



## 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 CHECKLIST OF CONCERNS

Please rate the following concerns according to the following.

(Leave the space blank indicates the issue is not a problem for you, whereas each problem issue is to be assigned a 1, 2 or 3.)

**1. – Sometimes a problem**

**2. – Frequently a problem**

**3. – Most all the time a problem**

- Feeling out of control
- Easily hurt feelings
- Frightening Thoughts
- Unhappiness
- Disturbing Grief
- Afraid to leave house
- Restlessness
- Emotional highs
- Lost or Adrift
- Feeling Shame
- Overwhelmed by Stress
- Hopelessness
- To easily influenced
- Feeling misunderstood
- Pessimism
- Self-disgust
- Self-centered
- Sleep Problems
- Excessive pain
- Jaw tension
- Chest pain
- Anger
- Crying spells
- Guilt
- Panic
- Easily bored
- Tiredness/Fatigue
- Fearful
- Nightmares
- Without pleasure
- Self-blame
- Feel worthless

- Sleepwalking
- Taking unnecessary risks
- Repetitive thoughts
- Weight Problems
- Excessive Worry
- Irritable
- Loneliness
- Feeling Numb
- Feeling Helpless
- Sexual Problems
- Depression
- Problems at work
- Feeling disconnected
- Bitterness
- No sense of direction
- Trouble concentrating
- Headaches
- Thoughts of death
- Violent Thoughts
- Feeling trapped
- Nervousness
- Hearing voices
- Legal problems
- Eating problems
- Skin Problems
- Difficulty with women
- Stomach Aches
- Difficulty trusting
- Gambling
- Unwelcome habits
- Feel strange or odd
- High Blood Pressure

- Thoughts that others want to hurt me
- Sees things that others do not see
- Needing a philosophy of life
- Feeling life is not worthwhile
- Drug Use
- Alcohol Use
- Financial problems
- Confused as to what I really want
- Bad Temper
- Not knowing what kind of person I want to be
- Feelings of inferiority
- Not smart enough
- Confused in my religious beliefs
- Physically unattractive
- Difficulty with decisions
- Feel Unloved
- Ashamed
- Memory loss/gaps
- Not ambitious
- Sense of others watching me
- Dizziness
- Heart pounds and races
- Trouble catching breath
- Uncomfortable with people
- Suicidal thoughts
- Difficulty with men
- Back or neck pain
- Peculiar sensations
- Bowel disturbances
- Tremors
- Hurting oneself
- OTHER \_\_\_\_\_



**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**

<b>Medication Management Evaluation</b>	<b>\$ 350.00</b>	
<b>Medication Management Monitoring</b>	<b>\$ 80.00</b>	<b>per 15 minutes</b>
<b>Therapy Intake Evaluation</b>	<b>\$ 325.00</b>	
<b>Therapy</b>	<b>\$ 220.00</b>	<b>per hour</b>
<b>Therapy</b>	<b>\$ 90.00</b>	<b>per 45 minutes</b>
<b>Therapy</b>	<b>\$ 60.00</b>	<b>per 30 minutes</b>
<b>Service Coordination (Case Management)</b>	<b>\$ 80.00</b>	<b>per hour</b>

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].

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Signature of Patient/Client

Date

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Signature of Parent, Guardian or Personal Representative

Date



**SUNBURST MENTAL HEALTH SERVICES  
NOTICE OF PRIVACY PRACTICES  
RECIPT 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**

