FOR OFFICE USE ONLY

Date of First Contact: _____ Date of Scheduled Appointment: _____ Date offered: _____

Caller: _____ Relationship to Caller: _____ Clinician: _____

Intake

If completing this form for your child (under 18) please provide child's information*

POTENTIAL CLIENT INFORMATION

***Please be aware that the name and gender you list below must also be listed on insurance and billing documents.**

If your preferred name, pronouns, or gender identity differ from what is listed, please note in sections below.

Client Name (Last, First, Middle): _____ Date of Birth: _____

Client's Preferred Name _____ Preferred Pronouns ☐ He/Him ☐ She/Her ☐ They/Them

Client's Gender: ☐ Male ☐ Female ☐ Non-binary

Client's Social Security Number: _____

Best Phone Contact Name & Number (Parent/Guardian's if applicable) : _____

Client's Address (Street, City, State, Zip): _____

Second Parent/Guardian's Name (if applicable) _____ Phone Number: _____

Emergency Contact Name: _____ Relationship to Client _____

Emergency Contact Phone Number: _____

Type of Appointment Reminder: ☐ Text ☐ Email ☐ Both

DBH Communication Email Address: _____

DBH Communication Cell Phone: _____

Family Size: _____ Number of dependent children the client is financially responsible for: _____

Name of the school the client attends: _____

Is the client pregnant? ☐ Yes ☐ No

Is the client seeking treatment specifically related to your maternal mental health? ☐ Yes ☐ No

DEMOGRAPHICS

Source of Payment

- ☐ Medicaid
- ☐ Medicare
- ☐ Commercial Insurance
- ☐ Self Pay
- ☐ Veteran's Administration
- ☐ Worker's Compensation
- ☐ Service Contract
- ☐ Other_____

Referral Source:

- ☐ Family/Friend
- ☐ School System
- ☐ Other Healthcare Provider
- ☐ Other Community Referral
- ☐ Self
- ☐ DCFS
- ☐ Employer
- ☐ Division of Workforce Services
- ☐ Mental Health Provider
- ☐ Substance Use Provider
- ☐ Clergy
- ☐ DPSD
- ☐ Justice Referral

Client's Marital Status:

- ☐ Married
- ☐ Never married/single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Client's Race (Primary):

- ☐ White
- ☐ Asian
- ☐ Alaskan Native
- ☐ Black/African
- ☐ Hawaiian/Pacific Islander
- ☐ Other Single Race
- ☐ American Indian
- ☐ Two or More Races

Client's Ethnicity (Primary):

- ☐ Cuban
- ☐ Other Hispanic
- ☐ Mexican
- ☐ Unknown
- ☐ Puerto Rican
- ☐ Other: _____
- ☐ Not of Hispanic Origin

Preferred Language (if other than English) _____

Client's Living Arrangement:

- ☐ 24 hour Residential
- ☐ Private Residence/Independent
- ☐ Foster Home (Adult or Child)
- ☐ Homeless or Shelter
- ☐ Institutional Setting
- ☐ Private Residence/Dependent
- ☐ Jail

Have you (client) been civilly commited? ☐ Yes ☐ No

Have you (client) ever or are you currently serving in the military? ☐ Yes ☐ No

Has the client been enrolled in school in the last 3 months? ☐ Yes ☐ No

Last grade client has completed in school: _____

Client's Employment:

- ☐ Age 0-5
- ☐ Retired
- ☐ Student
- ☐ Disabled, Not Working
- ☐ Unemployed/Seeking
- ☐ Employed Part Time -35 hours
- ☐ Employed Full Time 35+ hours
- ☐ Supported/Transitional Employment
- ☐ Homemaker

Unemployed/Not Seeking

Has the client previously had mental health treatment? ☐ Yes ☐ No

Has the client ever been hospitalized at the State Hospital? ☐ Yes ☐ No

Has the client ever been treated at Davis Behavioral Health? ☐ Yes ☐ No

Has the client ever taken any of the following medications - Clozaril, Seroquel, Zyprexa, Risperdal, Geodon?

