DEMOGRAPHIC INFORMATION

Client Name (First, MI, Last)	Client No.	Today's Date

Address	City	State	Zip
Primary			
Local ☐ Same as Primary			
Billing ☐ Same as Primary			

County of Legal Residence ☐ Out of State ☐ Unknown

Home Phone	Work Phone	Other Phone
( )	( )	( )

Where may we contact you?
☐ Primary Address ☐ Local Address ☐ Billing Address
☐ Home Phone ☐ Work Phone ☐ Other Phone

Where may we leave a message?
☐ Home ☐ Work
☐ Other:

Client Age	DOB (MM/DD/YYYY)	Gender	Soc. Sec. No.
		☐ Male ☐ Female	

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Other:

Race
☐ W – White ☐ N – Native Am. ☐ P – Native Hawaiian/Other Pacific Islander ☐ Multiple Race
☐ B – Black/African Am. ☐ A – Asian ☐ M – Alaskan Native ☐ Unknown

Ethnicity
☐ A – Puerto Rican ☐ B – Mexican ☐ C – Cuban ☐ D – Other Hispanic ☐ E – Not Hispanic or Latino

Parent/Guardian/Custodian if Minor (include name and address)	Parent/Guardian/Custodian Phone
	( )

Emergency Contact (name and address)	Relationship	Emergency Contact Phone
		( )

Primary Language	Client needs the assistance of an interpreter?
	☐ No ☐ Yes If yes ☐ American Sign Language ☐ Language Interpreter (specify):

Client needs assistance with visualization of material or alternate format?
☐ No ☐ Yes

Advance Directive?
☐ Yes If yes, request a copy of the directive.
☐ No If no, ask if client needs assistance in obtaining an advance directive.

Payers

Medicaid ☐	Medicaid No.	Medicare ☐	Medicare No.

EAP Involved/Eligible ☐	Company Name	No. of Visits
Primary Private Insurance	Insurance Plan No.	Group No.
Secondary Private Insurance	Insurance Plan No.	Group No.

☐ Workers Comp ☐ Veteran ☐ Self	Other (specify) ☐	Other (specify) ☐

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? ☐ Yes ☐ No **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): ____________
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Notice of Enrollment/Change in Billing Procedures
Multi-Agency Community Services Information Systems (MACSIS)

Client Name: ____

This is to let you know that the billing procedure for the mental health services paid by for by the Mental Health and Recovery Services Board of Mahoning County (MHB) will be changing over the next few months. THESE CHANGES WILL NOT EFFECT YOUR ELIGIBILITY FOR SERVICES

Currently "Travco" collect information at intake and submits bills for services provided to the Mahoning County Alcohol & Drug Board for Payment. "Travco" will continue to collect the same information, enroll you in a Mahoning County Behavioral Healthcare Plan, and submit billing information for services with your name and social security number to the Board. The Mahoning County Alcohol & Drug Board will:

- Determine what public funds can be used to pay for services, and...
- Pay bills through the Multi-Agency Community Services Information Systems (MACSIS) connected with the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Human Services.

All information will be kept confidential. Billing information will be stored with your name and all other information will stored by a unique number. Information will not be shared with other sources or used for other purposes.

After January 1, 1999 if you receive services from an agency in the MHB network, you will be asked to enroll in the MHB Plan. In order to do this, you will be required to sign a Disclosure (Billing Authorization) ("Consent for Treatment" may be substituted for Billing Authorization) Statement, which includes:

- Disclosure statement for enrollment in MACSIS
- Disclosure for billing statement, which allows the MHB to use public funds to subsidize the cost of services.

If you have any questions or concerns about this process, or need additional information or to review and comment upon your MACSIS record, please contact "Travco" at 330.286.0050.

I have presented and discussed the information to the above named individual.

______________________________ ______________
Client Date

______________________________ ______________
Original Signature/Credentials of
Qualified Staff 2-1-06(K) (8) Date

TRAVCO BEHAVIORAL HEALTH

Policy: Acknowledgement Of HIPAA | Effective Date: July 1, 2009

Approved By: Governing Board of Directors | Review Date: July 1, 2015

Acknowledgement:

I hereby acknowledge that I received a copy of the Travco Rehabilitation Center Privacy (HIPAA) notice, Client Rules and Expectations, Client's Rights and Grievances, and the Client Handbook.

____

Signature of Client | Date

____

Signature of Parent or Guardian | Date

____

Witness | Date

INSURANCE AGREEMENT:

I am aware that I am responsible for paying in full any services not covered and any co-payments set for by my insurance company or any other third party payer. I give the Provider Agency authorization to file a claim for my services with my insurance company or any other third party payer. I authorize the release of any medical information needed for the purpose of processing my claim as long as there is a balance due from ________________________(Client's name). I hereby authorize my insurance company or any other third party to pay the Provider Agency directly for any eligible services billed.

If for any reason I should receive the insurance check, I understand and agree to forward either the insurance check (endorsed on the back) OR money order OR cash for the exact amount of the insurance payment to the Provider Agency within (7) days from receipt.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Parent/Guardian Signature Date

______________________________ ______________________________

Witness Signature Date

POLICY FOR CANCELLATION OF APPOINTMENTS

It is very important to establish a policy regarding a cancellation for missing therapy appointments. A charge is levied because a late cancellation or no show potentially represents any income loss that might be a significant percentage of the practitioner's daily income. The established policy requires that you call our office at least **24 hours** in advance. A charge of ($25.00) may be assessed on the first no show with your therapist. After the second no show with your therapist the full fee may be assessed. You should be made aware that insurance companies generally do not pay for treatment that has not actually been rendered. As in all medical practices a short delay might still occur in the starting time of your appointment due to reasons beyond control (e.g. crisis interventions, phone calls from emergency rooms, etc.)

