COMMUNITY
BEHAVIORAL HEALTH

COMMUNITY FIRST SOLUTIONS

Community Behavioral Health and Foundations Counseling Core Intake Packet

Client Name:	
Date:	
Client Program:	

INFORMED CONSENT

Consent for Services and Consent to Participate in Telehealth Services

Consent Type:	☐ Initial Consent ☐ Withdrawal of Current Consent

CONSENT FOR SERVICES

I consent to assessment and treatment by Community Behavioral Health.

I agree to actively participate in my treatment, as outlined in my individualized treatment plan.

I agree to be contacted by email, mail, phone, and/or text during the course of my treatment.

I understand that follow-up contact may occur for up to 24 months following my discharge from treatment.

I UNDERSTAND MY RIGHTS AS FOLLOWS

When required by regulatory or CBH policy, a diagnosis, when given, must be explained along with symptoms associated with the diagnosis.

Agency information and program-specific information and rules will be provided to me.

Both benefits and risks of my treatment must be explained to me.

Goals, Objectives, Interventions will be reviewed, as set forth in my treatment plan, and adjustments made as deemed clinically appropriate. This will be a collaborative process between myself and my provider.

My service provider(s) are skilled and properly credentialed to provide services within the scope of their practice.

My service provider's qualifications must be provided to me.

I have the right to terminate services or withdraw my consent to receive services at any time. Should I choose to refuse or withdraw consent for treatment, the potential impacts of my

actions in doing so must be explained to me. I understand that information regarding my treatment is protected by state and federal law, and I acknowledge that I have been offered a copy of the rules governing confidentiality, and that the rules have been explained to me.

Do you agree to consent for treatment and Services?	☐ YES ☐ NO

CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

Telehealth is the provision of behavioral health service through interactive video conferencing.

I understand that telehealth is a live, two-way interaction between myself and a clinician/employee of Community Behavioral Health using audiovisual telecommunication technology.

I understand that telehealth is voluntary and that I may refuse to participate at any time verbally or in writing. I understand that my participation, refusal to participate, or decision to stop participation will be documented in my electronic health record.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth. I understand that during a pandemic these laws may be waived by government officials in order to continue to provide care.

Prior to receiving services, I will be educated and the process of telehealth will be explained. I understand that I may not record the audio content or the images of the session.

I have read this document and have had the opportunity to ask questions. I hereby consent to participation in treatment via telehealth video conferencing.

Do you agree to consent for treatment and Services?	☐ YES ☐ NO

PHOTOGRAPHY CONSENT

☐ I **DO NOT** consent to all images taken and videos filmed of me and / or my dependent child(ren). (Disregard 1-5 below)

☐ I **DO** consent to all images taken and videos filmed of me and / or my dependent child(ren). (Complete 1-5 below)

I AGREE THAT IMAGES MAY BE:

1. Used by healthcare professionals for client identification	☐ YES ☐ NO
2. Used by healthcare professionals for education and training.	☐ YES ☐ NO
3. Used in paper or electronic healthcare publications.	☐ YES ☐ NO
4. Used in commercial broadcasts.	☐ YES ☐ NO
5. Used in marketing materials.	☐ YES ☐ NO

ACKNOWLEDGEMENT

I further acknowledge that images and videos are not limited to one date and there are no promises of compensation between client and Community Behavioral Health and/or Community First Solutions, for the use of photos and videos, as outlined in this consent.

This consent may be changed/revoked at any time with written request by the patient.

42 CFR PART 2 PROGRAMS

WRITTEN SUMMARY OF FEDERAL CONFIDENTIALITY LAW & REGULATIONS FOR CUSTOMERS IN ALCOHOL AND/OR DRUG PROGRAMS

In accordance with 42 C.F.R. Part 2 alcohol and other drug customer records are subject to the following confidentiality conditions: Community Behavioral Health complies with these requirements.

1. Program staff shall not convey to a person outside of the program that a customer receives services from the program or disclose any information identifying a customer as an alcohol or drug services customer unless the customer consents in writing for this release of information, the disclosure is allowed by court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purpose.

2. Violation of the federal law and regulations governing this Program is a crime. Suspected violations may be reported to the United States Attorney's Office, Southern District of Ohio, 221 E. Fourth Street, Suite 400, Cincinnati, OH 45202, (513) 684-3711.

3. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a customer either at the program or against any person who works for the program.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Federal authorities.

Effective 3/31/10, Revised 9/22/21

ACKNOWLEDGEMENT OF CLIENT HANDBOOK

THE CLIENT HANDBOOK CONTAINS THE FOLLOWING INFORMATION

* Location, Hours of Operation, Services Offered
* Attendance Policy
* Notice of Privacy Practices
* 42 CFR Part 2 Programs
* Standards of Ethical Practice and Professional Conduct
* Client Rights
* Client Grievance Procedures & Resource Agencies

* Advanced Directives
* Crisis Line Information
* Emergency Site and Safety Information
* Infectious Disease Prevention
* Preventing Opioid Overdose

BY SIGNING THIS DOCUMENT
I acknowledge that I have been offered a copy of the Community Behavioral Health Client Handbook.

