# 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 ☐ 6th grade ☐ 7th grade ☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th 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

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.

Client/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: |
| 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: |
| 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: |
| 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

New Horizons Mental Health Services

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

## CONSENT TO RECEIVE EMAIL/TEXTS

New Horizons may use texting or email as a way to schedule or confirm appointments or to arrange transportation. Please be aware that email and texting should be used for appointment management only. These forms of digital communication should never contain confidential, clinical information or be considered treatment. Texting is not an appropriate way to reach out for help during a crisis or emergency situation. If you are experiencing an emergency please contact 911 or the Crisis Talk Line at (740) 687-8255.

I give my permission for communication by email/texting, understanding the limits of protection using such electronic means. I understand that I may revoke my authorization at any time, except to the extent that action will have been taken prior to the revocation of my consent. Otherwise, this authorization is valid for the duration of my treatment at New Horizons.

Email Address: _____

Cell Phone Number: _____ Cell Phone Provider: _____

_____ _____
Client/Guardian Signature Date

_____ _____
Staff Signature Date

## REVOCATION OF CONSENT

I wish to revoke my consent.

_____ _____
Client/Guardian Signature Date

_____ _____
Staff Signature Date

## Telehealth Informed Consent and Privacy Acknowledgement

We are able to offer you our services through a Telehealth option when you are not able to come on site or be otherwise available for face-to-face services with our agency. This option would allow you to community with your provider remotely through technology instead of in person. On your end this could be via a computer or laptop with camera and microphone, a tablet connected to the Internet, or a smart phone with a camera. Telehealth could also involve communicating by audio only with a telephone when video is not possible.

Expected benefits for using Telehealth/telephone sessions: Improved access to behavioral healthcare services. You can remain in your home or other chosen site for safety and health reasons and still receive a remote service with your provider. This also reduces travel time for appointments, allowing you more flexibility to fit them in your day.

Possible risks in using Telehealth/telephone sessions: As with any healthcare procedure, there are potential risks associated with the use of Telehealth. These include but may not be limited to: In rare cases, information transmitted may not be sufficient (example, poor resolution images or voice) to allow a complete session. Delays in treatment could occur due to deficiencies or failures of the equipment; in very rare instances security protocols could fail, causing a breach of privacy of personal information (as with traditional face-to-face services). In case we get disconnected or you are in crisis, we will ask you for a phone number and your current location and address at the beginning of the session. You can also call us back at the number(s) listed below if disconnection occurs.

To protect your privacy, we will never record Telehealth sessions (unless it has been previously agreed to by all parties for a specific reason), will use a video platform that is secure and encrypted, and will start each session with security questions to confirm your identity and contact information.

Our New Horizons Mental Health Services Privacy Policy (in the Client Handbook) and Informed Consent for Treatment applies to all services in all forms of delivery. The laws that protect privacy and the confidentiality of health information also apply to Telehealth, and no information obtained in the use of Telehealth which identifies you will be disclosed to other entities without your consent.

You have the right to withhold or withdraw your consent to the use of Telehealth services in the course of your care at any time without affecting your right to future care or treatment.

By signing below (or verbal verification when signature is not possible), you are verifying that you understand your privacy rights in regards to telehealth, you understand the benefits and risks, and you consent to participate.

_____ _____
Client/Guardian Signature Date

_____ _____
Staff Signature Date

# New Horizons Mental Health Services
## Fee Agreement

Terms and Conditions:

- I understand that if I am unable to keep my appointment, I must give 24 hours notice. I further understand that I may be charged a fee for the scheduled service unless I give 24 hours notice. Failed appointment fees are based on the type of appointment scheduled.

  Counseling Appointment - $50.00  Psychiatric Evaluation - $100.00  Psychiatric Follow up - $50.00

  - Failed Appointment fees may be reduced based on your sliding fee scale to a minimum of $10.00 per occurrence.
  - I understand that I am responsible for failed appointment charges, even if I have no other out-of-pocket responsibility.
  - **I further understand that two consecutive failed appointments or a pattern of failed/cancelled appointments may result in termination of services**.

