Brookings Behavioral Health & Wellness

Registration Form

Office Use Only

- ☐ Mental Health
- ☐ Chemical Dependency
- ☐ DUI 1st ☐ SED
- ☐ Ingestion

Referred By:

Self | Hospital | PCP
Friend | Court Services | Family
Other ____________________

Today's Date ____________ **Clinician** ____________

PATIENT DEMOGRAPHICS

Last Name | **First Name** | **Middle Name**

Is this your legal name? Yes No **If no, what is your legal name?** ____________

Known by any other name? Yes No **If yes, what other name(s)?** ____________

Date of Birth | **Social Security Number** | **Mother's First Name**

Street Address | **City** | **State** | **Zip Code**

Primary Phone Number | **Secondary Phone Number**

Sex

Male Female

Maritial Status

Single Married Widowed Divorced Separated

Veteran

YES NO

Race

- White
- Black
- Asian
- Native American / Alaskan Native
- Hawaiian / Other Island Native
- Other ____________

Ethnicity

- Puerto Rican
- Hispanic Origin
- Mexican
- Cuban
- Not of Hispanic Origin
- Other ____________

English Proficiency

- Full
- Limited
- Assistant Required

Current Living Situation (adult only)

Alone / Indepdendent	w/ Children Only	w/ Unrelated Person	Other Public/Private
w/ Spouse Only	w/ Parents	Adult Foster Home	Homeless
w/ Spouse & Children	w/ Other Family	Nursing Home	Other ____________________

Current Living Situation (adolescent only)

Both Parents	Foster Home	Private Care Facility
Single Parent	Independent Living	Homeless
Parent/Stepparent	Public Care Facility	Other ________________

Current Prescription Medications

____

____

Tobacco Use?

Yes No

EMPLOYMENT

Are you a student? Yes No **If yes, what school?** ________ **Highest Grade Completed** ________

Are you employed? Yes No **If yes, occupation?** ________ **Employer** ________

Employment Type (circle one)

Full Time	Homemaker	Retired	Not Applicable
Part Time	Student	Disabled	Other ________

Employment Length (circle one)

0 - 6 months	6 - 12 months	1 year	3 - 7 years
8 - 15 years	16 - 20 years	21 + years	Other ________

Income Source (circle one)

Wages/Salary	Alimony	Disability	
Veterans Benefits	Retirement Pension	Child Support	Other ________

Primary Insurance Company ________ **Secondary Insurance Company** ________

Policy Holder's Name ________ **Policy Holder's Name** ________

ID # ________ **ID #** ________

Group # ________ **Payor ID #** ________ **Group #** ________ **Payor ID #** ________

Relationship to Patient ________ **Relationship to Patient** ________

Date of Birth ________ **Social Security #** ________ **Date of Birth** ________ **Social Security #** ________

Brookings Behavioral Health & Wellness will submit claims to payers. Insurance benefits will be paid directly to Brookings Behavioral Health & Wellness for services rendered. If you have any questions or concerns, please contact us at 211 4th St. Brookings, SD 57006 or by calling (605) 697-2850.

Emergency Contact ________ **Emergency Contact Phone Number** ________ **Relationship** ________

Emergency Contact ________ **Emergency Contact Phone Number** ________ **Relationship** ________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician and/or clinician. I understand that I am financially responsible for any balance. I also authorize Brookings Behavioral Health & Wellness or insruance company to release any information required to process my claims.

Patient Signature ________ **Date** ________

Guardian Signature ________ **Date** ________

Brookings Behavioral Health & Wellness Staff Signature ________ **Date** ________

INFORMED CONSENT & PAYMENT FOR SERVICES AGREEMENT

Brookings Behavioral Health & Wellness is committed to providing cost effective, quality care on behalf of its clients. Our staff will be glad to assist you with any questions or concerns you may have about services, fees, and your rights and responsibilities as a client. The success of treatment is dependent on a number of variables to include client participation and compliance with prescribed interventions. However, Brookings Behavioral Health & Wellness makes no guarantee of improved functioning or problem resolution.

