SUNBURST MENTAL HEALTH SERVICES
INTAKE ACKNOWLEDGMENT

Participant's Name: ______________________________

I hereby acknowledge that I have reviewed or received the following information by initialing and dating the items:

At Reception:

		Initial	Date
1.	Consent to Bill Insurance and Fee Agreement	______	______
2.	Notice of Privacy Practices (HIPPA)	______	______
3.	Participant Grievance Procedure	______	______
4.	Participant Responsibilities	______	______
5.	Health Screening Form	______	______
6.	Policy on Visit Cancellations	______	______
7.	After Hours Crisis Line Information	______	______

At Intake:

		Initial	Date
1.	Introduction to Services & Confidentiality	______	______
2.	Potential Risks and Benefits of Therapy	______	______

Signature: ______________________________ Date: ______________
Participant or Legal Representative

Signature: ______________________________ Date: ______________
Sunburst Mental Health Representative

SUNBURST MENTAL HEALTH SERVICES
PARTICIPANT CONFIDENTIAL INFORMATION FORM

(Please note that the information requested on this form is confidential. However, you may choose to omit any item and discuss it in person.)

Today's Date: ______________________

IDENTIFICATION

Participant Name: ______________________ Social Security #: ______________
Date Of Birth: ____________ Age: Gender: ☐ F ☐ M Marital Status:
Parent/Legal Representative (if a minor): ______________________
Mailing Address: ______________________
Street City State Zip Code
Physical Address: ______________________
Street City State Zip Code
Home Phone: ______________ May I contact you at home? ☐ Yes ☐ No
Cell Phone: ______________ May I contact you on your cell phone? ☐ Yes ☐ No

Are you presently employed? ☐ Yes ☐ No
IF YES:
Employer: ______________________ Hrs./Wk. ________
Occupation: ______________________ How long at job? ________
Work Phone: ______________ May I contact you at work? ☐ Yes ☐ No

INSURANCE INFORMATION

If insurance reimburses you for mental health services please provide the following information, **AND** a copy of your insurance card:

Insurance Company: ______________________ Phone: ________
Mailing Address: ______________________
Street / P.O. Box City State Zip Code
Subscriber's Name: ______________________
Policy #: ______________ Group Number #: ______________

REFERRAL

Who gave you our organization's name to call?

Name: ______________________ Phone: ________
May I have your permission to thank this person for the referral? ☐ Yes ☐ No

YOUR MEDICAL CARE

From whom or where do you get your medical care? ______________________________

Phone: ____________________ Fax: ____________________

Mailing Address: ______________________________

Street / P.O. Box City State Zip Code

From whom or where do you get your dental care? ______________________________

Phone: ____________________ Fax: ____________________

Mailing Address: ______________________________

Street / P.O. Box City State Zip Code

PREVIOUS MENTAL HEALTH SERVICES

Have you received Mental Health Services before? ☐ Yes ☐ No

If yes, from where?: **(If you need more space, please continue on the next page)**

Organization's Name: ______________________________

Address: ______________________________

Street / P.O. Box City State Zip Code

From: __________ To: __________

Organization's Name: ______________________________

Address: ______________________________

Street / P.O. Box City State Zip Code

From: __________ To: __________

Have you been in an inpatient facility? ☐ Yes ☐ No

If yes, from where?: **(If you need more space, please continue on the next page)**

Organization's Name: ______________________________

Address: ______________________________

Street / P.O. Box City State Zip Code

From: __________ To: __________

Organization's Name: ______________________________

Address: ______________________________

Street / P.O. Box City State Zip Code

From: __________ To: __________

Signature: ______________________________ Date: ____________________

Participant or Legal Representative

Signature: ______________________________ Date: ____________________

Sunburst Mental Health Representative

SUNBURST MENTAL HEALTH SERVICES
PARTICIPANT AGREEMENT FORM

Our Agreement:

I, the participant (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement. It does not indicate that I am waiving any of my rights.

I understand that I can choose to discuss any concerns with my service coordinator (case manager) or therapist before I start (or the consumer starts) services. I understand that any of the points mentioned above can be discussed and may be open to change.

I understand that after services begin I have the right to withdraw my consent to services at any time, for any reason. I will make every effort to discuss my concerns about progress with you before ending services.

I understand that no specific promises have been made to me by this worker about the results of treatment, the effectiveness of the procedures used, or the number of sessions or length of time that we will work together to achieve results.

I have read, or have had read to me, the issues and points in this introduction. I have discussed those points I did not understand and have had my questions, if any, fully answered. I agree to act according to the points in this introduction. I hereby agree to enter into services with Sunburst Mental Health (or to have the participant enter services), and to cooperate fully and to the best of my ability, as shown by my signature here.

