



Behavioral Health Registration

Please fill out the following information for the person who will be receiving Mental Health or Addiction Services. If you require assistance completing any of the forms please let an office staff know. Thank you!

WHAT SERVICES ARE YOU SEEKING?

Mental Health Counseling Alcohol & Drug Treatment Problem Gambling Counseling Other _____

CLIENT INFORMATION:

Last Name	First Name	MI	Social Security No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address			City	State	Zip Code	Home Phone
Mailing Address (if different from above)			City	State	Zip Code	Cell Phone
ODL/Oregon DMV# (<i>required for DUII Program</i>)			May we send you a detailed reminder of your upcoming appointments? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Text <input type="checkbox"/> Voice Message <input type="checkbox"/> Email: _____			

CLIENT INSURANCE INFORMATION:

OREGON HEALTH PLAN ID #	Name of Mental Health Plan (if applicable)	Name of Medical Health Plan (if applicable)			
MEDICARE ID #	Coverage: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D				
SECONDARY INSURANCE COMPANY	Group No.	ID#	Insurance Phone Number:		
Responsible Party (if <u>different</u> than insured)	Relationship	Date of Birth	Social Security No.	Phone Number	
Is secondary insurance through: <input type="checkbox"/> Employer <input type="checkbox"/> Self-purchased <input type="checkbox"/> Absent Parent <input type="checkbox"/> Other					

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

_____ I agree to be financially responsible and pay for the services provided to me by Polk County Behavioral Health if the services are not covered or fully paid by insurance. I understand that the law allows Polk County Behavioral Health to collect from me the amount owing. If I have health insurance, I hereby authorize Polk County Behavioral Health to furnish all applicable information required by the insurance company(ies) for payment of claims. I hereby assign Polk County Behavioral Health all monies to which I am entitled from insurance, for expense related to the services received from Polk County Behavioral Health.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

_____ I have been given written information concerning Polk County Behavioral Health's Privacy Practices. I have had a chance to ask questions about how my information will be used.

ACKNOWLEDGEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

_____ I have been given written information concerning my Rights and Responsibilities while enrolled with Polk County Behavioral Health. I have had a chance to discuss any questions or concerns about this document with a Polk County Behavioral Health staff member.

CLIENT CONSENT

My initials beside the statements above indicate my understanding and agreement. I hereby consent authorize Polk County Behavioral Health to provide services for myself, or the named child/person for whom I am legal guardian for. I consent to evaluation and treatment which will be thoroughly discussed with me during the assessment. I understand that I have the right to ask questions of my provider about my treatment services at any time.

MEDICAL INFORMATION

INDICATE SERVICES YOU HAVE RECEIVED IN THE PAST *Please indicate if we may request these records?*

- | | | |
|---|--------------------|--|
| <input type="checkbox"/> Mental Health Counseling | Provided By: _____ | ROI for Records Request:
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> Med. Management | Provided By: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> A&D Treatment | Provided By: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> Gambling Treatment | Provided By: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |

PRIMARY CARE PROVIDER (PCP) Do you have a Primary Care Provider? YES NO

Dr. Name: _____ Clinic Name/ Location: _____

MEDICATIONS / ALLERGIES

Do you have any Allergies to Medication? YES NO

If yes, please list: _____

If you are currently being prescribed any of the following medications, please mark all that apply:

- | <u>Medication</u> | <u>Prescriber</u> |
|--|-------------------|
| <input type="checkbox"/> Abilify/aripiprazole _____ | _____ |
| <input type="checkbox"/> Clozaril, Fazalco/clozapine _____ | _____ |
| <input type="checkbox"/> Geodon/ziprasidone _____ | _____ |
| <input type="checkbox"/> Haldol/haloperidol _____ | _____ |
| <input type="checkbox"/> Invega/palliperidone _____ | _____ |
| <input type="checkbox"/> Risperdal/risperidone _____ | _____ |
| <input type="checkbox"/> Seroquel/quetiapine _____ | _____ |
| <input type="checkbox"/> Zyprexa/olanzapine _____ | _____ |

- | <u>Medication</u> | <u>Prescriber</u> |
|---|-------------------|
| BENZODIAZAPINES: | |
| <input type="checkbox"/> Ativan/loraepam _____ | _____ |
| <input type="checkbox"/> Klonopin/clonazepam _____ | _____ |
| <input type="checkbox"/> Valium/diazepam _____ | _____ |
| <input type="checkbox"/> Xanax/alpraolam _____ | _____ |
| <input type="checkbox"/> Librium/chlordiazepoxide _____ | _____ |