Brookings Behavioral Health & Wellness is a private, not for profit, agency. Our agency receives public funding, which allows us to work with clients on an individual basis to prevent the cost of services interfering with access to needed care. To this end, the following guidelines apply:

- **a.** Insurance policies may or may not cover all or part of the cost of services. Brookings Behavioral Health & Wellness will assist those with private insurance by submitting claims; but co-payments, deductibles, and any non-covered costs are the responsibility of the client.
- **b.** Unless prior arrangements have been made with the business office, payment for services are due at the time services are rendered. Cash, credit cards, or checks are accepted.
- **c.** If clients are unable to pay for the cost of services at the time services are delivered, it will be necessary for them to meet with business office staff to arrange for acceptable payment arrangements.
- **d.** Reduced fees are available for eligible South Dakota residents without insurance or other forms of coverage (e.g. Title XIX, Medicare). This reduced rate is calculated based off of family income guidelines.
- **e.** Unpaid bills will be turned over to a collection agency in the event that clients fail to fulfill established payment obligations and do not otherwise contact Brookings Behavioral Health & Wellness to resolve non-payment issues.

I hereby authorize Brookings Behavioral Health & Wellness to release any information required by my insurance carrier, ______________________________ for the purpose of adjudicating claims submitted on my behalf for services rendered by Brookings Behavioral Health & Wellness. Moreover, I hereby authorize assignment of my insurance benefits directly to Brookings Behavioral Health & Wellness, 211 Fourth Street, Brookings, SD 57006. This release will expire upon fulfillment of the purpose herein described.

____

PATIENT / INSURED SUBSCRIBER SIGNATURE DATE

I have read this document in its entirety and have had full opportunity to ask any questions or obtain clarification of its content. Further, I have been provided with a copy of the Brookings Behavioral Health & Wellness Informed Consent & Payment for Services Agreement and understand my rights and responsibilities in regard to receiving services through Brookings Behavioral Health & Wellness. Having considered all of this information I hereby consent to receive services offered by Brookings Behavioral Health & Wellness.

____

PATIENT SIGNATURE DATE

____

BROOKINGS BEHAVIORAL HEALTH & WELLNESS DATE

FINANCIAL ELIGIBILITY (Calendar Year 2020)

Instructions
Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Behavioral Health.

Behavioral Health Provider Use Only	
☐ **Eligible** – Annual Review Date:	
☐ **Ineligible**	BH Provider:
CID #:	Signature:

Personal Information *(Please Print)*

Client Name: ____
(First) *(MI)* *(Last)*

Parent/Guardian or Representative (if applicable): ______________________________

☐ Yes ☐ No I (CYF and/or SUD Client) have applied for and been denied Medicaid and CHIP-NM.
☐ Yes ☐ No I (SMI Client) have applied for and been denied SSI.

Description of Household

Total Number of Persons Living in Household (dependent on household income): ____________

Financial Information

Total Household Annual Gross Income: Include all sources of income (wages, TANF, child support) for the household members included above, except for any income from a child under the age of 18.

1) Earned Income *(i.e. wages)* $____________

2) Unearned Income *(i.e. child support, TANF, SSDI)* $____________

Minus Annual Deductions/Expenses:

3) $________ Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*

4) $________ Childcare Expenses *(up to $6,000/year)*

5) $ ________ Child Support Payments

Household Size	Annual Income
1	$23,606
2	$31,894
3	$40,182
4	$48,470
5	$56,758
6	$65,046
7	$73,334
8	$81,622
9	$89,910
10	$98,198

Annual Out of Pocket Disability Related Expenses:

6) $________ Prescription Medications/Labs *(related to mental illness)* ____________

7) $________ Health Insurance Premiums ____________

8) $________ Assistive Devices *(related to mental illness)* ____________

Equals Annual Net Income:

9) $________________ *(deduct lines 3 through 8 from line 1 and 2)*

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Behavioral Health Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in the household, and/or any other significant change in financial circumstance.

