatically enrolled in the Health Information Exchange so your medical records can be electronically shared among your doctors. You can opt out of this exchange by filling out the front page of this document.

Important Information for Doctors

Sharing records electronically is a simple, fast way for your healthcare provider to get a "whole" picture of your health in one record, no matter where you have been treated in Ohio.

Saving Time and Lives

This is especially important in an emergency, when you may be unconscious or unable to speak. Your doctor can save time and even your life when your medical history is right there.

Improved Patient Safety

If you're away from home and in Ohio when you get sick, clinicians can view what medical problems you have and see any allergies you might have. This improves your care and your safety.

Quicker Results

When your doctor orders tests, the health information exchange quickly sends those results in real time. Your physician also can get the most up-to-date and accurate information from others who have treated you.

Privacy and Security

Only doctors and staff who treat you can look at your health information. Your records remain private in a secure network that is audited.

Request to Change Consent

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you **DO NOT** want to have your records shared, please mark the box below.

☐ **I don't want to have my records shared on a Health Information Exchange.** I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously said you didn't want to have your records shared and **NOW WANT** them shared, please mark the box below. This will allow your status to be changed.

☐ **I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.**

First Name: _____ Middle Name: _____
Last Name: _____
Previous Last Name: _____ Date of Birth: _____/_____/_____
Gender: ☐ Male ☐ Female ☐ Undisclosed
Street Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____
Email Address: _____
Last Four Digits of Social Security Number: _____
Patient Signature: _____ Date: _____/_____/_____
(If under the age of 18, signature of parent or legal guardian): _____

You can have the information below filled out by your medical provider's office staff, hospital or other facility so they can change your consent. **OR**, you can have it notarized and mail it to: ***Attn: CONSENT STATUS, Ohio Health Information Partnership, 3455 Mill Run Drive, Ste 315, Hilliard, OH 43026***.

Section to be completed by a Notary Public or Medical Office:

I witnessed the above named individual sign this document and the individual is personally know to me or provided me with valid picture identification on this day _____ of _____, 20_____.

Notary or Medical Office Staff Print Name: _____

Phone Number: (_____) _____-_____

Notary or Medical Office Staff Signature: _____

CONSENT TO RELEASE TO MEDICAL LABORATORY SERVICES AND FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I, _____

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 HealthTrackRx for the purpose of laboratory services and allowing HealthTrackRx to send any relevant information to my third-party payer entity, if any, for payment purposes.

I understand that by 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

Signature of person signing form if not client

Describe authority to sign on behalf of client:

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:_____**

CONSENT TO RELEASE TO MEDICAL LABORATORY SERVICES AND FOR BILLING

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I, _____

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 Quest Diagnostics for the purpose of laboratory services and allowing Quest Diagnostics to send any relevant information to my third-party payer entity, if any, for payment purposes.

I understand that by 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

Signature of person signing form if not client

Describe authority to sign on behalf of client:

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.

OneEighty
Helping people change direction.

Client Information Form – Adult

In a few words or sentences what help or services do you need from OneEighty? How can we help you?

Gender:

☐ Female ☐ Trans Female ☐ Male ☐ Trans Male ☐ Decline to Answer ☐ Other

Pronouns:

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Ze ☐ Other

Date of Birth:

Marital Status:

☐ Single/Never Married ☐ Separated ☐ Married/Living Together as Married ☐ Divorced/Annulled ☐ Widowed ☐ Unknown

Race:

☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Caucasian/White ☐ Native Hawaiian/Other Pacific Islander ☐ Other Single Race ☐ Two or More Races ☐ Unknown

Ethnicity:

☐ Cuban ☐ Hispanic - Specific Origin Not Given ☐ Mexican ☐ Not of Hispanic Origin ☐ Puerto Rican ☐ Other Specific Hispanic ☐ Unknown

Living Situation:

☐ Private Residence (rent or own) ☐ Friend's or Family Home ☐ Foster Care ☐ Homeless/Lacking a Permanent Residence ☐ Jail or Correctional Facility ☐ Permanent Supportive Housing ☐ Residential Care/Group Home/ACF ☐ Community Residence ☐ Temporary Housing ☐ Mental Health Institution ☐ Nursing Home ☐ DD Licensed/Operated Facility ☐ Other Institution ☐ Other

Number of children in the household under 18:

Current Life Stressors: Check all that apply:

☐ Financial ☐ Family ☐ Job ☐ Health Issues ☐ Housing Difficulties ☐ Legal Trouble ☐ Work Trouble ☐ Chronic Pain ☐ Grief/Loss ☐ Recent Trauma (e.g. victim of crime, abuse, natural disaster) ☐ Other

Current Physical Disabilities/Limitations

☐ Yes ☐ No

If yes, describe:

Do you need any assistive devices or interpreters to participate in services?

☐ Yes ☐ No

If yes, describe:

The best way to communicate with me is:

☐ By phone call ☐ By text ☐ By e-mail ☐ By letter ☐ Other

Please identify someone who we would contact in an emergency: provide their name, relationship, and phone number

Health History

Primary Care Doctor Name	
Phone Number	
Date of Last Physical Exam	

Please list all medications now being taken

Row	Medication	Dose	How Long Taken	Prescribing Physician	OTC Medications (vitamins, diet aids, laxatives, etc.)

Allergies (drug or food):

Illnesses

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

Other Significant Illnesses/Date

Childbirth History:

Currently pregnant

☐ Yes ☐ No ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

Childbirth within the last 5 years?

☐ Yes ☐ No

Total number of births (live and still)

Significant weight loss/gain in the last year:

☐ Yes ☐ No

How much change?

☐ gained 10 pounds ☐ gained 20 pounds ☐ gained 30 or more pounds ☐ lost 10 pounds ☐ lost 20 pounds ☐ lost 30 or more pounds

Hospitalizations in the last 3 years

☐ Yes ☐ No

Yes, please complete below:

Hospital	City	Date(s)	Reason

Emergency Room Visits in the last year

☐ Yes ☐ No

Yes, please complete below:

Hospital	City	Date(s)	Reason

Do you currently use any of the following?

Tobacco products: ☐ Yes ☐ No If yes, what products? Ex: cigarettes, chew, cigars, etc.

If yes, how much did you use and for how long? #packs per day/# years

Have you used tobacco products in the past? Yes No

If yes, explain

Coffee, Tea, Cola Amount per day

Do you have health concerns not listed on this form?

☐ Yes ☐ No 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?

☐ Yes ☐ No If so, which do you use?

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

☐ Yes ☐ No If yes Please describe

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling or appearing down, depressed or hopeless.	☐	☐	☐	☐
c. Trouble falling or staying asleep or sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Indicating that s/he feels bad about self, is a failure, or has let self or family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people have noticed, or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual.	☐	☐	☐	☐
i. States that life isn't worth living, wishes for death, or attempts to harm self.	☐	☐	☐	☐
j. Being short-tempered, easily annoyed.	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____ x 0 =	_____
Several days	(#) _____ x 1 =	_____
More than half the days	(#) _____ x 2 =	_____
Nearly every day	(#) _____ x 3 =	_____

Total score: **_____**

Interpreting PHQ-9 Scores

Minimal depression	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Actions Based on PH9 Score

Score	Action
< 4	The score suggests the patient may not need depression treatment
> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/