New Horizons Mental Health Services
REGISTRATION FORM

Today's Date:

CLIENT INFORMATION

Last name:	First:	Middle Initial:

Parent/Guardian (if minor):

Birth date:	Age:	Gender:	Social Security No.:

Address: City: State: Zip Code:

County of Residence: Home phone no.: Cell phone no.:

Employer: Position: Employment Start Date:

Employment Status: (Please select one) ☐ Full Time (35+ hrs) ☐ Part Time (21-35 hrs) ☐ Sheltered ☐ Unemployed (Actively looking for work) ☐ Disabled ☐ Engaged in Residential/Hospitalization ☐ Homemaker ☐ Inmate ☐ Retired ☐ Student ☐ Volunteer Worker ☐ Other not in labor force ☐ Unknown

Military Status: (Please select one) ☐ Active ☐ Discharged ☐ Disabled veteran ☐ None

Number of arrests in the past 30 days:

Marital Status: (Please select one) ☐ Divorced ☐ Married and living together ☐ Separated ☐ Single-Never Married ☐ Widowed ☐ Unknown

Living arrangement at admission: ☐ Private residence-Adult ☐ Private residence-Child ☐ Residential care/Group home/ ACF ☐ Foster care ☐ Permanent supportive housing ☐ Community residence ☐ Temporary housing ☐ Foster care ☐ FDD licensed/Operated facility ☐ Correctional facility ☐ Homeless ☐ Other ☐ Unknown

Current Education Enrollment: (Please select one) ☐ Pre-school ☐ K-12th grade ☐ GED classes ☐ College ☐ Vocation/Job training ☐ Other schooling (e.g., Adult basic Ed., literacy) ☐ Has not attended school in last 3 months ☐ Unknown

Highest Education Level Completed ☐ < 1st grade ☐ 1st grade ☐ 2nd grade ☐ 3rd grade ☐ 4th grade ☐ 5th grade ☐ 6th grade ☐ 7th grade ☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ 12th grade ☐ High school diploma/GED ☐ Technical school ☐ Some college ☐ 2 year college/Associate degree ☐ 4 year college/Bach degree ☐ Graduate degree ☐ Unknown

Education type: ☐ Has Individual Education Plan (IEP) ☐ Does not have Individual Education Plan (IEP)

Referred by: ☐ Individual (self-referral/family/friend) ☐ AOD care provider ☐ Mental health provider ☐ Other health provider ☐ School ☐ Employer/EAP ☐ Child welfare (CDJFS, CSBS) ☐ Ohio Family and Children First Council ☐ Court ☐ Other

Race: (Please select one) ☐ White ☐ African American/Black ☐ Asian ☐ Other Ethnicity: ☐ Hispanic /Latino ☐ Non-Hispanic/Latino

Disabilities:

Client needs the assistance of an interpreter? Client needs assistance with visualization of material format?

Behavioral Health Advance Directives? ☐ Yes ☐ No, but like to request information ☐ No, and declines information

PRIMARY CARE PHYSICIAN

Name of Primary Care Physician: ☐ Do not have one

Physician Address: Phone number:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill: Home Phone:

Address (if different):

Please indicate primary insurance: ☐ EAP

Subscriber's name: Subscriber's S.S. no.: Birth date:

Policy or Medicaid No: Group No: Co-payment:

Patient's relationship to subscriber:

Please indicate secondary insurance (if applicable):

Subscriber's name: Subscriber's S.S. no.: Birth date:

Policy or Medicaid No: Group No:

Patient's relationship to subscriber:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Horizons Mental Health Agency. I understand that I am financially responsible for any balance. I also authorize New Horizons Mental Health Services or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

EMERGENCY CONTACTS

In case of an emergency of if we are unable to reach you, New Horizons Staff may contact the following:

☐ Client/Guardian declines to provide emergency contact or there is not one available. Staff Initials _____

Name:	Relationship to Client:		
Address:			
City:	State:	Zip:	Phone no.:

Is there anyone else we may call (For example: Your employer, family member, friend, pastor, etc)? ☐ Yes ☐ No

Name:	Relationship to Client:		
Address:			
City:	State:	Zip:	Phone no.:

Is there someone who can call on your behalf (For example: Spouse, partner, adult child, etc)? ☐ Yes ☐ No

Name:	Relationship to Client:		
Address:			
City:	State:	Zip:	Phone no.:

New Horizons will not release any clinical information to these contacts. Discussing clinical information requires a signed release of information. Your clinical information is strictly confidential.

New Horizons Mental Health Services
INFORMED CONSENT FOR TREATMENT

Today's Date: Client Name: Date of Birth:

ACKNOWLEDGMENT OF CONSENT FOR TREATMENT

1) I agree to receive ☐ Mental Health and / or ☐Alcohol and other Drug treatment offered by New Horizons for:
   ☐Myself ☐My child ☐The person for whom I am legal guardian

2) I give consent for the use of my Protected Health Information for treatment, payment and health care operations as described in the Notice of Privacy Practices.

3) I acknowledge this consent is voluntary.

4) I further acknowledge that I may revoke, in writing, this consent at any time; except to the extent that action based on this consent has already been taken.

Client/Guardian Signature _____ Date _____

Staff/Facilitator Signature _____ Date _____

I have received a copy of the Client Handbook → Client initials _____
I have declined a copy of the Client Handbook → Client initials _____
I received a copy of the Client Rights Statement at my annual redetermination →Client Initials _____

I understand that if at any time I decide to withdraw my consent for treatment I can ask front office staff or my provider for the Withdrawal of Consent for Treatment form.

If questions, I may discuss with my clinician, or obtain the Handbook at any time during my course of treatment.

☐Myself, being a minor 14 years of age or older → *Clinical Director prior-approval is required before first appointment is scheduled. Treatment will not exceed thirty (30) days or six (6) sessions, whichever occurs sooner. Treatment does not include Pharmacotherapy.*
Clinical Director Signature _____ Date _____

CLIENT HANDBOOK includes information about:

- Crisis Intervention
- Special Treatment Conditions Concerning:
  - Risk of Harm to Myself or Others
  - Child and Older Adult Abuse
- My Individual Treatment Process
- Clinical Treatment Process
- My Rights, Responsibilities and Satisfaction
- Benefits and Risks of Treatment and Services
- Privacy Policies
- Safety Practices on Agency Premises
- Various Health Information
- Community Resources Available

New Horizons Mental Health Services
INFORMED CONSENT FOR SHARING INFORMATION

Today's Date: Client Name: Date of Birth:

ACKNOWLEDGMENT OF CONSENT FOR SHARING INFORMATION WITH THE STATE OF OHIO

1) I agree to CONSENT TO SHARING INFORMATION FOR:
☐ Myself ☐ My child ☐ The person for whom I am legal guardian

2) I give consent for New Horizons Mental Health Services to share the Protected Health Information for treatment, payment and health care operations with the State of Ohio for the purpose of evaluation relating to state and federal funds expended for such purposes.

3) I acknowledge this consent is voluntary.

4) I further acknowledge that I may revoke, in writing, this consent at any time; except to the extent that action based on this consent has already been taken.

Client/Guardian Signature Date

Staff/Facilitator Signature Date