YELLOWSTONE BEHAVIORAL HEALTH CENTER
Offering Hope for a Better Tomorrow

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 Mailing Address: ______________________ ________ ____ ________ ______
City State Zip County

Client's Home Address: ______________________ __________ ____ ______ ______
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

If you have included a cell phone, you are giving our office or assignee permission to call that phone.

DOB: ______________Age:_______Gender:______SS#_______________________

Where born: __________________Mother's first name__________________

If less than 18 years old, who is the child's legal guardian? ___________________________

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

Who is your Primary Care Physician? ______________________________

Address?______________________________

Phone #?______________________________

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:__________

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

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:

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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

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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.

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YELLOWSTONE BEVAVIORAL HEALTH CENTER
CLIENT RIGHTS

1. This agency supports and protects the fundamental human, civil, constitutional, and statutory rights of each client, in the provision of outpatient mental health treatment.
2. Persons shall have impartial access to treatment regardless of race, religion, sex, ethnic origin, age, physical handicap, type of mental health disorder, or sources of financial support.
3. Each client's personal dignity and privacy shall be recognized and respected in the provision of care and treatment.
4. Client confidentiality and privacy practices are outlined in a separate Notice of Privacy Practices, which should be read as part of this agreement. It is noted here there are specific exceptions to confidentiality and privacy as mandated by law. Confidential information must be released when a disclosure is required by Federal, State or Local law, judicial or administrative proceedings, such as:
   A. Suspected abuse and/or neglect of a child, senior citizen, or handicapped person.
   B. Concern about a serious identifiable threat to your health or safety, or to others' health or safety.
   C. Health oversight agency activities, including public health requirements, such as audits, investigations, inspections, licensure, or disciplinary proceedings.
   D. Supervision of clinical staff by licensed mental health professionals.
   E. Court order.
5. Each client shall receive treatment appropriate to his or her needs, which shall include at least the following:
   A. The right to be involved in the development of your treatment plan and to know the therapist(s) credentials and orientation to therapy.
   B. The development of an individualized written treatment plan that is reviewed and updated as frequently as clinically indicated.
   C. The right to initiate a grievance and a mechanism for requesting a review of the grievance.
6. Clients should be aware that sex with a therapist is never an appropriate part of treatment. If inappropriate sexual comments or contact is made, this should be reported immediately to the Exectuive Director of Yellowstone Behavioral Health Center.
7. Each client (or where appropriate the client's guardian) shall receive a copy of these rights. If the client or guardian does not understand the client's written rights, these rights shall be explained orally in a language that the client or guardian understands.

I understand that I have the right to choose or refuse and have an expression of choice regarding:
The type of service delivery, release of information, concurrent services, the composition of the service delivery team.
I also understand that I have the freedom from: abuse, financial or other exploitation, retaliation, humiliation, and neglect by the Yellowstone Behavioral Health Center treatment team and staff.

I HAVE RECEIVED A COPY OF YBHC'S CLIENT HANDBOOK.

I HAVE RECEIVED, READ AND UNDERSTOOD YBHC'S NOTICE OF PRIVACY PRACTICES.

I HAVE RECEIVED AND REVIEWED A COPY OF MY THERAPIST'S PROFESSIONAL DISCLOSURE STATEMENT.

Informed Consent
I realize that mental health treatment is not an exact science and I acknowledge that no guarantees have been made to me as to the outcome of treatment. I hereby give my consent to treatment. I consent to vehicular transportation by Yellowstone Behavioral Health Center when it is necessary to deliver services.

____

Signature (Parent /Guardian, if primary client is underage) Date

____

Print Client's Name Here Witness

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YELLOWSTONE BEHAVIORAL HEALTH CENTER

Medication Prescription Record

Client: ____

Date	Medication	Dose	Prescribed by

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Yellowstone Behavioral Health Center

TEXT Messaging Consent Form

Client Name ______________________________ Cell Phone Number _________________________________

YBHC is now informing clients about upcoming appointments via text messages. This will be a text reminder only, you will not have the option to send YBHC a text. The text will say:
Good afternoon. This is a reminder that (firstname) has an appointment tomorrow (appt date) with YBHC at (appt time). Please call 307-587-2197 or 307-754-5687 to cancel or reschedule. Note: this number does not receive text messages.

Risk of using text messages:
Transmitting client information by text messaging has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:

a. Text messages can be circulated, forwarded or stored in electronic files.
b. Text messages can be broadcasted to unintended recipients.
c. Senders can accidentally misaddress a text message.
d. Text messages can be intercepted, altered, forwarded or used without detection or authorization.
e. Text messages can be used as evidence in court.
f. Text messages can be lost in transmission.

Conditions for the use of text messaging:
Because of the risks outlined above, we cannot guarantee the security and confidentiality of text messaging communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. Consent to the use of text messages includes agreement with the following conditions:

a. The client is responsible for protecting his/her password or other means of access. We are not liable for breaches of confidentiality caused by a client or other third party.
b. The client is responsible for notifying us of a change in cell phone number.
c. The client acknowledges that standard text messaging rates may apply as provided by his/her wireless plan and that the client is responsible for those charges.

Client Acknowledgement and Agreement:
I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. I further waive any and all claims that may arise against Yellowstone Behavioral Health Center resulting from the use or misuse of text messaging.

☐ I do not wish to receive any text messages from YBHC.

Client Signature ____ Date ________________

YBHC Staff Signature ____ Date _______________

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YBHC Information Consent for Telehealth

Patient Consent Form

I (Client Name) ______________________________ agree to receive this health care services (Type of service) ______________________________, as a telehealth service. I understand that the health care provider (Name)______________________________ is located in another location (Facility name and address)____. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for the follow-up telehealth service with the health care provider.

I also understand that:

- I can decline the telehealth services at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- The same confidentiality protections that apply to my other medical care also apply to the telehealth services.
- I will have access to all medical information resulting from the telehealth services as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all people who will be present at the site during my telehealth service.
- I may exclude anyone from any site during my telehealth service.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient______________________________________Date_______________________

Or

Signature of Parent or Legal Representative:____

Date____________________________

Telehealth Consent:

Signature or Person (Obtaining Consent)____

Date____________________________

Facility Name:____

Facility Address:____

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2538 Big Horn Avenue
Cody, WY 82414
307-587-2197
Fax 307-527-6218
www.ybhc.org

627 Wyoming Avenue
Powell, WY 82435
307-754-5687
Fax 307-754-5697

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
☐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

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