____
Signature (Client or Parent/Guardian) Date

Eligible Clients

- Individuals found eligible for services funded by the Division of Behavioral Health are required to immediately report any significant changes in income, household composition, and/or other circumstance that affect their eligibility status.
- Eligible clients/families are required to complete an annual review of eligibility. The Behavioral Health Provider will inform clients of the date of the review.

Ineligible Clients

- All individuals initially found ineligible for services funded by the Division of Behavioral Health will have the option of completing the Hardship Consideration process. This form must be completed and turned in (with necessary verifications) to the Division of Behavioral Heath within 60 days of the initial ineligibility determination. Failure to do so will result in the client/parent or guardian waiving his/her right to apply for the Hardship Consideration.
- Clients or parents/guardians who do not wish to proceed with the Hardship Consideration process must sign a Refusal of Hardship Consideration Process form, which will be provided by the Behavioral Health Provider. This refusal waives the right for all appeals.
- A client or parent/guardian who is interested in the Hardship Consideration process should contact the Behavioral Health Provider for a Hardship Consideration form and assistance in completing the process. Once completed this form should be returned to the Behavioral Health Provider. The Behavioral Health Provider will submit all appropriate documentation and forms to the Division of Behavioral Health.
- Within 30 days of receiving the Hardship Consideration forms, the Division of Behavioral Health shall provide a determination regarding eligibility.
- A client or parent/guardian who is dissatisfied with the Division of Behavioral Health's decision regarding eligibility may request an Administrative Review (see process outlined below).

Administrative Review/Fair Hearing Process

- All individuals found ineligible for services funded by the Division of Behavioral Health, after the Hardship Consideration process, will be informed of their right to an Administrative Review and, if still dissatisfied, a Fair Hearing, including the manner to initiate the review.
- A client or parent/guardian may appeal the decision regarding ineligibility by submitting the request in writing to the Division of Behavioral Health within 30 days of receipt of the notice regarding ineligibility.
- Clients may have mental health visits paid for by the Division of Behavioral Health within the first 30 days in which their eligibility is being determined. However, if eligibility has not been determined after the first 30 days, then the client or parent/guardian is responsible for payment of services.
- The Division of Behavioral Health shall provide a determination within 30 days of receipt of the request for review.
- A client or parent/guardian who is dissatisfied with the Division's determination regarding eligibility may request a Fair Hearing by notifying the Department of Social Services in writing within 30 days of receipt of the Division's decision.
- An impartial hearing officer will be sought to handle all arrangements and correspondence with the client and the Department of Social Services, including the date and location for the hearing. The hearing officer will send notice of the hearing to both parties.
- The client may be represented at his/her own expense by counsel or other appropriate advocate(s) and will be afforded the opportunity to examine all witnesses and other sources of information or evidence.
- The client or his/her representative may present additional evidence, information, and witnesses to the impartial hearing officer.
- Within 45 days of the hearing, the impartial hearing officer will provide a full written report of findings to the client (or designee if appropriate) and the Department of Social Services.
- The hearing officer's decision will be final.

For more information about this process you may contact: Department of Social Services, Division of Behavioral Health, Kneip Building, c/o 700 Governors Drive, Pierre, SD 57501, 1-855-878-6057.

Non-Discrimination Statement

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605-773-3305.

Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).

TELEHEALTH SERVICE AGREEMENT

I (name) ____ agree during the Covid-19 Crisis to receive this health care service as a Telehealth service. I understand that the health care practitioner is located in another location.

Telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for **6 months** for follow-up Telehealth services with the health care provider. I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- If I decline the Telehealth services, during this time of the Covid-19 social distancing, I understand that Brookings Behavioral Health & Wellness **does not** have other options/alternatives available for me, including in-person services at this time.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I understand I am responsible for the security of my personal equipment that I use during my appointment.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service cannot be released to anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from any site during my Telehealth service.
- I also understand that my insurance will be billed for this visit and that I may be billed for what my insurance and/or South Dakota State Funding (if applicable) does not cover as well as copays. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payer.
- I give permission for Brookings Behavioral Health & Wellness to provide limited information to the coordinator at this site for billing purposes. I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months during the Covid-19 crisis and may need to be renewed as deemed necessary.

☐ I accept Telehealth services ☐ I refuse Telehealth services

____ ______________

Signature of Patient Date

________________________________ __________________ ______________

Signature of Parent or Legal Representative Relationship Date

Consumer Rights

- The right to participate in decision making, related to treatment, to the greatest extent possible.
- The right to services regardless of age, gender, social support, disability determination, attributed diagnosis, race/cultural orientation, psychological characteristics, sexual orientation, physical situation and/or spiritual beliefs.
- The right to refuse any treatment suggested by any Brookings Behavioral Health & Wellness staff member.
- The right to be free of any exploitation (i.e. wrongful taking or exercising of control over your property with intent to defraud) by any Brookings Behavioral Health & Wellness staff member.
- The right to confidentiality of all records, correspondence, and information relating to assessment, diagnosis and treatment. Information you share with staff members is confidential. It will not be revealed outside Brookings Behavioral Health & Wellness without your written consent. The rare exceptions to this policy are vital emergencies and/or legal situations, including:
    - Court order for disclosure
    - All Brookings Behavioral Health & Wellness staff members are mandatory child abuse/dependent adult abuse reporters
    - You request to see a copy of your records in writing
- The right to amend your records. If your request is denied you can write a statement of disagreement which will be kept with your information.
- At all times, the right to seek and have access to legal counsel.

Grievance Process

Brookings Behavioral Health & Wellness is committed to provision of professional and ethical behavioral health services; addressing the specific and individualized needs of consumers of those services. Consumer satisfaction with these behavioral health services is of paramount interest to our organization and governing entities. If a Brookings Behavioral Health & Wellness service consumer has concerns about services provided, that consumer is encouraged to make those concerns known through the steps of the following grievance process:

- Service consumers should discuss concerns directly with their assigned service provider.
- If the concern is not satisfactorily addressed by the assigned service provider, the consumer should bring the concern to the attention of the Brookings Behavioral Health & Wellness Executive Director in the form of a letter, telephone contact or face-to-face appointment.
  211 4th St. Brookings, SD 57006 (605) 697-2850
- If the concern is not satisfactorily addressed in either step 1 or 2 (above), it may be brought before the Brookings Behavioral Health & Wellness Board of Directors as a written grievance to be placed on the agenda for the next Board of Directors meeting. Board of Directors meetings are open to the public and announced in the *Brookings Register*. Further, request to be placed on the agenda may be made by calling (605) 697-2850.
- If a satisfactory resolution is not reached after taking these actions (steps 1, 2, 3; above), the consumer may contact the South Dakota Division of Behavioral Health.
  Department of Social Services, Division of Behavioral Health, 700 Governors Drive, Kneip Building, Pierre, SD 57501 1-855-878-6057
  [Note: Any grievance brought to the South Dakota Division of Mental Health constitutes a legal situation under which Brookings Behavioral Health & Wellness will no longer be able to ensure the consumer's right to confidentiality.]

Signature________________________________Date___________ Staff_____________________

SDAR 67:62:07:04

Notice of Privacy Practices

Accomplishing change during service provision is a mutual task both Brookings Behavioral Health & Wellness staff and you will work together to achieve an agreeable result. This agreement is to assure that you understand the policies in effect at Brookings Behavioral Health & Wellness.

