Pawnee Mental Health

Patient Information Form

Client Information

Name: _____ Nickname: _____ Email: _____

Birth Date: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Race: _____

Ethnicity: Hispanic or Latino Yes No

Has the client ever served in the military? Yes No

Please Check here ___ if you do not want text messaging appointment reminders.

Please Check here ___ if you do not want phone call reminders.

Client Gender Assigned at Birth:	Client Pronouns:
Male Female Intersex	He/Him/His She/Her/Hers They/Them/Their Other

Sexual Orientation: _____ Gender Identity: _____

What type of service(s) are you seeking?_____

In a few words, tell us why you are seeking treatment: _____

_____

_____

_____

Emergency Contact Information:

_____ _____ _____

Name Phone Relationship

Court Ordered: Yes No

Name/Location of Court:_____

Name of Attorney/PO/CSO:_____

Court Date:_____

Type of Court Order:_____

Primary Care Physician, Address & Phone: _____

Pawnee Mental Health

Financial Agreement

☐ Yes, I have Insurance.

The amount dictated by insurance will be applied to the client's account upon receipt of the Explanation of Benefits from the insurance company. Payment of copay/deductible/coinsurance amounts are due at time of service.

Primary Insurance:	_____	Secondary Insurance:	_____
Policy Number:	_____	Policy Number:	_____
Group Number:	_____	Group Number:	_____
Subscriber Name:	_____	Subscriber Name:	_____
Subscriber SS#:	_____	Subscriber SS#:	_____
Subscriber Date of Birth:	_____	Subscriber Date of Birth:	_____

Authorization and Release:

I give permission to Pawnee Mental Health to bill my insurance. I allow Pawnee Mental Health to obtain and release any information, including diagnosis to my insurance company to allow for the processing of insurance claims. I further acknowledge that I am financially responsible for all charges not covered by my insurance.

☐ No, I Do Not Have Insurance.

Pawnee Mental Health provides a sliding fee scale based on gross annual income and number of dependents for clients without insurance. **An admissions representative will reach out to you with more information to get you on the sliding fee scale.**

We accept the following documents as verification of income:

- Income Tax Return
- Paycheck Stub(s)
- Retirement/Pension (SSI/SSDI)
- Social Security Benefits
- Unemployment Stubs
- Child Support / Alimony
- Student Loans / Grants
- Letter from the Department of Children and Families
- Letter of Support
- Other

_____ _____

Printed Name of Client or Legal Representative Financially Responsible *Date*

_____ _____

Signature of Client or Legal Representative Financially Responsible *Date*

_____ _____

Signature of Witness *Date*

For questions about your account please contact the Pawnee Mental Health billing department at (785) 587-4344 or (866) 337-3353.

FORM # FN202301F
06/12/2023

Pawnee
Mental Health

CLIENT RIGHTS CHECKLIST

Client/Legal Guardian, please **initial** on each applicable line. If not applicable, please put NA.

_____ I **hereby acknowledge a written receipt of the following information, or I can have the information verbally explained to me:**

- List of my rights as a client of Pawnee
- List of my responsibilities as a client
- Description of Pawnee services.
- Information about HIV/TB (alcohol/drug services only)
- How to obtain services during regular hours of operation
- How to obtain services after-hours or in an emergency
- Information about confidentiality practices and exceptions.
- Copy of Notice of Privacy Practices
- Information about billing and payment
- Information regarding fees and co-payments
- Information about treatment of minors
- Process for submitting a complaint or suggestion
- Information about satisfaction surveys

Consent for Treatment of a Minor:

_____ As legal guardian of _____ I authorize and give legal consent to treatment at Pawnee Mental Health Services.

Informed Consent:

_____ I am initiating treatment with a Community Mental Health Provider that holds one or more degrees and/or licensures from MD/DO, APRN, PHD, LSCSW, LMLP, LMSW, LCP/LAC, LCMFT, LMFT, LPC, LMAC, LCAC, BS.

Pawnee Mental Health Services employees student interns who are completing a requirement for a Clinical Degree. Clinical work provided by Student Interns is supervised by Therapy and Recovery Supervisors.

Primary Care Provider Collaboration: Initial Only One

_____ At this time, I would like my primary care provider contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care. ***Separate Authorization Required***.

_____ At this time, I would not like my primary care provider contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care.

Payment Authorization:

____ I hereby authorize Pawnee Mental Health Services to disclose diagnosis, dates of service, and type of service as well as any other additional information required by my insurance carrier to process insurance claims for payment. I further authorize the payment of insurance benefits directly to Pawnee Mental Health Services for services provided.

_____	_____	_____	_____
Client Signature/Legal Guardian	Date	Witness Signature	Date

Client Name: _____ (printed)

Pawnee Mental Health

Pawnee Mental Health Services

Informed Consent Checklist for Telehealth Services

Prior to starting telehealth services, I acknowledge the following:

• There are potential benefits and risks of telehealth services (e.g. limits to patient confidentiality) that differ from in-person sessions.

• Confidentiality still applies for telehealth services, and neither Pawnee nor I will record the session without the permission from the others person(s).

• We will use telehealth to conduct our appointment until further notice.

• It is important to be in a quiet, private space that is free of distractions (including cellphone or other devices) during the appointment.

• I will wear appropriate attire during the telehealth appointment.

• It is important to be on time. If I need to cancel or change my telehealth appointment, I will notify Pawnee as soon as possible.

• In the event of technical problems (i.e., dropped call) Pawnee will attempt to call me back once to continue the appointment. If we cannot reconnect, I will be expected to call back at a later time and reschedule the appointment.

• In the event of a crisis, Pawnee will provide me with the information for Pawnee's crisis department.

• If I am a minor, Pawnee needs the permission of my parent or legal guardian (and their contact information) for me to participate in telehealth sessions.

• My provider may determine that due to certain circumstances telehealth treatment is no longer appropriate and that we will discuss alternative options for me.

My signature below indicates that I agree to this informed consent and agree to telehealth services.

_____ _____

Client/Legal Representative Printed/Typed: Client Date of Birth

_____ _____

Client Signature/Legal Representative Date

_____ _____

Client Phone Number Client Email Address