- | <u>Medication</u> | <u>Prescriber</u> |
|---|-------------------|
| STIMULANT DRUGS: | |
| <input type="checkbox"/> Adderall _____ | _____ |
| <input type="checkbox"/> Adderall XR _____ | _____ |
| <input type="checkbox"/> Concerta _____ | _____ |
| <input type="checkbox"/> Dexedrine _____ | _____ |
| <input type="checkbox"/> Dexedrine spansule _____ | _____ |
| <input type="checkbox"/> Daytrana _____ | _____ |
| <input type="checkbox"/> Metadate CD _____ | _____ |
| <input type="checkbox"/> Metadate ER _____ | _____ |
| <input type="checkbox"/> Methylin ER _____ | _____ |
| <input type="checkbox"/> Ritalin _____ | _____ |
| <input type="checkbox"/> Ritalin LA _____ | _____ |
| <input type="checkbox"/> Ritalin SR _____ | _____ |
| <input type="checkbox"/> Vyvanse _____ | _____ |
| <input type="checkbox"/> Quillivant XR _____ | _____ |

- | <u>Medication</u> | <u>Prescriber</u> |
|--|-------------------|
| OTHER: | |
| <input type="checkbox"/> Vicodin _____ | _____ |
| <input type="checkbox"/> Oxycontin _____ | _____ |
| <input type="checkbox"/> Fentanyl/Duragesic./Fentora _____ | _____ |
| <input type="checkbox"/> Lorcet/Lortab/Norco _____ | _____ |
| <input type="checkbox"/> Hydromorphone/ Dilaudid _____ | _____ |
| <input type="checkbox"/> Meperidine/Demerol _____ | _____ |
| <input type="checkbox"/> Methadone/Dolophine _____ | _____ |
| <input type="checkbox"/> Morphine/ MS Contin _____ | _____ |
| <input type="checkbox"/> Oxycodone _____ | _____ |
| <input type="checkbox"/> Oxyfast/Roxicodone _____ | _____ |
| <input type="checkbox"/> Targiniq ER _____ | _____ |
| <input type="checkbox"/> Percocet _____ | _____ |
| <input type="checkbox"/> Tramadal _____ | _____ |
| <input type="checkbox"/> Suboxone _____ | _____ |

Other prescribed drugs not on this list: _____

- Are you Pregnant?** YES NO
- Do you use Tobacco?** YES NO
- Do you now or have you ever used IV Drugs?** YES NO
- Have you used non-prescribed drugs or alcohol in the past 90 days?** YES NO

DEMOGRAPHIC INFORMATION Because we are a Medicaid provider, we are required to ask the following questions.

1. Client last name at birth? _____
2. Do you need an interpreter? YES NO Hearing Impaired? Primary Language: _____
3. Is the client a veteran? YES NO
4. What is client's legal status?
 None DUII Diversion DUII Conviction Parole Probation Child Welfare Guardianship Court Guardianship (non-DHS)
5. What is the highest grade completed by client? _____ If currently a student, what school do you attend? _____

6. What is client's county of residence? Polk Marion Other: _____

7. What is client's marital status? (If Living as Married – Please check married)
 Never Married Married Divorced Separated Widowed

8. What is client's employment?
 Full Time Part Time Unemployed Disabled Not in Labor Force
 Student Homemaker Retired Other: _____

9. What is the primary source of income/support for client or parent of client?
 Wages/Salary Public Assistance Disability/SSDI Retirement/Pension/SSI
 Other None

10. Estimated Gross Monthly Household Income: _____ No Income Refuse to Answer

11. What is the client's living arrangement?
 Live Alone Live w/Significant other Live w/parent Foster Home
 Jail Oxford Home Residential Facility Room and Board
 Supported Housing Homeless Other _____

12. Please list the number of: _____ Arrests in the past month _____ Arrests in ^ [^] lifetime _____
 _____ Arrests in the past month _____ Arrests in your lifetime _____

13. Which of the following best describes client's:
Race? White Alaska Native American Indian Black or African American
 Mark all that apply Asian Native Hawaiian or Pacific Islander Other Single Race
Ethnicity? Not of Hispanic Origin Cuban Mexican Puerto Rican
 Other Specific Hispanic _____

Tribal Affiliation ? Not Applicable Burns Paiute Conf Tribe Coos, Lower Ump & Siuslaw
 Conf Tribe of Grand Ronde Conf Tribe of Siletz Conf Tribe of Umatilla
 Conf Tribe of Warm Springs Coquille Indian Tribe Cow Creek / Ump Indians
 Klamath Tribes Other _____

14. Who Referred You To Us?
 Self Police or Sheriff State Prison
 Family/Friend Parole Federal Prison
 Doctor, Nurse or Physician Probation State Psychiatric Facility
 Crisis Helpline Employer PSRB Board
 Media, Internet Employment Services Municipal Court
 Advocacy Group Vocational Rehab Justice Court
 School Attorney Circuit Court
 DD Services Child Welfare Federal Court
 Aging & Disability Health Plan / CCO None
 ADES Jail Other _____

FOR OFFICE USE ONLY

RECEIVED BY: _____

CLIENT ID# _____