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: _____ _____ _____ _____ _____
E-mail 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
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 - 20: _____ (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 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 ☐ CDT ☐ Scan

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

Effective Date: _____

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

Offering Hope for a Better Tomorrow

YBHC's No Show/Cancellation Policy

A. Policy on cancelling Therapy/Psychiatrist:
    a. Definition of "cancel": An appointment will be considered "cancelled" if the client cancels the scheduled appointment at the time of the reminder call or before (but no later than 3pm the day before the appointment).
    b. Cancel Therapy: If a client cancels half of their scheduled appointments in a consecutive two month period, they may be closed. This includes all appointments: therapy, case management, group, psychiatric, and nurse appointments. If the client wishes to reengage after closure, they may reschedule after 90 days.
    c. Cancel Psychiatrist: If the client cancels before or at the time of the reminder call, the appointment will be noted as "cancelled." If the client cancels a follow-up appointment with the psychiatrist after the reminder call or the day of the appointment, the appointment will be noted as "no show – non-billable." If the client does not contact the agency to cancel their appointment with the psychiatrist, the appointment will be noted as "no show – billable" and they will be charged their sliding fee rate for the appointment.
B. No show with Therapist/Psychiatrist:
    a. Definition of "no show": An appointment will be considered a "no show" if the client cancels after 3pm the day before the appointment, the day of the appointment, or does not contact the agency and does not attend the appointment.
    b. No Show Therapy: The client's appointment will be considered a "no show" if the client contacts the agency after 3pm the day before the scheduled appointment, or if the client does not contact the agency and does not attend the scheduled appointment. If the client no shows two appointments in two months, the client's file may be closed and if the client wishes to reengage after closure, they may reschedule after 90 days.
    c. No Show Psychiatrist: If the client no shows the initial (intake) appointment with the psychiatrist, the client will be billed their sliding fee for that appointment and must pay off that balance before another appointment can be scheduled. If the client no shows the "intake" twice they will be referred to another medication provider in the community and may not be eligible for psychiatric services through YBHC for 90 days.

By signing this form, I acknowledge that I have read and understood the YBHC No Show/Cancellation policy.

_____ _____

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

_____

Print Client's Name Here

☐ CDT ☐ Scan

Yellowstone Behavioral Health Center
Electronic Communications Consent Form

Client Name _____Cell Phone Number _____
Email_____

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 electronic communications:
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 or email address.
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 electronic communications.

☐ I do not wish to receive any electronic communications from YBHC.

Client Signature _____ Date _____

YBHC Staff Signature _____ Date _____

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YBHC Patient Consent for Telehealth

Client Name: _____

Please initial one of the below options:

_____ ***I agree to receive Mental Health Counseling, Case Management, and/or Medication Management, as a telehealth service(s).***

_____ ***I DO NOT agree to receive Mental Health Counseling, Case Management, and/or Medication Management, as a telehealth service(s).***

I understand that the health care provider is located at our Powell, WY office, Cody WY office, or at a Facility contracted by YBHC to provide services to our clients.

A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment, or by telephone access. This consent is valid until the client leaves YBHC's services, or until revoked in writing by the client.

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 Client_____Date_____

Signature of Parent or Legal Representative:_____
Date_____

12/11/23

YELLOWSTONE BEHAVIORAL HEALTH CENTER
Offering Hope for a Better Tomorrow

YELLOWSTONE BEHAVIORAL HEALTH CENTER

Medication, Prescription, and Supplement Records

Client: _____Date _____

☐ Not on any medication at this time

Medication/Supplements	Dosage	Prescribed By	Providers Phone #
1.			
2.			
3.			
4.			
5.			
6.			
7			
8.			
9.			
10.			

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