1ST _____
2ND _____
BSA _____

REGISTRATION INFORMATION

Client ID

Client Name: _____

Date of Birth: ___/___/_____Social Security Number: _____ Gender: ☐Female ☐Male

Who referred you to **Health Solutions West?** Examples: Self, Friend, Minister, School, Probation, Employer, etc.

_____

_____

If you are seeking substance use treatment and meet any one of the following please inform the staff at the front desk.

☐ IV drug user
☐ Pregnant or have dependent children
☐ Court ordered on an involuntary commitment

Veteran : ☐ Yes ☐ No I am a US Citizen: ☐ **Yes** ☐ **No** I am a documented immigrant: ☐ **Yes** ☐ **No**

This information is used to determine public funding resources and will NOT be used to deny services.

Physical Address: _____ _____

City: _____ State: _____ Zip: _____

Mailing Address same as Physical Address? ☐ **Yes** ☐ **No**

If No: Mailing Address: _____ City: _____ St.: _____ Zip: _____

Primary Phone:_____☐ HOME ☐ CELL ☐ WORK ☐OTHER

Other Phone:_____☐ HOME ☐ CELL ☐ WOR K ☐OTHER

Email address: _____

I prefer to be contacted via ☐ Home Phone ☐Cell Phone ☐Text ☐ Email ☐Do Not Contact

Primary Language: _____ Other Language: _____

Is an Interpreter Needed? ☐Yes ☐No

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐Black/African American ☐ Native Hawaiian/Pacific Islander

☐ White/Caucasian ☐ Declined

Ethnic Origin: Hispanic ☐ NO ☐ YES: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic ☐ Declined

Marital Status: ☐ Never Married/Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Education Level in Years _____(High school = 12; Bachelors = 16 etc.)

Employment Status: ☐ Full Time (35+ hours/week) ☐ Part Time (less than 35 hours/week)

☐ Homemaker, not otherwise employed ☐ Supported Employment ☐ Not in Labor Force ☐ Military

☐ Unemployed ☐ Student ☐ Retired ☐ Disabled ☐ Inmate ☐ Volunteer

Sexual Orientation: ☐ Bisexual ☐ Chose not to Disclose ☐ Lesbian, Gay or Homosexual ☐ Other

☐ Straight or Heterosexual

Maiden Name: _____ ☐N/A Preferred Name/Alias _____

Place of Residence: ☐Independent Living ☐Assisted Living ☐ ATU Adult Only ☐ Boarding Home
☐ Correctional Facility/Jail ☐ Foster Home (Youth) ☐ Group Home (Adult) ☐ Halfway House
☐ Homeless/Lacking a Perm Residence ☐ Inpatient ☐ Nursing Home ☐ Residential Facility (MH Adult)
☐Residential Facility (Other) ☐ Residential Treatment/Group ☐ Sober Living ☐ Supported Housing

Living Arrangements: ☐ Alone ☐Children ☐Father ☐ Foster Parents ☐Guardian ☐Mother ☐ Parents
☐Partner/Significant Other ☐ Relatives/Kin ☐ Siblings ☐ Spouse ☐ Unrelated Person

Disabilities: ☐ None ☐ Blind/Vision Loss ☐Deaf/Hearing Loss ☐Developmental Disability ☐Learning Disability
☐ Traumatic Brain Injury

Smoking /Tobacco Status: ☐Current Smoker/Tobacco User – Every Day ☐Current Smoker/Tobacco User – Periodically
☐Former Smoker/Tobacco User ☐ Never Smoked/Used Tobacco ☐ Refused

Financial Information INCOME:

Number of Children (under age of 18)? _____ Number of people this income supports: _____

Annual GROSS Household Income: $ _____

I receive SSI Benefits ☐ Yes ☐No I receive SSDI Benefits ☐ Yes ☐ No

Your income may qualify you for a discount. Please review and complete the financial packet being provided to you at this time or you may also obtain the information at www.healthsolutionswest.org. Services will not be discounted until a completed application and proof of income is received.

