Wings Support & Recovery

Client Intake Form

Contact Information

______________________________ ________________ ____/____/________
Name SSN Date of Birth

__________________ ____________ _______________ ____________
Ethnicity Gender Identity Primary Language Marital Status

Race ("X" all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Client Refused/Doesn't Know

____
Address

____
City State Zip Code

______________________ Is this a ☐ Home Phone or ☐ Cell Phone
Phone

____
Email

Guardianship

Do you have a guardian? ☐ Yes ☐ No *If you checked Yes, fill in the information below:*

____
Name

____
Address

____
City State Zip Code

________________________ Is This a ☐ Home Phone or ☐ Cell Phone
Number

EMERGENCY CONTACT NUMBER

____
Name

____
Relationship to you

______________________________ Is This a ☐ Home Phone or ☐ Cell Phone
Phone

The person listed above will be contacted in the event of an emergency, and/or if fifteen days (15) or more have passed since our last contact with you.

Wings Support & Recovery

PERMISSION TO CONTACT

I, ______________________________ authorize a Wings- Support & Recovery Peer Supporter to
Your Name
contact me using the following methods (please check all that apply and fill in current information):

☐ Phone

☐ Texting

☐ Email

☐ Other (please describe and list contact information below)

____

Best time to be contacted (check all that apply)?

☐ Morning (7-12) ☐ Afternoon (12-5) ☐ Evening (5-10) ☐ Anytime

Is it OK to leave a message? ☐ Yes ☐ No

__________ Initialing here, I agree to keep current contact information on file at Wings Support & Recovery. If I need to update my information I will contact Wings Support and Recovery as soon as possible.

Current Services

We want you to be successful and achieve your recovery goals. It would be helpful for us to know if you are working with another area agency. Having this information will help us serve you better. Disclosure of this information is strictly voluntary. Please check all the agencies you are currently receiving services from below:

☐ Maryhaven at the Mills Center

☐ Union County Job & Family Services

☐ Lower Lights Unionstar

☐ Lighthouse Behavioral Health

☐ Social Security Admin. (SSI, SSDI)

☐ New Vision at Memorial Hospital

☐ Logan County Metropolitan Housing (for Union County Subsidized Housing)

☐ Memorial Hospital of Union County

☐ Other agencies (Please list below)

____

____

Are you currently involved with the Union County Criminal Justice System? (If "Yes", please specify in what area: e.g.: Felony Drug Court, Family Treatment Drug Court, Probation, etc.)

____

____

INSURANCE INFORMATION

Primary Insurance Patient's Insurance ID#: ____

Subscriber (whose job provides plan?): ____
(Last) (First) (MI)
Subscriber's Date of Birth: _________________Sex: M or F Subscriber's Social Security #: ______________________

Insurance Company: _________________________________ ID #: ____________________ Group#: _________________

Second Insurance? Y or N Patient's Insurance ID#: ____

Subscriber: ____
(Last) (First) (MI)
Subscriber's Date of Birth: _________________ Sex: M or F Subscriber's Social Security #: ______________________

Insurance Company: __________________________________ ID #: ____________________ Group #: ________________

If there is a third plan, please put information on back. Is this related to a Motor Vehicle Accident or Worker's Comp ?

Ultimately, who is responsible for the bill (the Guarantor)?: ____

Address: ____

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Wings Support & Recovery to perform evaluation and associated services. I understand the explanation(s) given and I acknowledge that no guarantee can be given to me by anyone concerning the results of services.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to Wings Support & Recovery of all service(s) furnished to me. I authorize Wings Support & Recovery to release any medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPAA release of protected health information standards. Further, I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Wings Support & Recovery. I hereby authorize the photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Wings Support & Recovery from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: I have been made aware and understand that Wings Support and Recovery may use an Electronic Health Record. I further understand that my protected health information will remain secure as required by law.

____ _______________________
Signature of Responsible Party (relationship) Date

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. With exception to mandatory reporting laws. ORC 5123.61, ORC 2151.421, and ORC 5101.63

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Executive Director in person or by phone at 937-642-9555.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Your signature below indicates that you have received and have read this notice.

Signature of consumer or guardian____ Date ____________________

Signature of Witness______________________________________ Date ______________