- I understand that my fee will be determined by the agency sliding fee scale, which is based upon my gross annual family income and the number of dependents in my home. I understand that if I am not a resident of Fairfield County, I **do not** qualify for a sliding fee scale discount. I further understand that in order to receive a discount, I must supply verification of income within 30 days of the date of this agreement.
- Although the fees may change without notice, other than posting at the reception window, my percent rate will not change without my signing a new fee agreement. My fee will be redetermined on or about _____.
- If court testimony or deposition is required, I will be charged the full cost of services for the staff member's time away from the office.
- I understand that payment/co-payment is required at the time of service and that future appointments will not be scheduled if I have an outstanding balance, or if I do not provide payment or co-payment at the time of service.
- I understand that I have the right to request an exception to the collection policy if I am unable to make a payment at the time of service. To do so, I will inform the billing office that I need an exception, and then my doctor or therapist will be notified to determine my eligibility. I may contact the billing office the next workday regarding my request. We may ask you for additional financial information. If approved, I may schedule an appointment. If denied, I may request to speak to the billing office supervisor, and then to the clients' rights officer to appeal the decision.
- I understand that there will be a $25.00 charge to my account for any returned checks.
- My gross annual income is $_____ per year. The total number of dependents in my home is _____.
- My fee payment source is (check all that apply):

| | | |
|---|---|---|
| ___Private Insurance | ___Other Government Payments | ___Self Pay |
| ___Medicaid | ___Other Health Insurance | ___Other payment source |
| ___Medicare | ___Title XX | ___Worker's Compensation |
| ___No charge | ___EAP | |

Title XX clients will be charged 5% for **ALL** services when Title XX funds have been exhausted.
Please present insurance information or medical card at each appointment.

- My primary source of income/support:

| | | |
|---|---|---|
| ___Disability (SSI, SS, WC) | ___Retirement/Pension | ___Other |
| ___Family/relative | ___Wages/Salary | ___Unknown |
| ___Public Assistance | ___None | ___No charge |

- My fee percentage will be _____%.

If my insurance pays part of the full service cost, I will be responsible for my percent of the unpaid balance. If I live outside of Fairfield County, I will not be eligible for a discount. If I have managed care coverage, I will not be eligible for a discount.

- I understand that there are varying charges for each service, and if any additional services are required, I will be responsible for the fees charged for those services.

I further agree:

- To report any changes in my family income to the Billing Office.
- To bring any insurance payments that I receive directly to New Horizons Mental Health Services.

I understand that my failure to comply with the terms and conditions of this agreement may result in termination of service.

_____ _____ _____ _____
Signature  Date  Staff  Date

New Horizons Mental Health Services does not discriminate in employment or services because of race, creed, color, national origin, sex, or political affiliation.

**New Horizons Mental Health Services**
**CONSENT FOR TREATMENT/AUTHORIZATION FOR BILLING**
**Confirmation of ADAMH Privacy Notice**

To be eligible to receive public funds to help pay for the cost of your mental health, substance use and/or supportive services, you will need to sign this statement that allows the agency to give demographic and billing information to **Fairfield County Alcohol, Drug Addiction & Mental Health Board; the Ohio Department of Mental Health and Addiction Services; the Ohio Department of Job and Family Services; The Ohio Department of Medicaid,** and **GOSH (Great Office Solution Helper)** and process claims in compliance with state requirements.

**ALL INFORMATION COLLECTED WILL BE CONFIDENTIAL,** consistent with state and federal law. Name identified information will only be used to pay for services received. Other information will be kept without your name attached. This information will not be available to any other sources or used for any other purposes. You have the right to review your records and notify the agency of errors in your record. Billing information will be kept for seven (7) years after you have received services, and only demographic information will be kept after that time.

If you do not agree to sign this disclosure and authorization form, the Board may not be able to use public funds to pay for your services.

Agency Name: New Horizons Mental Health Services

☐ I have read and understand the above and authorize the disclosure of name identifying billing information to the Fairfield County Alcohol, Drug Addiction & Mental Health Board; the Ohio Department of Mental Health and Addiction Services; the Ohio Department of Job and Family Services and GOSH (Great Office Solution Helper).

☐ I received or have been offered the Fairfield County ADAMH Privacy Notice and understand if I have questions or concerns, I can reach out to the ADAMH Board at 740-654-0829 or Fairfield County ADAMH Board (fairfieldadamh.org)

Name of Client:_____ Client ID # _____

_____ _____
Signature of Client/Guardian Date

## NOTICE OF ENROLLMENT – GREAT OFFICE SOLUTION HELPER (GOSH)

To receive mental health services paid for by public funds, you must provide information so that the Fairfield County Alcohol, Drug Addiction & Mental Health Board and/or the Mental Health Board of your home county can:

- Enroll you in the county behavioral health care plan
- Determine if you are eligible for publicly funded services, and
- Pay the provider for your services through the GOSH computer system, which connects the Board to the Public-Private Solutions hub, the Ohio Department of Mental Health, and the Ohio Department of Human Services.