Advance Directives
1. Do you have Medical Advanced Directives or Advanced Directives for Behavioral Health Orders? ☐ Yes ☐ No
2. Would you like information on either Medical Advance Directives or Advanced Directives for Behavioral Health Orders? ☐ Yes ☐ No
3. If you have Advanced Directives in place, may we have a copy? ☐ Yes (Please bring a copy to our office). ☐ No

Emergency Contact Information:

Name: _____ Relationship to Client: _____

Living with Client ☐ Yes ☐ No

Address: _____ City: _____ St.: _____ Zip: _____

Phone #_____

Parent/Guardian Information:

Name: _____ Relationship to Client: _____
Living with Client ☐Yes ☐No

Address: _____ City: _____ St.: _____ Zip: _____

Phone #_____

Insurance Information

Reason for Seeking Services: _____ for persons with health insurance only, enter number from the Reason for Seeking Services List

☐ I have Medicaid ☐ I have health insurance of my own ☐ I have health insurance through spouse/parent

If client is a minor, is there a divorce decree indicating which insurance is primary? ☐ Yes ☐ No

☐ I have EAP benefits through my employer Employer: _____

EAP benefits may require an authorization which is your responsibility to obtain. Please contact your Human Resources Dept. for further information.

Primary Insurance Company Name: _____ Policy # _____

Subscriber/Policy Holder's Name: _____ Relationship to Client _____

DOB: _____/_____/_____ Employer :_____

Secondary Insurance Company Name: _____Policy # _____

Subscriber/Policy Holder's Name: _____Relationship to Client _____

DOB: _____/_____/_____Employer:_____

____ I hereby apply for services for myself and/or my dependents at Health Solutions West. I attest that 1) the above stated number in household is correct; 2) my reported household income is correct; 3) I understand that payment must be made at the time of service.

_____ *I attest that I and/or my dependents are uninsured or have insurance coverage that does not include mental health and/or substance abuse benefits. I wish to apply for a sliding scale fee.*

_____ If applicable, I request my insurance company or other third-party coverage to pay all claims directly to Health Solutions West. I authorize payment of insurance benefits directly to Health Solutions West for services rendered. I authorize Health Solutions West to release all information with respect to me and/or my dependents as may be required to process the insurance claim. I authorize my insurance company to release to Health Solutions West any information regarding my insurance claims with Health Solutions West. I understand that I am financially responsible to Health Solutions West for any monies paid directly to me by my insurance company for those same services.

_____ I agree that by providing my contact information I may be contacted via auto-dialer technology, prerecorded messages, or text, for the purposes of appointment reminders, payments or to exchange information about my treatment. I understand that I can revoke the consent to receive contact via auto-dialer technology, prerecorded messages, or text, by notifying a staff member at Health Solutions West and indicating this change on a new Registration Information form.

_____ _____

Printed Name Client/Authorized Person Date

_____

Client or Authorized Person's Signature

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CONSENT FOR MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT

CONSENT TO TREAT:
I understand Health Solutions West provides mental health and/or substance abuse treatment services. I agree to treatment for
☐ Myself ☐ My child ☐ The person for whom I am legal guardian/custodian

CLIENT RIGHTS AND RESPONSIBILITIES:
I have received the Client Rights handout and relevant handouts outlining my responsibilities as a client of HEALTH SOLUTIONS WEST. I understand that it is my right to ask questions if I need clarification or have concerns. I understand that Health Solutions West prohibits me from audio or video recording any of my treatment services. Health Solutions West will not record my treatment sessions without my written consent.

ACKNOWLEDGMENT OF PRIVACY NOTICE:
I understand that a copy of the current Notice of Privacy Practices is available for review at my request, and on the Health Solutions West internet site. I may speak to the Privacy Officer for more information.

FINANCIAL AGREEMENT AND/OR ASSIGNMENT OF BENEFITS:
I request my insurance company or other third party coverage to pay all claims directly to Health Solutions West. If my insurance determines a service is not covered, I understand that I am financially responsible for full payment of associated charges. I understand that I have the right to request in-network providers perform all covered services. If I have to receive services from an out-of-network provider because an in-network provider is not available, then the most I can be billed for covered services is my in-network cost sharing. I understand I am financially responsible for any co-payment or co-insurance determined by my insurance benefits, and this payment is expected at time of service. In the event that I fail to honor my financial obligation to Health Solutions West, I understand that my services may be re-scheduled and/or terminated.

