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	☐Male ☐Female ☐Other
Street Address City State Zip Code			Home Phone
Mailing Address (if different from above) City State Zip Code			Cell Phone
ODL/Oregon DMV# *(required for DUII Program)*	May we send you a detailed reminder of your upcoming appointments? ☐YES ☐NO ☐Text ☐Voice Message ☐Email: _____		

For Minor Children:

Parent Name: (*please print*) _____

Parent Name: (*please print*) _____

CLIENT INSURANCE INFORMATION:

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

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS *(please initial)*

_____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. ☐ OYA Financial Exception

ACKNOWLEDGEMENT OF PRIVACY PRACTICES *(please initial)*

_____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 *(please initial)*

_____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.

_____ _____ _____

Client or Legal Guardian Signature Relationship Date

Printed Name _____

MEDICAL INFORMATION

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

		ROI for Records Request:
☐ Mental Health Counseling	Provided By:_____	☐YES ☐NO
☐ Med. Management	Provided By: _____	☐YES ☐NO
☐ A&D Treatment	Provided By: _____	☐YES ☐NO
☐ Gambling Treatment	Provided By: _____	☐YES ☐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:

Medication	Prescriber
☐Abilify/aripiprazole	
☐Clozaril, Fazalco/clozapine	
☐Geodon/ziprasidone	
☐Haldol/haloperidol	
☐Invega/pallperidone	
☐Risperdal/risperidone	
☐Seroquel/quetiapine	
☐Zyprexa/olanzapine	

Medication	Prescriber
BENZODIAZAPINES:	
☐Ativan/loraepam	
☐Klonopin/clonazepam	
☐Valium/diazepam	
☐Xanax/alpraolam	
☐Librium/chlordiazepoxide	

Medication	Prescriber
STIMULANT DRUGS:	
☐Adderall	
☐Adderall XR	
☐Concerta	
☐Dexedrine	
☐Dexedrine spansule	
☐Daytrana	
☐Metadate CD	
☐Metadate ER	
☐Methylin ER	
☐Ritalin	
☐Ritalin LA	
☐Ritalin SR	
☐Vyvanse	
☐Quillivant XR	

Medication	Prescriber
OTHER:	
☐Vicodin	
☐Oxycontin	
☐Fentanyl/Duragesic,/Fentora	
☐Lorcet/Lortab/Norco	
☐Hydromorphone/ Dilaudid	
☐Meperidine/Demerol	
☐Methadone/Dolophine	
☐Morphine/ MS Contin	
☐Oxycodone	
☐Oxyfast/Roxicodone	
☐Targiniq ER	
☐Percocet	
☐Tramadal	
☐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 ☐ Current or Former Active Duty Military ☐ Current or Former Guard/Reserve Military

4. What is client's legal status? *(mark all that apply)*
☐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 does client 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? (Mark all that apply)
☐Full Time ☐Part Time ☐Unemployed ☐Disabled ☐Not in Labor Force
☐Student ☐Homemaker ☐Retired ☐Other: _____

8a. Are you interested in receiving information about how to find employment? ☐ YES ☐ NO

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 total number of people dependent upon household income? ____

12. How many children ages 0-17 that are dependent upon the household income? ____

13. 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 _____

14. Please list the number of: DUII Arrests in the past month _____ DUII Arrests in your lifetime _____
Arrests in the past month _____ Arrests in your lifetime_____

15. Which of the following best describes client's:
Race? *Mark all that apply* ☐ White ☐ Alaska Native ☐ American Indian ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Single Race

Ethnicity? ☐ Not of Hispanic Origin ☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Other Specific Hispanic _____

Tribal Affiliation ? *Mark all that apply*
☐ 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_____

16. Who Referred You To Us? *(Mark all that apply)*
☐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# _____