All information will be kept confidential, consistent with state and federal law. Name identifying information will be used only to pay for services provided to you. Demographic information will be kept without your name attached, and reported to the State Department and the Ohio Health Care Data Center. This information will not be available to other sources or used for other purposes. Billing information will only be kept for up to seven (7) years after you have received services, and only demographic information will be kept after that time.

I have read and explained this information to the above-named individual:

_____ _____
Agency Staff Signature Date

********THIS SECTION TO BE COMPLETED ONLY BY OUT-OF-COUNTY CLIENTS ********

## GOSH 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 the 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, out-of-county).

A client's or legal guardian'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?<br>☐ Yes ☐ No If yes, complete the following information. | |
| County | |
| Client Name (please print) | |
| Street Address for Residency Determination Purposes | |
| City, State, Zip for Residency Determination Purposes | |
| Signature of Client | Date |

**Minor**

| | |
|---|---|
| Client is a minor?<br>☐ Yes ☐ No | If yes, indicate if child is in legal custody of the following (this is not the foster parent):<br>☐ 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) | |
| City, State, Zip for Residency Determination Purposes | |
| 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.

# New Horizons Mental Health Services

230 N Columbus St Ste 2
Lancaster, Ohio 43130
p-740.901.3150
f-740.808.8172

2652 Kull Rd.
Lancaster, Ohio 43130
p- 740.277.6733
f- 740.277.7020

NEW HORIZONS
MENTAL HEALTH SERVICES

2660 & 2680 Kull Rd.
Lancaster, Ohio 43130
p-740-277-6166
f- 740-277-6700

1550 Sheridan Dr Ste. 202.
Lancaster, Ohio 43130
p-740-808-8371
f- 740-785-4924

## Authorization to Use and Disclose Confidential Protected Health Information [3793:2-1-06(H)]

Regarding: **CLIENT NAME**_____**DOB** _____**ID#**_____

_____

**Name of Physician** **Address** **Phone** **Fax**

**The above named may ☐ disclose to, or ☐ receive from, or ☐ exchange information with:** The above listed New Horizons locations.

**Purpose of Disclosure**:
☐ Continuity of Care ☐ Disability Determination ☐ Ongoing Treatment ☐ Treatment Planning with Client
☐ Other Purposes (Specify): _____

**Description of Information to be Disclosed**:
☐ Attendance ☐ Crisis Assessment ☐ Diagnosis-Diagnostic Assessment ☐ HIV/AIDS Test Results or Status
☐ Information on Mental Illness and/or Treatment ☐ Laboratory & Medication Results ☐ Outside Agency Records
☐ Physician's Orders/Medical Notes ☐ Pregnancy Test Results ☐ Prenatal Care Received ☐ Progress of Treatment
☐ Psychiatric Evaluation ☐ Psychological Evaluation ☐ Urine Testing ☐ ENTIRE CHART (including outside records)
☐ Other Information (Specify): _____

**Amount of Information to be Disclosed**:
☐ Previous Three Months ☐ Previous _____ year(s) ☐ Most Recent Admission or Episode of Care

☐ Other (Specify) _____

*I understand this authorization remains in effect until the date of expiration. I understand this authorization may be withdrawn any time in writing (except to the extent that action has already been taken). Further release shall cease (except as allowed by law) upon New Horizon's receipt of the written revocation. I also understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.*

**Indicate only one of the following:**
☐This authorization will expire when (condition) _____
☐This authorization will expire on (date) _____/_____/_____

**Signature ☐Client ☐Guardian** _____ **Date** _____

**Signature of Staff and Title** _____ **Date** _____

**Provider: Please check box if you would like a request for records sent**

**NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164. These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.**

## Notice of Revocation to Use and Disclose Confidential Protected Health Information

**Client Name _____ DOB _____ ID# _____**

**I revoke authorization for further use and disclosure of my protected health information effective:**

**Date Revoked_____**

**Signature ☐Client ☐Guardian _____ Date _____**

**Signature of Staff and Title _____ Date _____**