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