Gallatin Mental Health Center
699 Farmhouse Lane
Bozeman, MT 59715
(406) 522-7357 x. 14
(406) 522-8361 – fax

When you have completely filled out the enclosed packet please bring it into our office so that we may also make copies of your **driver's license**, **social security card**, and any **insurance cards** that you may have. If you do not have insurance please bring in **proof of income for your household**.

Once we have verified your insurance or set up a payment agreement we can schedule your first appointment.

We are open Monday, Tuesday and Wednesday from 8 a.m. to 5 p.m. Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 4 p.m. If you are feeling unsafe or need to talk to someone outside of our regular hours please call the Help Center at 586-3333. The Help Center is a 24-hour crisis hotline and there is always someone you can talk to there.

Please feel free to call or email me (dgalloway@wmmhc.org) with any questions you may have.

Sincerely,

Deja Galloway

INTAKE SCREENING FORM

Adult Mental Health Services

Name____

Address____

Phone: Home-____________________ Work-___________________ Message- __________________

DOB: _______________ Age: _____ Social Security Number: _______________

1. Have you ever been seen at this Mental Health Center? ☐YES ☐NO

2. Who suggested that you contact the Mental Health Center?

____

3. What did they refer you for? OR What did they think we could help you with?

____

____

4. Are you currently seeing a therapist for your mental health needs? ☐YES ☐NO
If yes, who? ____

5. Are you currently on medications for mental health issues? ☐YES ☐NO
If yes, who prescribed them? ____
What medications are you taking? ____
____
Is your current doctor going to continue prescribing these medications? ☐YES NO☐
If yes, what services do you want from the mental health center? _______________________________
____
____

6. Are alcohol and/or drugs an issue? ☐YES ☐NO Sobriety? ___________________

7. Have you ever been hospitalized? ☐Yes ☐No

FINANCIAL DATA

Do you have Medicaid? ☐YES ☐NO Do you have Medicare? ☐YES ☐NO
Do you have private insurance? ☐YES ☐NO If yes, what is the name of the insurance company?
____

****Remind them to please bring the appropriate insurance cards with them when returning this packet.****

How many hours are you working? __________ Where? ___________________ Wage? ______________
Do you receive Social Security Disability? ☐YES ☐NO For mental or physical reasons? (Circle one)
What is the monthly income of the household? _________ How many people live off this income? ______
(Let the individual know if they meet the financial guidelines of MHSP, if not, inform them they will be responsible for the services they receive and let them know the cost for the service they are requesting.)

Remind them to bring **PROOF** of income for the household.

Screener ____ Date ______________________

Scheduled for Intake with ________________________________ Date _____________ Time __________

Western Montana Mental Health Center

SELF ASSESSMENT/DATA INFORMATION FORM

Full name (include Maiden) ____ Date: ________________

Address: ____ City/State/Zip: ___________________________

Phone: (H) ________________ (W) ________________ (C) ________________ (Msg) _______________

DOB: ____________ Age: ________ Sex: Female __________ Male __________

Marital Status: Married ______ Divorced ______ Widowed ______ Single ______ Common Law ______

Social Security Number __________________

Who referred you to WMMHC? ____

FAMILY MEMBERS (Please list: Name of Spouse(s), Live in Partner(s), Common Law Partner(s))

1. Name: ____ Date Relationship Began: _________________
Children from this Relationship: _______________________Date Relationship Ended: ________________
a) __________________________ b) _____________________________ c) ___________________________

2. Name: ____ Date Relationship Began: _________________
Children from this Relationship: _______________________Date Relationship Ended: ________________
a) __________________________ b) _____________________________ c) ___________________________

3. Name: ____ Date Relationship Began: _________________
Children from this Relationship: _______________________Date Relationship Ended: ________________
a) __________________________ b) _____________________________ c) ___________________________

What brings you to Gallatin Mental Health Center at this time? (i.e., what has happened and what do you hope to gain from therapy?)