☐ Yes ☐ No

Client's Nicotine Use:

☐ Never smoked/vaped ☐ Former Smoke/Vape ☐ Current Someday Smoker ☐ Current Everyday Smoker

☐ Use Smokeless Tobacco ☐ Age of First Use: _____

HOUSEHOLD FINANCIAL INFORMATION

If you are uninsured or seeking substance use services, please complete the information below to qualify for a discounted rate.

If the client is a minor, please include the parent's financial information.

Earnings/Wages _____

Workers Compensation _____

SSI: _____

SSD: _____

Social Security _____

Retirement _____

Food Stamps _____

Welfare Benefits _____

Alimony/Child _____

Other Income _____

Total Monthly Income _____

☐ Client does not want to provide financial information

INSURANCE INFORMATION

Primary Insurance Company Name _____ Address _____

Primary Insurance Phone Number _____ Policy Holder Name _____

Primary Insurance Policy Holder Date of Birth _____ Policy Number _____

Seconday Insurance Company Name _____ Address _____

Secondary Insurance Phone Number _____ Policy Holder Name _____

Secondary Insurance Policy Holder Date of Birth _____ Policy Number _____

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Client does not want to provide income informtaion

Therapy Copay $_____

Medical Copay $_____

BHN SSF PCG CASH _____ visits at $_____

Intake Consent Form

Consent and Privacy Rights

☐ **CO-PAY:** It is my responsibility to pay my co-pay at the time of each session. Should my private insurance pay me directly, I understand I will be billed the full cost of service.

☐ **Cancellation and No Shows:** I understand that I may be charged a $25 no-show fee for missed appointments, or if I fail to cancel my appointment within 24 hours.

☐ **Insurance:** I understand that changes in monthly income and insurance coverage may occur and that my co-payment may change as a result. I will notify Davis Behavioral Health of any changes immediately.

☐ **Billing Information:** I agree that my family member, guardian, or person acting on my behalf may talk with DBH about my billing information and other billing matters related to my treatment at DBH.

☐ **Collections:** If for any reason your account has not been paid in full at discharge, an 18% collection fee will be added, and the account will be turned over to collections.

☐ **Privacy and Clients Rights:** I have been made aware that the DBH Notice of Privacy Practices and Client Rights Statement can be found on the DBH Website.

☐ **Advance Directives:** I have been provided with information regarding Advance Directives and know that I may ask a therapist about any questions I may have.

☐ Yes ☐ No I currently have Advance Directives and a copy has been provided to DBH.

☐ Yes ☐ No Medicaid Transportation: I am aware of how to access alternative methods of transportation (for clients enrolled in the Prepaid Mental Health Plan.

☐ Yes ☐ No Grievance/Appeals: I am aware of how to access Davis Behavioral Health's grievance and appeals process.

☐ Yes ☐ No I give permission to Davis Behavioral Health to treat me for my behavioral health problems.

☐ Yes ☐ No Jail Evaluation, if Applicable, can be found in jail record.

☐ Yes ☐ No I agree to let DBH share my medical records with my other medical providers through the Health Information Exchange HIE.

☐ I have fully considered the benefits and risks of participating in Telehealth and have had the opportunity to ask questions of DBH staff. **I consent to participation in Telehealth services from DBH by one or more of the following methods: 1) signing this form electronically, 2) signing and mailing a hard copy, OR 3) (if one of the previous two methods is not feasible such as during the COVID-19 outbreak), by connecting with my healthcare provider via technology at which time the provider will note my verbal consent.**

Cash Price at time-of-service		**Full Fee**
MH Evaluation	$93.00	$177.32/hour
Medical Evaluation	$175.00	$177.32/hour
Individual Therapy	$76.00	$163.14/hour
Group Therapy	$30.00	$48.52/hour
Med Management	$76.00	$102.45/visit
Injection	$40.72	$40.72/visit

Client Signature (Parent/Guardian's if client is a minor): _____ Date: _____

Please Print Client Name: _____