Chrysalis Institute New Client Intake Form

CLIENT INFORMATION:

Legal Name: _____ Address: _____ City: _____

County: _____ State: _____ Zip: _____ Email: _____

Phone: (___) _____-_____ Cellular: (___) ____-_____ Male Female Other: _____
Race: _____ Age:_____ DOB _____/_____/_____ SSN _____-___-_____

Marital Status: Single Married Divorced Widowed Responsible Party: _____
Relationship to Client: _____

EMERGENCY CONTACT:
Name: _____ Phone: (___)____-_____ Address: _____

City/State/Zip: _____ Relationship: _____

Medicaid #: _____ Medicare #: _____ Medigap #: _____

Other Insurance/Payment Source: _____ Address: _____
City/State/Zip: _____ Prior Authorization Required: _____

Special Billing Instructions: _____ Phone (___) ____-_____ ID#: _____

Primary Physician: _____ Phone (___) ____-_____ Last Seen: _____

Psychiatrist: _____ Phone (___) ____-_____ Last Seen: _____

PRESENTING PROBLEM:

__ Anxiety	__ Depression	__ Substance Abuse	__ Psychosis
__Family Problems	__Aggressive Behavior	__ Assaultive	__Verbally Threatening
__ Homicidal Threats	__ Suicide Threats	__ Suicide Attempts	__ PTSD

Comments:
_____

_____

_____

_____

Chrysalis Institute Authorization and Consent Form

Client Name _____

Initial

_____ **Consent for Treatment**

I have been informed of and understand the nature of the services provided by Chrysalis Institute. I consent to the mental health evaluations and treatments prescribed by the Chrysalis Institute treatment team.

_____ **Consumer Orientation**

I have read the consumer orientation rights and responsibilities downloadable at http://chrysalisinstitute.com/wp1/handbook. I understand the services offered, treatment planning, emergency service availability and grievance procedures.

_____ **Confidentiality Practices**

I understand that my records of treatment will be kept confidential and released only with a signed consent form except when required by law. Providers of services have a duty to protect, warn and/or report suicidal or homicidal threats, abuse of children, or intent to commit a felony act.

_____**Notice of Privacy Practices**

I have been provided a link http://ciokc.com/handbook to the Notice of Privacy Practices contained in the Chrysalis Institute Person Served Handbook and I understand "my protected health information."

It Is Okay Not Okay to contact me for appointment reminders.
It Is Okay Not Okay to identify as Chrysalis Institute by telephone contact
It Is Okay Not Okay to mail post-discharge client satisfaction survey.

_____ **Billing Consent**

I have read and agree to the financial arrangements on the Payment Agreement for services at Chrysalis Institute. I authorize the release of protected health information necessary for payment. I authorize my payment source to reimburse directly to Chrysalis Institute the benefits due for services rendered.

_____**Consent for Medical Care**

In the event that a medical emergency occurs while I and/or my family members are with any Chrysalis Institute representatives and I/we are unable to consent to medical treatment, I hereby authorize any Chrysalis Institute representative to seek appropriate medical treatment for me and/or my family members. I also give permission for attending medical personnel to execute on my behalf permission forms or other medical documents and to act on my behalf if I am unable to do so.

_____ _____
Signature of Consumer Date

_____ _____
Signature of Personal Representative Date

_____ _____
Signature of Mental Health Provider Date

Payment Agreement

Client Name: _____ DOB: _____/____/_____ SSN ____-___-_____
I understand that I am financially responsible for all charges.

____ Financial Responsibility for Medicaid Services
Chrysalis Institute charges a fee for services provided. As per law, Chrysalis Institute accepts assignment of benefits on all claims of Medicaid. Ad Medicaid rates pay 100% of the cost of services. I will not be billed for services.

____ Financial Responsibility for Insurance Services
Chrysalis Institute charges a fee for services provided. I accept financial responsibility for the charges incurred. I am responsible for the payment of my insurance deductible, co-pay, and any charges not covered under my insurance plan. I agree to pay any portion remaining after my insurance pays.

____ Financial Responsibility for Self-Pay Services
Chrysalis Institute charges a fee for services provided. I am not filing Medicaid, Medicare or private insurance claims for the services received at Chrysalis Institute. I will be personally responsible for the cost of services I receive. All payments are due at the time of service. I acknowledge that if I am late or miss my scheduled appointment, I will be charged for the entire session.