____
____
____

Additional stressors in your life other than those stated above:

____
____
____

DRUG AND ALCOHOL HISTORY

Do you use either/both? ☐ YES ☐ NO
If yes, please indicate how much you use: ____

Alcohol: Length of use _______________________ Beginning age of use ____________________________
Frequency of use ________________________________

Drugs: Length of use ________________________ Beginning age of use _____________________________
Frequency of use ________________________________
Have you ever received treatment for drug or alcohol usage? ☐ YES ☐ NO

Where: __________________________ When _________________________ How Long _______________
Is there a history of drug/alcohol use/abuse in your family? (Please be specific)

____

PSYCHO/SOCIAL/MEDICAL HISTORY

Where were you born? ______________________________

How long did you live there? ______________________________

Were you raised in a different community from the one you were born? ☐YES ☐NO

If so, where? ______________________________

Who are your parents? ______________________________

Are they living? Mother ☐YES ☐NO If deceased, when? ____________________

Father ☐YES ☐NO If deceased, when? ____________________

Are they still married to each other? ☐YES ☐NO

If no, have they remarried? Mother ☐YES ☐NO

Father ☐YES ☐NO

Mother's Occupation ____________________ Father's Occupation ____________________

Number of Brothers ____________________ Number of Sisters ____________________

Please list their names ______________________________

Your birth order in the family unit

SCHOOL HISTORY

Graduate ☐YES ☐NO From Where? ____________________

GED ☐YES ☐NO From Where? ____________________

College Education ☐YES ☐NO Number of Years? ____________________

Highest degree obtained? ______________________________

MILITARY HISTORY

Have you ever served in the military? ☐YES ☐NO

a) Branch ______________________________

b) From ______________________________

c) Rank at Discharge ______________________________

d) Honorable ☐YES ☐NO (if yes, please explain) ____________________

e) Any Demotions ☐YES ☐NO (if yes, please explain) ____________________

f) Disciplinary Actions ☐YES ☐NO (if yes, please explain) ____________________

EMPLOYMENT HISTORY

Please list last three positions held ______________________________

____

____

Current Employer ____________________ Job Title ____________________

Years worked at this position ____________________

CRIMINAL HISTORY

a) Have you ever been convicted of a crime? ☐YES ☐NO

b) If yes, were they Misdemeanors ____________________ Felonies ____________________

c) What crime(s)? ______________________________

d) Where? ______________________________

e) Time served, if any? ______________________________

f) Are you currently on probation? ☐YES ☐NO

g) Have you ever had any DUI's? ☐YES ☐NO

How many? __________ Where? __________ When? __________

Did you attend Court School? ☐YES ☐NO

ADDITIONAL HISTORY

Have you ever attempted Suicide? ☐YES ☐NO

If yes, list the number of times and circumstances. (Please explain fully) ____________________

____

____

____

____

Have you ever been hospitalized for any psychiatric disorder? ☐YES ☐NO
If yes, where? ____ When? ____________________________
For what? ____

Have you ever received any Outpatient Psychiatric Counseling? ☐YES ☐NO
If yes, where? ____ When? ____________________________
For what? ____

Has any immediate family member received psychiatric treatment and/or counseling? ☐YES ☐NO
If yes, who? ____ When? ____________________________
For what? ____

INCOME VALIDATION
1. Salary, wages, tips ……………………………………………………………………………$___________
2. Salary, wages, tips ……………………………………………………………………………$___________
3. Salary, wages, tips ……………………………………………………………………………$___________

4. Additional Income:
    a) Alimony and/or Child Support ……………………………………………………. $____________
    b) Pension, Annuity, IRA Distributions ……………………………………………$____________
    c) Net income from rent, partnerships, estates, trusts, etc…………………………..$____________
    d) Unemployment and/or Worker's Comp Benefits……………………………….. $___________
    e) Gross Social Security or Railroad Retirement Benefits ………………………….$___________
    f) General Assistance Benefits ……………………………………………………......$____________

TOTAL GROSS FAMILY INCOME (before taxes)………………………………………$___________

Indicate the number of family members dependent on your gross family income. (This number must match the number of dependents claimed on your Federal Income Tax Return.) ___________________________

I affirm that the above information is true, correct and complete.

Signature ____ Date ___________________

EXTENDED DEMOGRAPHIC INFORMATION: PLEASE CHECK THE APPROPRIATE BOX.