- During the course of service many issues may be important. Often subjects that may seem irrelevant will be discussed. Some issues that could possibly be dealt with include: personal adjustment, parenting skills, extended family, relationship difficulties, previous services, interests, marital adjustment, personal/family history, child rearing practices, hygiene, sexual adjustment, employment, living arrangements, employment history, health, nutrition, hospitalizations, drug/alcohol usage, available resources, finances, legal involvement, etc. Care should be exercised so that you disclose only what and as much as you wish Brookings Behavioral Health & Wellness staff members to know.

- A team approach is used by Brookings Behavioral Health & Wellness. Information necessary to facilitate effective assessment and/or service provision may be shared between staff members. Videotaping, audio taping and/or one-way mirror observation may be used to allow the Brookings Behavioral Health & Wellness team the best possible access in offering assistance, supervision or education. If used, these methods would be applied only to assure that you receive the highest quality services.

- Information you share with Brookings Behavioral Health & Wellness staff is confidential. It will not be revealed outside the agency without your written consent. The rare exceptions to this policy are vital emergencies and/or legal situations, including:
    - Court order for disclosure;
    - All staff members are mandatory child abuse/dependent adult abuse reporters
    - Necessary Disclosures for coordination of treatment with other health care providers and those involved in assuring your safety.

- All customers have a legal right to appeal actions by Brookings Behavioral Health & Wellness staff. If you have a concern, please let your assigned staff or the Executive Director know about it. All adults who will be involved in service must sign this agreement. Signature by parents/legal guardians constitutes consent for services to minors.

- Any Special conditions, requirements or exceptions agreed to:

I/We certify that I/we understand the notice of privacy practice and specifications described above and offer my/our informed consent to assessment and professional treatment at Brookings Behavioral Health & Wellness.

Signature______________________________Date____________ Staff______________________

SDAR 67:62:07:04

No Show / Late Cancel Policy

I, ______________________________understand that no show and late cancelled appointments jeopardize the ability of Brookings Behavioral Health & Wellness to provide appropriate care to address my needs and the needs of other patients and I agree to the following:

- I agree to attend all scheduled appointments and group sessions.
- If I arrive 10 or more minutes late, I may be asked to reschedule, and the appointment will be considered a Late Cancel.

If I am unable to attend a scheduled appointment or group session, **I agree to call and cancel the appointment before 1pm the day prior to my appointment.** In cases of extraordinary circumstances that arise **after 1pm the day prior to my appointment** which prevent me from keeping my appointment (e.g. physical illness), I agree that I will still call and inform the clinic that I will be missing my appointment.

I understand that failure to cancel my appointment before 1pm the day prior to my appointment will result in being assessed a no show/late fee. This fee is due when billed, or at my next appointment, whichever comes first.

There is a $15 fee for all No Show/Late Cancel for group sessions.

The No Show/Late Cancel fee schedule for individual appointments is as follows:

- First incidence within six months - $15
- Second incidence within six months - $30
- Third incidence within six months - $45

Any further no show or late cancelled appointment within a six-month period will result in being assessed a $45 no show/late cancel fee. This fee will be assessed for all further fails until I have complied with the policy for at least six months without fails. At the time the original no show/late fee schedule will be followed. In certain cases, Brookings Behavioral Health & Wellness reserves the right to double book an appointment at the time of your appointment based on patterns of non-compliance with this policy.

I recognize that Brookings Behavioral Health & Wellness will be under no obligation to pay for any charges incurred by our facility. It will be my sole responsibility to cover these expenses.

______________________________ ______________________

Signature Date

BROOKINGS
behavioral health & wellness

TB Screening

Date:________________________

Name of Client: ____

Date of last TB Test: _____________________________________

Results: Negative_____________ Positive_____________

If you have not completed a TB test in the past 12 months, please complete the following:

Have you experienced any of the following symptoms within the last three months?

1. Productive cough for 2-3 weeks in duration	Yes	No
2. Unexplained night sweats	Yes	No
3. Unexplained fevers	Yes	No
4. Unexplained weight loss	Yes	No

If you have answered 'Yes' to any of the above, please explain:

____

____

____

____

Client Signature: ____

Staff Signature:____