

ASSIGNMENT of BENEFITS

Your signature below will:

- Permit the Bert Nash Center to bill for services you may be entitled to have paid for by third party payors, including insurance companies and government programs such as Medicaid and Medicare, and to directly receive those payments.
- Authorize the Bert Nash Center to provide information required for filing third party medical claims.

Name of Insurance Company or other Third Party Payor: _____

I authorize benefits payable under the above named insurance to be paid directly to the provider (Bert Nash Community Mental Health Center, Inc.). A copy of this form shall be considered as valid as the original form.

Signed by:

Client Parent Guardian

SIGNATURE: ⊗ _____ **DATE:** _____

CONSENT to TREAT

In order to provide you with services, we need your authorization.

(If the client is under 18 years of age, we require authorization by the minor's parent or guardian.)

By signing below you are:

- Authorizing the Bert Nash Center to provide you or your minor child with mental health services, which may include individual counseling, group therapy, psychiatric testing, psychological and psychiatric care and other related service. The Bert Nash Center will provide these services in a confidential manner that complies with state and federal laws and professional standards.
- Acknowledging that you or your minor child may be seen and treated by a licensed professional (Master's or Ph.D.) This person is not a physician and will not be providing medical treatment nor writing prescriptions. Certain mental disorders can have medical or biological origins, and you may need to consult with a physician.
- Acknowledging that you have been informed that the Bert Nash Center required 24 hour notice when canceling appointments.
- Certifying that all of the information provided is accurate.

MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES

Consent and Authorization signed by:

Client Parent Guardian

SIGNATURE ⊗ _____ **DATE:** _____

CONSENT for MEDICAL RECORD REVIEW

In order to allow authorized Bert Nash staff to access your medical record to conduct research, we need your authorization. *(If the client is under 18 years of age, we require authorization by the minor's parent or guardian.)*

By signing below you are:

- Acknowledging that research takes place at the Bert Nash Center to improve services, and at times your record may be reviewed to see if you are eligible to participate in our research. If you are eligible, a researcher may contact you to describe the research. Research participation is *VOLUNTARY* and never affects your services at Bert Nash.
- Authorizing the Bert Nash Center to extract non-identifying information from the client's medical record for research purposes, including test scores, diagnoses, number of sessions, and other non-identifying demographic information.

Consent for Medical Record Review signed by:

Client Parent Guardian

SIGNATURE ⊗ _____ **DATE:** _____

Reg. ID# _____ Client Name: _____
BERT NASH CMHC

Client Information Form
Access Center – Approval Date: 12/6/2002

If Client is Under 18 Years of Age, a Parent or Other Adult Should Complete this Form

Client Information

Initial Contact Date: _____

Client Name: _____

First Name MI Last Name Other Names

Date of Birth: _____ / _____ / _____ Age: _____ SSN# _____ / _____ / _____

Client's Address: _____

Street, Rural Route or Box Number City State Zip County

Client's Home Telephone: _____ Client's Work/Alt. Telephone: _____

Client's Employer/School: _____

New Client Former Client Date Last Seen: _____

Responsible Party (Indicate who will be paying for the services client will receive)

Self Parent Other

***Responsible Party Information, If Other Than Client:**

Name: _____ SSN#: _____ / _____ / _____ DOB: _____ / _____ / _____

First Name MI Last Name

Address: _____

Street, Rural Route or Box Number City State Zip

Home Phone: _____ Work Phone: _____ Employer: _____

Client Income

This section must be completed so that we can determine your fee. Please include all of your income sources. Adults under 23 years of age, who either receive financial support from their parents or who are covered through their parents' health insurance must include their parents' income when answering this section.

Clients who DO NOT complete this section will be charged the Center's FULL FEE!!!

Total Yearly Gross Household Income: _____

Total Number of People this Income Supports: _____

Billing Information

All billing information must be complete and accurate. If this information is not complete and accurate, we reserve the right NOT to schedule additional appointments until the information is supplied.

Responsible Party's Payment Method

Insurance* Medical Card * (Either MediKan or Medicaid) Medicare*

No current health insurance coverage (Fees will be paid at time of service)

Employee Assistance Program Provided by Employer _____

Employer Name

Other _____

*Requires proof of coverage (Insurance card, medical card, etc.) that must be copied for our records

Therapist: _____ Lapse Code: _____

Reg. ID# _____ Client Name: _____

BERT NASH CMHC

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITIES

Your signature below will acknowledge that:

- The Bert Nash Center's Sliding Scale fee and fee policies have been explained to me, and that I have received a copy of the Bert Nash Center's brochure, Client Handbook: A guide to Using our Services, which contains information about client's rights as well as financial and billing information.
- The Bert Nash Center will bill my insurance or third party payor at full cost for the service. I have been informed that services not covered either by private insurance, Medicare or Kansas Medical Card will be the responsibility of the client (or parent or guardian if the client is under 18 years of age.)
- I understand that even if I have insurance, I will need to pay the sliding scale fee. If payment is received from insurance, any resulting credit may be applied to future services.
- I understand that I am to pay my sliding scale/co-pay fee before each session at the time of check-in at the reception desk.
- My sliding scale/copay fee is:

_____ for the initial visit
_____ for 1 hour of individual treatment-not including psychiatrist
_____ for medication management visits with a psychiatrist (up to 30
minutes.)
_____ for one hour of service with a psychiatrist
_____ for each hour of group therapy
_____ phone prescription refills or phone consultation
_____ insurance co-pay
_____ Medicaid co-pay

- I further understand and accept that services may be discontinued if I choose not to pay the sliding scale/co-pay fee at each visit.
- By signing this form I acknowledge that this information has been explained to me and that I understand and accept my financial responsibilities.

MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES

Consent and Authorization signed by:

- Client Parent Guardian

SIGNATURE: ⊗ _____ **DATE:** _____

Insurance Information

Primary Coverage FS# _____
Policyholder's Name: _____ Effective Date: _____
Policyholder's Address: _____
Policyholder's ID Number: _____ Group or Plan Number: _____
Name of Company Providing Coverage: _____
Insurance Billing Address: _____
Name of Employer: _____

Secondary Coverage FS# _____
Policyholder's Name: _____ Effective Date: _____
Policyholder's Address: _____
Policyholder's ID Number: _____ Group or Plan Number: _____
Name of Company Providing Coverage: _____ Effective Date: _____
Insurance Billing Address: _____
Name of Employer: _____

Reg. ID# _____ **Client Name:** _____
BERT NASH CMHC