NEW CLIENT INFORMATION

Client #:	Admit Date:

CLIENT INFORMATION: Name: _____ Who Were You Referred by: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

S.S.#: _____ Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Male: _____ Female: _____

Ethnic Group: Caucasian _____ American Indian ____ Asian _____ Black _____ Hispanic_____ Latino _____ Puerto Rican _____ Cuban _____
Mexican _____ Other Latino _____ Other_____

Primary Language: English _____ Spanish _____ Other _____ Military Veteran: Yes _____ No _____

Smoking Status: Current _____ Former_____ Never_____ Client is under age 13: _____

GROSS YEARLY HOUSEHOLD INCOME: _____ Wages:_____
Number of Persons in household supported by Income: _____ Number of Persons in household under 18: _____
_____

Receiving SSI/SSDI/Other Yes/No – Amount? _____ Receiving Unemployment Yes/No – Amount? _____

STATEMENT SENT TO: Name: _____ Relationship: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

I hereby apply for services for myself and/or my dependents at Midwestern Colorado Mental Health Center. I attest that:
1) The above stated number of dependents is correct; 2) my reported household income is correct; 3) I understand that payment must be made at the time of service. _____ (Please initial)
I have been given a sheet entitled "INFORMATION REGARDING YOUR TREATMENT" that describes my therapist's qualifications. _____(Please initial)

Appointment Reminders: How would you like to receive reminders for your appointments? Phone Number: _____
May we leave a message with whoever answers the phone or on your answering machine: _____ Yes _____ No (Please initial)

Email Address: _____ Text Number: _____
I do not wish to be reminded of my appointments: _____(Please initial)

PAYOR: Self: _____ Medicare#: _____ Medicaid #: _____
Private Insurance: _____Other: _____ *PLEASE BRING YOUR INSURANCE CARD*

I authorize payment of third party benefits directly to the Center for Mental Health for services rendered for myself and/or my dependents. I further authorize the Center for Mental Health to release all information with respect to myself or my dependents as may be required to process claims for payment for services provided. I authorize my insurance company or "provider" to release to the Center for Mental Health any information regarding my claims or claims of my dependents for services rendered. I understand that am ultimately financially responsible to the Center for Mental Health for any monies paid directly to me or my insurance company or other "payee," and for any other services not covered by my insurance or "payee."

CLIENT OR RESPONSIBLE PARTY SIGNATURE	DATE

FOR OFFICE USE ONLY - FEES:

_____ Intake session/Readmission
_____ Individual session
_____ Group session
_____ 1st Psychiatrist visit
_____ Psychiatrist fee for all following visits
_____ Per session payment towards Medicare Co-Pay & Deductible (20%)
or Insurance Co-Pay/Deductible (*check eligibility)
- Medicare $25 or 20% of services requested

PROGRAMS/SERVICE

_____ MH
_____ MH CORE
_____ WSCU
_____ DBT
_____ SCHOOL-BASED
_____ PEDIATRICS
_____ FAMILY PRESERVATION
_____ RIVER VALLEY
_____ UMC
_____ MED SERVICES
_____ JBBS
_____ SUD
_____ SUD CORE
_____ LEVEL I/II
_____ LEVEL II FOUR PLUS
_____ DRUG COURT
_____ METH FREE DC
_____ OTHER

Reviewed 7/26/2018