1. **ARE YOU:** ☐MALE FEMALE

2. **RACE:**
WHITE/CAUCASIAN(1)
☐BLACK/AFRICAN AMERICAN(2)
AMERICAN INDIAN/ALASKAN NATIVE(3)
HISPANIC(4)
ASIAN(5)
☐ NATIVE HAWIIAN/PACIFIC ISLANDER(6)
☐ MORE THAN ONE RACE (7)
☐UNKNOWN(9)

3. **MARITAL STATUS:**
☐SINGLE (1)
☐MARRIED (2)
☐DIVORCED (3)
☐WIDOWED (4)
SEPARATED (5)
☐ UNKNOWN (7)

4. **SSI ELIGIBILITY:**
☐ SSI DUE TO MENTAL ILLNESS (1)
☐SSI NOT DUE TO MENTAL ILLNESS (2)
☐SSDI DUE TO MENTAL ILLNESS (3)
☐SSDI NOT DUE TO MENTAL ILLNESS (4)
☐NOT APPLICABLE (5)

5. **LEGAL CUSTODY:**
BUREAU OF INDIAN AFFAIRS (B)
☐DEPT OF CORRECTIONS(C)
DEPT OF FAMILY SERVICES (D)
☐ GUARDIAN (G)
☐ OTHER(O)
☐ PARENT OR GRANDPARENT(P)
☐ SELF(S)
☐ UNKNOWN (U)

6. **EMPLOYMENT STATUS:**
☐ FULL TIME (1)
☐PART TIME (2)
☐ UNEMPLOYED BUT ABLE (3)
☐STUDENT (4)
☐ HOMEMAKER/CAREGIVER (5)
☐ RETIRED (6)
☐ DISABLED/UNABLE TO WORK(7)
☐NO INTEREST IN WORK (10)
☐ SUPPORTED/SHELTERED TRANSITIONAL(9)
☐ UNPAID/VOLUNTEER (11)
☐OTHER (14)

7. **EDUCATIONAL STATUS:**
☐ NO FORMAL EDUCATION (1)
☐ ADULT ED/GED (2)
☐ VOCATIONAL SCHOOL (3)
☐ COLLEGE PART TIME (4)
☐ COLLEGE FULL TIME (5)
☐ OTHER (6)
☐ HOME SCHOOLED (7)
☐ PUBLIC SCHOOL K-12 (8)
☐ PRIVATE SCHOOL (9)
☐ UNKNOWN (99)

8. **YEARS OF EDUCATION:** COMPLETED GRADE
☐COMPLETED HS/GED (12)
☐HS PLUS 1 YR COLLEGE (13)
☐HS PLUS 2 YRS COLLEGE (14)
☐HS PLUS 3 YRS COLLEGE (15)
☐BACHELORS DEGREE (16)
☐GRADUATE STUDENT OR HIGHER (21)
☐KINDERGARTEN/PRE-SCHOOL ONLY (23)
☐ UNKNOWN (99)

9. **VETERAN:** ☐ Y ☐N ☐UNKNOWN

EXTENDED INTAKE INFORMATION
For Medicaid and Potential MHSP

Who referred you to the mental health center? (Select one):
❑Self ❑Family ❑Friend ❑School ❑Hospital Inpatient/ER ❑Police ❑Native American Agency ❑Veteran's Administration ❑Homeless Shelter ❑Alcohol/Drug Treatment Center ❑Employee Assistance Program ❑Agency for the Elderly ❑Clergy ❑Agency for Children ❑Developmental Disabilities Agency ❑Other MH Provider ❑Non-Psychiatric Physician ❑Montana State Hospital ❑Residential Facility ❑Other Mental Health Center ❑Court ❑Other

What is your current living situation? (Select one)
❑Homeless ❑Jail ❑Hospitalized ❑Nursing Home ❑Transient ❑Hotel ❑Shelter ❑Mission ❑Personal Care ❑Home ❑Mental Health (Therapeutic) Group Home ❑Child Foster Home ❑Adult Foster Home ❑Living With Family/Friend ❑Supported Independent Living ❑Living Independently With Others ❑Living Independently ❑Therapeutic Foster Care ❑Psychiatric Residential Treatment Facility ❑Other

What mental health services have you received in the past?
❑Montana State Hospital ❑Other Inpatient Hospitalization ❑Partial Hospitalization ❑Outpatient Care ❑No Prior Service ❑This Mental Health Center ❑Psychiatric Residential/Other Residential Care

Are you coming here voluntarily or have you been court ordered to receive services?
❑Voluntary ❑Court Ordered

