YELLOWSTONE BEHAVIORAL HEALTH CENTER
CLIENT INFORMATION FORM

Name:_____ Today's date_____
First MI Last
(Maiden or previous names)_____

Name of person completing form: _____ Relationship to client:_____

Client's Address:_____ _____ _____ _____ _____
Number & Street or PO Box City State Zip County

Client's phone: Can we identify ourselves when we call or leave a message on the following numbers?

Home: _____ yes / no Cell: _____ yes / no Work: _____ yes / no

DOB: _____Age:_____Gender:_____SS#_____

Who should we contact in case of emergency? _____

Relationship:_____ Phone:_____

Current Marital Status: (Please check the appropriate box to the ***left***)

☐ Never married ☐ Now married or living as married ☐ Legally or otherwise separated ☐ Divorced ☐ Widowed ☐ Minor child

Race: (Please check the appropriate box(es) to the ***left***)

☐ White ☐ Black ☐ Native American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ Other ☐ More than One Race

Have you been treated at YBHC (formerly Park County Mental Health) before? ☐ Yes ☐ No

Religion:_____Veteran: Yes / No Active Duty: Yes / No Military ID# _____

List persons living in the home:

Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____
Name:_____Relationship:_____Age:_____

Education: Please indicate the highest grade completed, 00 - 24: _____ (completed HS = 12)

Primary Client's Employment at Admission (please check box to the *left*)

- ☐ Unemployed
- ☐ Part-time: Paid work Less than 30 hrs/week
- ☐ Full-time: Paid work 30 or more hrs/week
- ☐ Homemaker: Adult not in work force
- ☐ Retired: Retired from active employment
- ☐ Disabled unemployed: Unable to work
- ☐ Child: Under 15 Years of age
- ☐ Student: 15 yrs or older, not working
- ☐ Inmate of institution

Who referred you for service? Please check the box to the *left* for all that apply.

	Criminal Justice	**Healthcare/Treatment Systems**	**Agencies**
☐ Self	☐ Police/Law Enforcement	☐ Community Mental Health Center	☐ Developmental Disabled
☐ Family/Friends	☐ Court or Correction Agency	☐ Other Private Mental Health	☐ Dept. of Family Services
☐ Schools	☐ Adult Drug Court	☐ Private Psychiatrist	☐ Dept. of Vocational Rehabilitation
☐ Employer	☐ Juvenile Drug Court	☐ Other Physician	☐ Shelter for the Homeless
☐ Clergy	☐ Adult Probation & Parole	☐ State or County Mental Hospital	
☐ Other	☐ Juvenile Probation (DFS)	☐ Other Inpatient Psychiatric Service	
☐ EAP	☐ Attorney	☐ Alcohol Abuse Treatment Facility	
		☐ Drug Abuse Treatment Facility	
		☐ Nursing Home	
		☐ Hospital (local)	

Why are you seeking help today? (List in order with the most important first.)

1. _____
2. _____
3. _____

Please check the box to the *left* for all that apply:

- ☐ Difficulty Sleeping
- ☐ Thoughts of Suicide
- ☐ Disturbing thoughts
- ☐ Thoughts of hurting someone else
- ☐ Anger control problems
- ☐ Victim of Abuse/ Assault/rape
- ☐ Drug or Alcohol Abuse
- ☐ None
- ☐ Other: (Please describe): _____

Have any other immediate or extended family member(s) experienced mental, emotional or substance abuse problems? If so, please describe:

_____

_____

Will you need assistive technology? ___Yes ___ No
Please describe:_____
_____

Yellowstone Behavioral Health Center

Confidential Income Statement
Sliding Fee Scale Application

Client Name _____ Date _____

Yellowstone Behavioral Health Center's reduced fees are based on a person's ability to pay for services. "Ability to pay" is based on household income. A reduced fee on the sliding scale is available to clients who are unable to pay the full fee for outpatient therapy services.

Please complete the following:

- ☐ I **DO** want to apply for the sliding fee scale. (Please complete the rest of the form.)
- ☐ I **DO NOT** want to apply for the sliding fee scale. I will pay the **full fee** for YBHC services. (Please sign at the bottom.)