Other Payor Source: _____

Services Charge Sliding Fee Scale

X_____
Signature of Patient (if 14 years or older)

_____ _____
Client/guardian Signature Date

_____ _____
Witness Signature Date

CHRYSALIS INSTITUTE, LLC
802 N.E. 19th Street
Moore, Oklahoma 73160

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ___LPC ____LBP _____LMFT

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation/techniques, experience, fees credentials.
I am licensed to practice my profession by the Oklahoma State Department of Health.
My license number LPC_____ LBP_____ LMFT_____
On the licensing website you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the Professional Counselor Licensing Division at:

Oklahoma State Department of Health Protective Health Services
Professional Counselor Licensing-0504
100 NE 10th Street
Oklahoma City, Oklahoma 73117-1299
Telephone: (405) 271-6030
Fax: (405) 271-1918

Licensee's Printed Name: _____

Licensee's Signature: _____

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice.

Client Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Chrysalis Institute, LLC.
802 NE 19th Street
Moore Oklahoma 73160
Ph. (405) 912-5145

Authorize to Release Medicaid Records

Client Name: _____ Date: _____

Client #: _____ DOB: _____

1. I authorize the Chrysalis Institute, LLC. to release the above individual's Medicaid information as described below:

ANY AND ALL INFORMATION PERTINENT TO TREATMENT SUCH AS CDC, MENTAL HEALTH ASSESSMENT, TREATMENT PLANNING, TREATMENT PLAN UPDATES, PROGRESS NOTES AND BILLING

2. I understand the information in my Medicaid record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be released to the following: _____

For the purpose of: TREATMENT AND BILLING

3. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to Chrysalis Institute, LLC. I understand that information may have already been released based on this authorization.

Unless changed, this authorization will expire on the following date: _____

If I don't put a date, this authorization will expire in six months.

4. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.

Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

X_____
Signature of Patient
X_____
Signature of Patient or Legal Representative. (*Legal representative must show relationship to patient):*

X_____
Signature of Witness:

Chrysalis Institute, LLC.
802 NE 19th Street
Moore Oklahoma 73160
Ph. (405) 912-5145

Authorize to Release Medicaid Records

Client Name: _____ Date: _____

Client #: _____ DOB: _____

5. I authorize the CHRYSALIS INSTITUTE LLC to release the above individual's Medicaid information as described below:

ANY AND ALL INFORMATION PERTINENT TO TREATMENT SUCH AS CDC, MENTAL HEALTH ASSESSMENT, TREATMENT PLANNING, TREATMENT PLAN UPDATES, PROGRESS NOTES AND BILLING

6. I understand the information in my Medicaid record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be released to the following: _____

For the purpose of: TREATMENT AND BILLING

7. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to Chrysalis Institute, LLC. I understand that information may have already been released based on this authorization.

Unless changed, this authorization will expire on the following date: _____

If I don't put a date, this authorization will expire in six months.

8. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.

Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

X_____
Signature of Patient (if 14 years or older)
X_____
Signature of Patient or Legal Representative. (*Legal representative must show relationship to patient):*

X_____
Signature of Witness:

NO CALL, NO SHOW POLICY

At Chrysalis Institute we strive to provide professional behavioral health services to all in need. To ensure equal access to said services we have to minimize missed appointments and maximize the number of people our care providers see daily. We maintain a waiting list of potential clients who are in need of services. This, because counseling is currently a shortage field both locally and nationally. This means there are not enough licensed counselors to go around. As such, **beginning on October 1, 2019** Chrysalis Institute will institute a **NO CALL, NO SHOW POLICY** that states anyone missing a scheduled appointment who does not call or text us to let us know what is going on will not be carried forward on that care provider's schedule. What this means is, a No Call, No Show on your appointment will automatically result in the cancellation of all subsequent appointments you may have on the schedule in the days and weeks ahead. At that point your file will be placed in waiting list status and you will have to wait for your name to make its way back to the top of that list in order to be seen again.

I understand that not showing up or contacting Chrysalis Institute or its representative(s) about having to miss my appointment means that I will be dropped from that care provider's schedule entirely and my file will be placed in waiting list status until such time as resources are available to accommodate myself and the other people ahead of me on the waiting list.

A simple call or text ahead of time will secure your ongoing status active treatment status.

I understand and agree to these terms of service.

_____ _____

Signature of Consumer Date

_____ _____

Signature of Personal Representative Date

_____ _____

Signature of Mental Health Provider Date

Last updated 10/24/2019

Chrysalis Institute LLC

Telehealth Services Consent Form

I understand that my mental health provider wishes me to engage in a telehealth consultation. My mental health provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct mental health provider visit due to the fact that I will not be in the same room as my mental health provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my mental health provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my mental health provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my behavioral health history that are personally, sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

In an emergent consultation, I understand that the responsibility of the telehealth consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

I understand that billing will occur from both my mental health provider and as a facility fee from the site from which I am presented.

I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered.

_____ _____ Date _____

Patient Printed Name Patient Signature

_____ _____ Date _____

Parent/Guardian Printed Name Parent/Guardian Signature

_____ _____ Date _____

Witness Printed Name Witness Signature