I have read and agree to the contents of the above policy.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Guardian Date

Informed Consent for Treatment

Each treatment service that I receive has risks and benefits associated with it. The risks and benefits are outlined below and have been explained to me. My signature indicates that I wish to receive treatment and that I have had these benefits and risks explained to me as well as any others that may apply.

- **Diagnostic Assessment:** Diagnostic Assessment is an evaluation done to identify problems presented. It indicates information received from the client in a variety of areas including stressors, health problems, medications, specific behaviors, hospitalizations, prior mental health treatment, etc.
- **Medication/Somatic:** The medication I am prescribed will help control or eliminate my symptoms. It may also have some side effects including but not limited to drowsiness, photosensitivity, tremors, diarrhea, muscle spasms, dry mouth, constipation, or blurred vision. My psychiatrist will explain to me the possible side effects and I should notify my psychiatrist if any occur. I understand that there in no absolute guarantee that this medication will help me. However, my psychiatrist has recommended it as it is his professional opinion that it will alleviate my symptoms. I can not be forced to take medication. If I choose to discontinue against my doctor's advice, I do so taking the risk that my symptoms will recur and I may experience withdrawal symptoms. I understand that I have the right to refuse any and all treatments. However, my service provider may also decline to provide me treatment if I refuse or cannot comply with the necessary requirements of that treatment.
- **Counseling/Psychotherapy:** I understand that therapy is a collaborative effort and that success or failure is a function of the efforts of both the therapist and me. Specific benefits of an effective therapy for me are outlined in my Individual Service Plan. General benefits of therapy may include relief of symptoms, increased insight and confidence, and improvement in my daily functioning. I understand that verbal therapies may produce a temporary increase in stress due to focus on problems, and professional literature suggests that approximately 10% of therapy clients become more dysfunctional as a result of the stress treatment.
- **Supervision Notification:** The counseling staff of Travco Behavioral Health Associates, Inc. is trained and qualified to be of assistance to you. In addition to his or her skills, your counselor may function under a supervisor and he or she may review your case with that supervisor. It also means that you have the right to meet with your counselor's supervisor at any time upon your request.
- **Client Rights**: I understand that I have the rights to refuse any and all treatments. However, my service provider may also decline to provide me a treatment if I refuse or cannot comply with the necessary requirements of that treatment. I understand that I have the right to withdrawal any consent for any and all treatments. If I refuse or withdraw from a treatment, my service provider will make an effort to develop alternate approaches with me to get the services I need.

I hereby **CONSENT** to receive the services or for my child to receive the services for which I have signed and dated above

______________________________ ____________

Client/Guardian Date

______________________________ ____________

Service Provider Date

I hereby **WITHDRAW** my consent for the services recommended for me or my child

______________________________ ____________

Client/Guardian Date

______________________________ ____________

Service Provider Date

TRAVCO BEHAVIORAL HEALTH, INC.

CLIENT FINANCIAL OBLIGATON POLICY.

PLEASE READ THE FOLLOWING TERMS OF YOUR FINANCIAL OBLIGATION WHILE RECEIVING TREATMENT AT OUR FACILITY. IF THERE IS SOMETHING THAT YOU DO NOT UNDERSTAND, PLEASE ASK YOUR COUNSELOR AT THIS TIME. WHEN FINISHED, PLEASE SIGN BELOW THAT YOU AGREE AND UNDERSTAND YOUR FINANCIAL RESPONSIBILITY.

IF YOU HAVE INSURANCE WITH A DEDUCTIBLE AND IT HAS NOT BEEN MET, YOU THE CLIENT, ARE LIABLE FOR PAYMENT OF THE SERVICE AFTER THE CLAIM IS PROCESSED.

IF YOU HAVE A COPAY WITH YOUR INSURANCE, YOU WILL BE RESPONSIBLE TO MAKE THAT COPAY **BEFORE** YOU SEE YOUR COUNSELOR.

IF YOU DO NOT HAVE ANY TYPE OF HEALTH CARE COVERAGE YOU MAY BE PUT ON A SLIDING FEE SCALE, IF SO, YOU WILL BE RESPONSIBLE FOR THAT PAYMENT **BEFORE** YOU SEE YOUR COUNSELOR.

SOME INSURANCE COMPANIES WILL NOT COVER DRUG TESTING OR CASE MANAGEMENT. AS A COURTESY TO THE CLIENT WE WILL BILL THE INSURANCE, BUT IF THE COMPANY DENIES PAYMENT YOU WILL BE RESPONSIBLE FOR PAYMENT.

IF YOU DO NOT HAVE YOUR PAYMENT FOR SERVICES PRIOR TO RECEIVING THEM, WE HAVE THE RIGHT TO REFUSE TREATMENT. **ANY REPORTS NEEDED BY AN OUTSIDE SOURCE WILL NOT BE COMPLETED** UNTIL YOUR FINANCIAL OBLIGATION HAS BEEN MET IN FULL.

ALTHOUGH WE DO CONTACT YOUR INSURANCE COMPANY FOR MENTAL HEALTH AND/OR SUBSTANCE ABUSE BENEFITS, IT IS YOUR RESPONSIBILITY TO PERSONALLY CONTACT YOUR INSURANCE COMPANY AND KNOW WHAT YOUR BENEFITS INCLUDE. IT IS ALSO THE **CLIENT'S RESPONSIBILITY** TO NOTIFY OUR BILLING DEPARTMENT SHOULD INSURANCE COVERAGE CHANGE.

IF, AT ANY TIME, YOUR FINANCIAL OBLIGATION HAS NOT BEEN MET, WE HAVE THE RIGHT TO SUSPEND TREATMENT UNTIL IT HAS BEEN MET.

____________________________ ________ ____________________

SIGNATURE DATE WITNESS