INCOME STATEMENT

Please list all sources of MONTHLY INCOME for the household:

	Amount	
Employment	_____	
Unemployment Compensation	_____	
Supplemental Security Income (SSI) - adults and children	_____	
Social Security Disability Income (SSDI)	_____	
Child Support income	_____	
Pension	_____	**Total Gross**
Social Security	_____	**Monthly Income ****
AFDC	_____	_____
Other _____	_____	

**** Please provide verification of income (check stubs, income tax return, social security statement, etc.)**

INSURANCE INFORMATION

Do you have health insurance? No Yes # _____
Please bring card to your appointment.

Do you have KidCare/Equality Care/Medicaid? No Yes # _____
Please bring card to your appointment.

Do you have Medicare? No Yes # _____
Please bring card to your appointment.

Do you have Medicare Supplemental insurance? No Yes # _____
Please bring card to your appointment.

I certify that all the information is true and complete. I understand that verification of income is required in order to receive a discounted rate.

_____ _____
Signature of Client (or Parent or Guardian) Date

Yellowstone Behavioral Health Center
Insurance Form

NAME OF INSURED:_____SSN : _____

INSURED'S PHONE: _____DATE OF BIRTH: _____

ADDRESS OF INSURED: _____

_____

_____

NAME OF INSURANCE COMPANY: _____

DEPENDENT INFORMATION:

NAME: _____ SSN: _____

Relationship to insured: _____ Date of Birth: _____

NAME: _____ SSN: _____

Relationship to insured: _____ Date of Birth: _____

NAME: _____ SSN: _____

Relationship to insured: _____ Date of Birth: _____

NAME: _____ SSN: _____

Relationship to insured: _____ Date of Birth: _____

I authorize Yellowstone Behavioral Health Center to bill my health insurance company and to receive direct payment for services. I also give Yellowstone Behavioral Health Center authority to contact the insurance company in order to collect above their usual and customary fee. Should the insurance company pay me directly, I agree to sign the check over to Yellowstone Behavioral Health Center.

_____

Insured Person's Signature Date

NOTE: A copy of the insurance card(s) should be attached to this form.

Individual therapy sessions will be billed to your insurance company at the standard full fee rate. If your payment for a session (based on your contracted fee) combined with the insurance company reimbursement exceeds the full fee rate, you will be reimbursed for the difference.

YELLOWSTONE BEHAVIORAL HEALTH CENTER
Offering Hope for a Better Tomorrow

YELLOWSTONE BEHAVIORAL HEALTH CENTER

Medication Prescription Record

Client: ____

Date	Medication	Dose	Prescribed by

YELLOWSTONE BEHAVIORAL HEALTH CENTER
Offering Hope for a Better Tomorrow
2538 Big Horn Avenue
Cody, WY 82414
307-587-2197
627 Wyoming Avenue
Powell, WY 82435
307-754-5687
www.ybhc.org

Authorization for Release of Protected Health Information

Client Name: _____ DOB: _____

I authorize Yellowstone Behavioral Health Center to release/receive the following protected health information:

☐Evaluation Report ☐Verification of attendance at treatment appointments
☐Treatment Plan ☐Clinical Assessment
☐Discharge Summary ☐Treatment Progress
☐Collateral Information ☐Substance abuse information (requires client initials)_____
☐ HIV information (requires client's initials)_____
☐Other (specify) _____

To/from (circle one) the following person/organization:
Name: _____

Address: _____

Phone: _____ Fax: _____

This protected health information is being released/received for the following reason:
☐Compliance with court or probationary order ☐Referral for additional services
☐Progress/compliance with treatment
☐Substance abuse information requires client initials)_____
☐ HIV information (requires client's initials)_____
☐Other (specify) _____

This authorization shall be in effect until_____(or 1 year from today's date).

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and 45 CFR part 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Official at Yellowstone Behavioral Health Center at 2538 Big Horn Avenue, Cody, WY 82414. I understand that a revocation is only effective to the extent that the Center has not already relied on this authorization to release/receive protected health information.

Yellowstone Behavioral Health Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization for the requested use or disclosure.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Witness Date