BROOKINGS
behavioral health & wellness

Mission Statement

To provide comprehensive, integrated behavioral health services that promote personal well-being and quality of life for all.

Principles guiding Brookings Behavioral Health & Wellness in achieving its mission are:

1. We will focus on the needs of our clients first and foremost.

2. We will perform our duties with professional integrity and honesty, striving for excellence.

3. We will provide services to clients in the most efficient and effective manner possible to maximize the resources available to us.

4. We will create an environment that values all of our partners and staff to encourage teamwork, growth, and improvement through development and empowerment.

5. We will operate as a unified agency and not allow internal differences and allocation of resources to divert staff energy and focus from our singular mission.

Brookings Behavioral Health & Wellness

Registration Form

Office Use Only

- ☐ Mental Health
- ☐ Chemical Dependency
- ☐ SED
- ☐ DUI _____
- ☐ Other

Referred By:

- ☐ Self
- ☐ PCP
- ☐ Family
- ☐ Hospital
- ☐ Court Services
- ☐ Friend

Date **Clinician**

PATIENT DEMOGRAPHICS

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

Preferred Name **Maiden Name** **Other Known Names**

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

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

Home Phone Number **Cell Phone Number** **Email Address**

Do you want Appt Reminder Text ☐

Sex

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Prefer Not To Answer

Military Status

- ☐ Active Duty
- ☐ Reserves
- ☐ Veteran
- ☐ Non-Military

Do You Use:

- ☐ Cigarettes
- ☐ Chewing Tobacco
- ☐ Vapes
- ☐ None/Other: _____

Current Marital Status

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown

Race

- ☐ Black
- ☐ White
- ☐ Asian
- ☐ Native American / Alaskan Native
- ☐ Hawaiian / Other Island Native
- ☐ Other _____

Ethnicity

- ☐ Puerto Rican
- ☐ Hispanic Origin
- ☐ Mexican
- ☐ Cuban
- ☐ Not of Hispanic Origin
- ☐ Other _____

Current Living Situation (adult only)

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

Current Living Situation (adolescent only)

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

Current Prescription Medications

EDUCATION INFORMATION

Highest Grade Completed _____ **Current Student?** Yes No **If yes, what school?** _____

EMPLOYMENT

EMPLOYMENT INFORMATION

Are you employed? Yes No

If "yes", Occupation? _____

Current Employer _____

Employment Type

- ☐ Full Time
- ☐ Part Time
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Disabled
- ☐ Other

Employment Length

- ☐ Less Than 6 Months
- ☐ 6 Months < 1 Year
- ☐ 2 Years
- ☐ 3 - 5 Year
- ☐ 6 - 7 Year
- ☐ 9 - 15 Years
- ☐ 16+ Years

Income Source

- ☐ Wages/Salaries
- ☐ Alimony
- ☐ Other: _____
- ☐ Child Support
- ☐ Disability
- ☐ Retirement
- ☐ Veterans Benefits

FINANCIAL RESPONSIBILITY

Financial Responsibility: First Name | **Financial Responsibility: Last Name** | **Relationship to Patient**

Date of Birth | **Social Security Number** | **Phone Number**

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

Insurance Information

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**

Parent / Guardian Signature **Date**

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

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INFORMED CONSENT & PAYMENT FOR SERVICES AGREEMENT

Brookings Behavioral Health & Wellness is committed to providing cost effective, quality care in behalf of its clients. To that end it is important that you read and fully understand the information contained herein. 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.

Fee Policies: Brookings Behavioral Health & Wellness is a private, not for profit, agency which as a result of public funding support is in a position to work with clients on an individual basis to do whatever is possible to prevent the cost of services from interfering with the access to needed care. To this end, the following guidelines apply:

1. Unless prior arrangements have been made with the business office, payment for services is due at the time that services are rendered. Cash, credit cards, or checks are accepted.
2. 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.
3. If clients are unable to pay for the cost of services at the time that services are rendered, it will be necessary for them to meet with business office staff to arrange for acceptable payment arrangements.
4. South Dakota State funding is available for South Dakota residents. This is calculated based off of household income guidelines.
5. Unpaid bills for clients not CARE eligible 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.

No Guarantee of Improvement Functioning: 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.

FINANCIAL INFORMATION ***(Line 9 from Financial Eligibility)*****:** _____

___Insurance ___Medicare ___Medicaid ___State Contract

___Court Services ___Self Pay ___Other: _____

Patient Copay (if applicable): _____

Cost for Services: Counseling Session (per hr.): 1st session $225.00 / 2nd+ session $170.00
Medication Management (per hr.): $300.00 per hour

Class Expense (if applicable): _____

Copays are expected at the time of service. Payment arrangements are available if needed. For more information, please select the following and someone from our office will contact you.

_____ Reduced Fees

_____ Payment Arrangements

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RELEASE OF INFORMATION FOR INSURANCE BENEFITS

I hereby authorize Brookings Behavioral Health & Wellness to release any information required by my insurance carrier/SD State Funding,_____for the purpose of adjudicating claims submitted in 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/Subscriber Signature:_____**Date**_____

Parent/Guardian Signature:_____**Date:** _____
(if applicable)

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 fee schedule 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**_____

Parent/Guardian Signature:_____**Date:** _____
(if applicable)

Staff Signature:_____**Date**_____

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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 **1 year** 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 one year 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

211 4th Street Brookings, SD 57006 Ph: 605-697-2850 Fax: 605-697-2874

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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.]

Patient Signature:_____ Date_____

Parent/Guardian Signature:_____ Date: _____
(if applicable)

Staff Signature:_____ Date: _____

SDAR 67:62:07:04

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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.

Patient Signature:_____ Date_____

Parent/Guardian Signature:_____ Date: _____
(if applicable)

Staff Signature:_____ Date: _____

SDAR 67:62:07:04

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TB Screening

Date:_____

Name of Patient: _____

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:

_____
_____
_____
_____

Patient Signature: _____

Parent/Guardian Signature:_____
(If Applicable)

Staff Signature: _____