GRIEVANCES:
I understand that a copy of the current Grievance Policy is available for review at my request, and on the Health Solutions West internet site. I understand that I may file a grievance or obtain the assistance of a Client Advocate without jeopardizing my care.

FOLLOW-UP CONTACT AND SURVEYS:
I understand Health Solutions West or their representatives may contact me to by email, text message, or telephone obtain follow-up information or ask about my satisfaction with treatment or services. Such information is confidential and will be used for quality assessment. I may choose to participate in these surveys or not without jeopardizing my treatment.

CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES:
I understand that I may have the opportunity to participate in telehealth services. I have the option to refuse the delivery of the services via telehealth at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. All applicable confidentiality protections shall apply to my telehealth services; and I will have access to all medical information resulting from these telehealth services as provided by applicable law.

ACKNOWLEDMENT OF CLIENT PICTURE IDENTIFICATION POLICY:
I understand that it may I be necessary for Health Solutions West to obtain a picture ID of myself and/or take a photograph of me for the purpose of identification, safety, and protection against identity theft.

REASONS FOR DISCONTINUING SCHEDULED SERVICES: I understand that services from Health Solutions West may be discontinued for:

- Completion of treatment by mutual consent;
- **Two consecutive late cancelled appointment (less than 24 hours) or no-shows;**
- **Three late cancelled appointments (less than 24 hours) or no-shows within a 90 day period;**
- Lack of progress toward agreed-upon Service Plan goals;
- Behavior that poses a substantial risk to others;
- Failure to pay for services;
- Demonstrated need for services that Health Solutions West is unable to provide;
- No contact with Health Solutions West for 45 days without a scheduled appointment.

Client Signature _____ Date _____

Witness Signature _____ Date _____

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SURPRISE BILLING -- KNOW YOUR RIGHTS

BEGINNING JANUARY 1, 2020, COLORADO STATE LAW PROTECTS YOU* FROM "SURPRISE BILLING," ALSO KNOWN AS "BALANCE BILLING." THESE PROTECTIONS APPLY WHEN:

• YOU RECEIVE COVERED EMERGENCY SERVICES, OTHER THAN AMBULANCE SERVICES, FROM AN OUT-OF-NETWORK PROVIDER IN COLORADO, AND/OR
• YOU UNINTENTIONALLY RECEIVE COVERED SERVICES FROM AN OUT-OF-NETWORK PROVIDER AT AN IN NETWORK FACILITY IN COLORADO.*

WHAT IS SURPRISE/BALANCE BILLING, AND WHEN DOES IT HAPPEN?
IF YOU ARE SEEN BY A PROVIDER OR USE SERVICES IN A FACILITY OR AGENCY THAT IS **NOT** IN YOUR HEALTH INSURANCE PLAN'S PROVIDER NETWORK, SOMETIMES REFERRED TO AS "OUT-OF-NETWORK," YOU MAY RECEIVE A BILL FOR ADDITIONAL COSTS ASSOCIATED WITH THAT CARE. OUT-OF-NETWORK FACILITIES OR AGENCIES OFTEN BILL YOU THE DIFFERENCE BETWEEN WHAT YOUR INSURER DECIDES IS THE ELIGIBLE CHARGE AND WHAT THE OUT OF-NETWORK PROVIDER BILLS AS THE TOTAL CHARGE. THIS IS CALLED "SURPRISE" OR "BALANCE" BILLING.

WHEN YOU CANNOT BE BALANCE-BILLED:

NON-EMERGENCY SERVICES AT AN IN-NETWORK FACILITY BY AN OUT-OF-NETWORK PROVIDER
THE FACILITY OR AGENCY MUST TELL YOU IF YOU ARE AT AN OUT-OF-NETWORK LOCATION OR AT AN IN-NETWORK LOCATION THAT IS USING OUT OF NETWORK PROVIDERS. THEY MUST ALSO TELL YOU WHAT TYPES OF SERVICES THAT YOU WILL BE USING MAY BE PROVIDED BY AN OUT-OF-NETWORK PROVIDER.