I hereby give permission to Sunburst Mental Health for med evaluation and med management.

Signature: ______________________________ Date: ____________________
Participant or Legal Representative

Printed Name: ______________________________
Participant or Legal Representative

Relationship to consumer:

☐ Self ☐ Parent ☐ Legal Guardian ☐ Other person authorized to act on behalf of the consumer

I, the Sunburst Mental Health Worker, have met with this participant (and or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this document. I have responded to all of his or her questions. I believe that this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into services with this participant, as shown by my signature here.

Signature: ______________________________ Date: ____________________
Sunburst Mental Health Representative

☐ **Copy accepted by participant** ☐ **Copy kept by Mental Health Representative**

SUNBURST MENTAL HEALTH SERVICES
PARTICIPANT EMERGENCY CONTACT FORM

If I Need To Contact Someone About You:

If there is an emergency during our work together or if we become concerned about your personal safety, we are required to contact a person of your choosing and/or the authorities. We are also required to contact this person and/or the authorities if we become concerned about you harming someone else. Please write down the name and information of your chosen contact person in the blanks below.

Name: ______________________________

Phone Number: ______________________________

Address: ______________________________
Street Number/P.O. Box City State Zip Code

Relationship to you: ______________________________

If you are receiving therapy services, please review the "Potential Risks and Benefits of Therapy

SUNBURST MENTAL HEALTH SERVICES
HEALTH AND MEDICAL HISTORY

Today's Date: ______________________

Participant's Name: ______________________ Date of Birth: ______________________

Primary Health Care Provider: ______________________ Phone: ______________________

Have you been diagnosed with diabetes?	☐ Yes	☐ No	If so, are you insulin dependent?	______________________
Have you had a history of head injuries?	☐ Yes	☐ No	If so, how many and when?	______________________
Do you have high blood pressure?	☐ Yes	☐ No		______________________
Have you had your thyroid checked?	☐ Yes	☐ No	If so, when?	______________________
Do you have thyroid problems?	☐ Yes	☐ No	If so, please describe:	______________________
Have you had a history of Heart problems?	☐ Yes	☐ No	If so, please describe:	______________________
Have you had a history of lung disease?	☐ Yes	☐ No	If so, please describe:	______________________
Do you have a history of seizures?	☐ Yes	☐ No	If so, please describe:	______________________
Could you be pregnant at this time?	☐ Yes	☐ No	If so, how many weeks? Due Date?	______________________
Are you allergic to any medications?	☐ Yes	☐ No	If so, please describe:	______________________

Any other physical health concerns: ______________________

____

Please tell us the approximate date of last health exam and or physical: ______________________

Last Dental Exam: ______________________ Last Eye Exam: ______________________

Signature: ______________________ Date: ______________________

Participant or Legal Representative

SUNBURST MENTAL HEALTH SERVICES
FEE SCHEDULE & CONSENT TO BILL INSURANCE

Service		Fee	Unit
Medication Management Evaluation	**$**	**350.00**	
Medication Management Monitoring	**$**	**80.00**	**per 15 minutes**
Therapy Intake Evaluation	**$**	**325.00**	
Therapy	**$**	**220.00**	**per hour**
Therapy	**$**	**90.00**	**per 45 minutes**
Therapy	**$**	**60.00**	**per 30 minutes**
Service Coordination (Case Management)	**$**	**80.00**	**per hour**

I ________________________________ hereby give my permission to Sunburst Mental Health to bill my insurance and to receive payment directly from my insurance(s). I also give permission to Sunburst Mental Health to release any and all information necessary to submit claims and receive insurance payments.

It is understood that any amount not paid by my insurance, is my sole responsibility and I agree to submit payment to Sunburst Mental Health within 30 days from the date billed.

______________________________________ ______________________________

Participant or Responsible Party **Date**

Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, ________________________________ [Insert Name of Participant], authorize **Sunburst Mental Health Services** to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI). Such conversation shall be documented by **Sunburst Mental Health Services**.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of [Insert Name of Social Work Organization].

____

Signature of Patient/Client   Date

____

Signature of Parent, Guardian or Personal Representative   Date

SUNBURST MENTAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT

Participant's Name: ______________________________

Date of Birth: ____________________ **Phone Number:** ____________________

I/We hereby acknowledge that I/we have received and have been given an opportunity to read a copy of the Sunburst Mental Health Services "Notice of Privacy Practices". I/We understand that if I/we have any questions regarding the Notice or my Privacy Rights. I/We can contact Nicole Hutcherson at 406-756-8721.

Signature: ______________________________ **Date:** ____________________
Participant or Legal Representative

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of attorney, healthcare surrogate etc.)

Signature: ______________________________ **Date:** ____________________
Sunburst Mental Health Representative

☐ **Participant refuses to Acknowledge Receipt**