I agree to read and become familiar with the information contained in the handbook.

I agree to seek clarification from my provider or CBH support staff to fully understand the content of the handbook, if necessary.

I agree to comply with all policies, laws, and regulations as stated within the Community of Behavioral Health Client Handbook.

PATIENT RESPONSIBILITY

Thank you for choosing Community Behavioral Health for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and complete this form to acknowledge your understanding of your current patient financial responsibilities.

1) The patient (or patient's parent/legal guardian, if a minor) is ultimately responsible for the payment for treatment and care.

2) We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.

3) Clients with commercial insurance payers - coverage of services by commercial payers may vary depending on our organization's specific provider agreement with each commercial payer.

4) You will be responsible for any fees associated with services that are not covered by your specific commercial insurance company or insurance plan.

5) Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

6) Copays are due at the time of service.

7) Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

8) Patients may incur, and are responsible for, payment of additional charges, if applicable. These charges may include a charge for returned checks up to $30.00

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

We respect patient confidentiality and only release personal health information about you in accordance with the state and federal law. Our privacy notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature on this document, I acknowledge that I have received and read the privacy notice provided by Community Behavioral Health and I hereby authorize Community Behavioral Health and the physicians, staff, and hospitals associated with Community Behavioral Health to release medical and other information acquired during the course of assessment and treatment to the necessary insurance companies, third party payers, other physicians or healthcare entities required to participate in my care.

Furthermore, I hereby authorize assignment of financial benefits directly to Community Behavioral Health and any associated healthcare entities for services rendered as allowable under standard third party contracts, and I understand that I am financially responsible for charges not covered by this assignment.

Community Behavioral Health reserves the right to change or modify the terms and conditions of this agreement if we feel it becomes necessary.

SIGNATURES

Print Name & Relationship to Client Served:	
Signature:	
Date:	

Print Name & Relationship to Client Served:	
Signature:	
Date:	

Staff Name:	
Signature:	
Date:	

People Quality Integrity Compassion Community

COMMUNITY BEHAVIORAL HEALTH

COMMUNITY FIRST SOLUTIONS

Intake Demographics Form

Date	
Name	**Preferred Name** _____
Primary Phone **Alternate Phone**	Primary _____ ☐ cell ☐ landline ☐ work Alternate _____ ☐ cell ☐ landline ☐ work
Email	
Physical Address	
Mailing Address	☐ Same as Physical Address
Date of Birth	
Legal Gender	☐ Female ☐ Male | **Birth Sex:** ☐ Female ☐ Male
Preferred Pronouns	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____
Race	☐ Alaska Native ☐ Native America ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ White ☐ Other Single Race ☐ 2 or More Races ☐ Unknown
Ethnicity	☐ Cuban ☐ Hispanic (no specific origin) ☐ Mexican ☐ Not Hispanic ☐ Other Hispanic ☐ Puerto Rican ☐ Unknown
Marital Status	☐ Unmarried (never married) ☐ Married (includes domestic partnership) ☐ Divorced ☐ Unmarried ☐ Separated ☐ Widowed ☐ Other _____
Tobacco Use	☐ User ☐ Non User **Type of User** _____
Smoking Status	☐ Current Smoker ☐ Former Smoker ☐ Never Smoked
Preferred Language	
Military Status	☐ Active Duty ☐ Disabled Veteran ☐ Honorably Discharged ☐ Other Discharge

Please bring photo identification and insurance card with you to your first visit.

SSN	**If no SSN, explain _____**
How did you hear about us?	
Employment Status	☐ Full-Time ☐ Part-Time ☐ Disabled ☐ Retired ☐ Student ☐ Not Employed
Occupation/Job Title	
How many days have you worked in the last month?	
Highest Education Completed	☐ High School/GED ☐ Some College ☐ 2-Year College Degree ☐ 4-Year College Degree ☐ Graduate Degree ☐ Technical Certificate ☐ Other _____
# of Individuals in Household	
Do you have any dependents?	☐ YES ☐ NO **If NO, can someone else claim you as a dependent?** ☐ YES ☐ NO
Source of Income	
Emergency Contact	

Payer Information

Primary Insurance	Name: _____ Policy ID: _____
Subscriber Information	☐ Self Name: _____ Birthdate: _____ Relationship: _____
Secondary Insurance	Name: _____ Policy ID: _____
Subscriber Information	☐ Self Name: _____ Birthdate: _____ Relationship: _____
Self-Pay	☐ I do not have insurance and will be paying out-of-pocket.

Bring completed forms to your first appointment.

Community Behavioral Health
820 S Martin Luther King Jr Blvd | Hamilton, OH 45011 | (513) 887- 8500

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