YOU HAVE THE RIGHT TO REQUEST THAT IN-NETWORK PROVIDERS PERFORM ALL COVERED MEDICAL SERVICES. HOWEVER, YOU MAY HAVE TO RECEIVE MEDICAL SERVICES FROM AN OUT-OF-NETWORK PROVIDER IF AN IN NETWORK PROVIDER IS NOT AVAILABLE. IN THIS CASE, THE MOST YOU CAN BE BILLED FOR **COVERED** SERVICES IS YOUR IN-NETWORK COST-SHARING AMOUNT WHICH ARE COPAYMENTS, DEDUCTIBLES, AND/OR COINSURANCE. THESE PROVIDERS CANNOT BALANCE BILL YOU FOR ADDITIONAL COSTS.

ADDITIONAL PROTECTIONS
• YOUR INSURER WILL PAY OUT-OF-NETWORK PROVIDERS AND FACILITIES DIRECTLY.
• YOUR INSURER MUST COUNT ANY AMOUNT YOU PAY FOR EMERGENCY SERVICES OR CERTAIN OUT-OF-NETWORK SERVICES (DESCRIBED ABOVE) TOWARD YOUR IN-NETWORK DEDUCTIBLE AND OUT-OF-POCKET LIMIT.
• YOUR PROVIDER, FACILITY, HOSPITAL, OR AGENCY MUST REFUND ANY AMOUNT YOU OVERPAY WITHIN 60 DAYS OF BEING NOTIFIED.
• NO ONE, INCLUDING A PROVIDER, HOSPITAL, OR INSURER, CAN ASK YOU TO LIMIT OR GIVE UP THESE RIGHTS.

IF YOU RECEIVE SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR FACILITY OR AGENCY IN ANY OTHER SITUATION, YOU MAY STILL BE BALANCE BILLED, OR YOU MAY BE RESPONSIBLE FOR THE ENTIRE BILL. IF YOU INTENTIONALLY RECEIVE NON-EMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR FACILITY, YOU MAY ALSO BE BALANCE BILLED.

IF YOU THINK YOU HAVE RECEIVED A BILL FOR AMOUNTS OTHER THAN YOUR COPAYMENTS, DEDUCTIBLE, AND/OR COINSURANCE, PLEASE CONTACT THE BILLING DEPARTMENT, OR THE COLORADO DIVISION OF INSURANCE AT 303- 894-7490 OR 1-800-930-3745.
* THIS LAW DOES NOT APPLY TO ALL COLORADO HEALTH PLANS. IT ONLY APPLIES IF:
• YOU HAVE A "**CO-DOI**" ON YOUR HEALTH INSURANCE ID CARD, AND
• YOU ARE RECEIVING CARE AND SERVICES PROVIDED AT A REGULATED FACILITY IN THE STATE OF COLORADO.

PLEASE CONTACT YOUR HEALTH INSURANCE PLAN AT THE NUMBER ON YOUR HEALTH INSURANCE ID CARD OR THE COLORADO DIVISION OF INSURANCE WITH QUESTIONS.

_____ _____
Client Printed Name Date

_____
Client Signature or Representative

CONSENT TO DISCLOSURE OF SUBSTANCE ABUSE INFORMATION

Print Name of Patient

I authorize Health Solutions West to disclose information concerning my, or the above-named patient's, treatment for alcohol and/or drug abuse to my health insurer:

(insurance company name).

Rocky Mountain Health Partnerships; the Colorado Department of Human Services, Office of Behavioral Health; and the Colorado Department of Health Care Policy and Financing.

I also authorize Rocky Mountain Health Partnerships and the Colorado Department of Human Services, Office of Behavioral Health, to further disclose information concerning my, or the above-named patient's, treatment for alcohol and, or, drug abuse, to the Colorado Department of Health Care Policy and Financing.

I authorize such disclosures for the purpose of payment and collection, care coordination, utilization management, quality assurance, and handling grievances and appeals.

I understand that if I do not sign this consent form, my health insurer may refuse to pay for my, or the above-named patient's, treatment.

I understand that I have the right to revoke this consent at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it.

If not previously revoked, this consent will terminate upon the date that I am, or the above-named patient is, no longer covered by the above-named insurer, or two years from the date of my signature, whichever is earlier.

Signature of Patient, Parent or Guardian **Date**