Are you involved with any of the following Social Service Agencies? (Select all that apply)
❑Department of Family Services ❑School/Special Education ❑Bureau of Indian Affairs ❑Indian Health Services ❑Vocational Rehabilitation ❑Alcohol or Drug Services ❑Primary Health Care ❑Case Management Other Than State Agencies ❑Juvenile Probation ❑PLUK (Parents Let's Unite For Kids) ❑Developmental Disabilities ❑Mental Health Center ❑Housing Agency ❑Veteran's Administration ❑Other ❑None

Number of criminal charges in the past 3 months? ______

Have you been on probation or parole in the past 3 months? ❑YES ❑NO

Do you have any chronic medical problems? ❑YES ❑NO

Have you had a medical exam in the past year? ❑YES ❑NO

Have you had a dental exam in the past year? ❑YES ❑NO

Have you had a vision exam in the past year? ❑YES ❑NO

Are you taking any new generation medications such as Clozaril (clozapine), Zyprexa (olanzapine), Seroquel (quetiapine), Risperdal (risperidone) or Geodon (ziprasidone)?
❑YES ❑NO

Have you been homeless in the past 3 months? ❑YES ❑NO

WESTERN MONTANA MENTAL HEALTH CENTER – INSURANCE INFORMATION CARD

Client Number ________________________

Client Name _____________________________________ Client Relationship to Insured SELF SPOUSE
LAST FIRST MI CHILD OTHER

Insured's Name _______________________________ Insured's DOB _________________ (mm/dd/yyyy)
LAST FIRST MI

Insured's Address _____________________________________ Insured's Phone Number _______________
STREET

____
CITY ST ZIP

Insured's Employer ____

Insurance Company ________________________Policy # __________________ Group # _______________

Address ____
STREET CITY ST ZIP

DO YOU HAVE CO-INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Insurance Company ________________________Policy # __________________ Group # _______________

Address ____
STREET CITY ST ZIP

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE BENEFITS BE PAID DIRECTLY TO WMMHC. I ALSO AUTHORIZE THE WMMHC TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. A PHOTOCOPY OF THIS FORM IS VALID AS ORIGINAL.

CLIENT/AUTHORIZED SIGNATURE _____________________________________ DATE ____________

OFFICE USE ONLY

INSURANCE VERIFICATION

INSURANCE INFORMATION	(TO BE COMPLETED BY OFFICE)				
INSURANCE COMPANY	ADDRESS		INSURANCE PHONE NUMBER		
PATIENT'S NAME	PATIENT'S SS #	DOB	GROUP #	POLICY #	Co-payment
					$ or %
Pre-auth/treatment plan needed	Coverage period	Effective date	Max # visits/period	Max $ amount/period	
MH Benefits	Therapy	Case Mgmt	Group Sessions	Restrictions/Notes	

WESTERN MONTANA MENTAL HEALTH CENTER
ADULT CLIENT MEDICAL HISTORY SURVEY

Client Name :	Date:

Please place a check in front of each statement that applies to you at the present time:

☐ I have trouble sleeping
☐ I am very nervous most of the time
☐ I have spells of crying.
☐ I cannot keep my feelings under control.
☐ My body feels strange at time.
☐ I don't trust most people.
☐ I lose my temper frequently.
☐ My emotions seem to go up and down in regular
☐ les.
☐ Not many people like me.
☐ I have been feeling sad and blue.
☐ I take medicine for my nerves.

☐ Sometimes I see things that others don't see.
☐ I feel tired all of the time.
☐ Most of the time I wish I was dead.

☐ I feel guilty about things.
☐ I am afraid to leave the house.

☐ My spouse or lover has hit me in the past.
☐ I often do dumb thing I regret later.
☐ I have trouble making even minor decisions
☐ I was physically or sexually abused as a child.
☐ I seem to get sick more than most people.
☐ I often think something suspicious is going on.
☐ I am bored most of the time.
☐ I worry about things too much.

☐ I let people take advantage of me too much.
☐ I am afraid to be alone at night.
☐ I find it hard to collect my thoughts or concentrate.
☐ I have thoughts of killing myself.
☐ My weight is a problem to me.
☐ Sometimes I hear voices and I don't know where they are coming from.
☐ I take too many drugs.
☐ My sex life troubles me.
☐

MEDICAL HISTORY

Please answer all questions below:

1. Do you have any medical problems you are now being treated for? ☐YES ☐NO
   If yes, please explain:

2. When did you last see a physician? _________ For what reason? _____________
3. Have you had surgery or an illness in the last 5 years? ☐YES ☐NO
   If yes, please explain:

4. Current height: _________________ Current weight: ______________________
5. Are you now taking prescribed medication? ☐YES ☐NO
   If so, please list all medications:

6. Have you ever had trouble with any medication prescribed for you? ☐YES ☐NO
   Are you allergic to any medications? ☐YES ☐NO
   If yes to either question, please explain:

7. Has there been an important change in your overall health in the last year? ☐YES ☐NO
   If yes, please explain:

8. In the past five years, have you been hospitalized for more that one week? ☐YES ☐NO
   If yes, please explain:

9. Are you now under the care of a physician? ☐YES ☐NO
   Physician Name: ______________________ For what reason? ____________________________
10. Do you take any non-prescribed medications or drugs? ☐YES ☐NO
   If yes, please specify:

11. Do you have now, or have you ever had: (check all that apply)

	Condition	Date(s)		Condition	Date(s)
☐	Rheumatic Fever		☐	Seizures	
☐	Stroke		☐	High or Low Blood Pressure	
☐	Chest Pains		☐	Stomach or Digestive Problems	
☐	Sinus Problems		☐	Allergies	
☐	Problem with Coordination or Balance		☐	Anemia or Blood Disorder	
☐	Diabetes		☐	Been Unconscious	
☐	Hepatitis		☐	Radiation Therapy or Treatment	
☐	Glaucoma		☐	Hearing Problems	
☐	Head Injuries		☐	Bleeding Problems	
☐	Kidney Problems		☐	Venereal Disease	
☐	Tuberculosis (TB)		☐	Frequent Headaches	
☐	Cancer or Tumor		☐	Substance Abuse	

12. Is there any disease or condition we should know about? ☐YES ☐NO
If yes, please explain:

13. FEMALES ONLY Did you have difficulties after the birth of children? ☐YES ☐NO
If yes, please explain:

Are you currently pregnant? ☐YES ☐NO

Client Signature____ Date ___________________

Your Mental Health Rights in Montana

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving mental health services at any Montana Mental Health facility.

2. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your mental health services. You have a right to receive a reasonable explanation in terms you can understand of your general condition, treatment objectives, the nature and significant possible adverse affects of recommended treatment, reasons this treatment is considered appropriate and what, if any, alternative treatment services and types of mental health providers are appropriate and available.

3. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.

4. You have the right to confidential records. Although you must give written approval to allow your records to be released to most others, there are some exceptions to this rule under Montana law. The Center will not disclose your record to others unless you direct us to do so, or unless the law compels us to do so.

5. You have a right to review your records at the Center. You may ask to have your records corrected. You may see your records or get more information about it from your Therapist, Case Manager or Program Manager.

6. You are entitled to the maximum amount of privacy consistent with the effective delivery of services to you.

7. You have a right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

8. You have the right not to be subjected to experimental research or other experimentation without your informed voluntary and written consent.

9. You have a right to be free from abuse and neglect or threats of abuse and neglect while receiving services at any mental health facility in Montana.

10. You have the right to a humane psychological and physical environment while you are in the mental health facility.

11. You have the right to receive information about the Center's client grievance procedure and to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate available treatment. The Center recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect the Center will provide a referral to a local client support group, a family members support group or a state designated advocacy agency.

12. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and right during an involuntary commitment process. Your primary therapist or case manager will explain those rights to you if you have concerns in these areas.

By signing below, you are stating that you hereby understand your rights.

Name ____ Date _______________________

Western Montana Mental Health Center

Gallatin Mental Health Center
699 Farmhouse Lane
Bozeman, MT 59715
Phone: 406-522-7357
Fax: 406-522-8361

AGGRESSIVE BEHAVIOR POLICY

All Gallatin Mental Health Center Programs (Outpatient Services, Hope House, and Outreach Case Management) are designed to provide a safe place for our consumers and staff.
Aggressive Behavior does not fit into this philosophy and will not be tolerated at WMMHC facilities.
Aggressive Behavior is defined as **yelling, pushing, physical fighting, throwing objects, swearing or acting in a threatening manner.**

If aggressive behavior occurs, the following procedure will be enacted:

FIRST OFFENSE: Asked to leave the program/office for the day and a referral to a therapist, chemical dependency counselor, etc, to deal with anger management.

SECOND OFFENSE: Asked to leave the program/office for one week.

THIRD OFFENSE: Asked to leave the program/office for three weeks. The treatment team will then meet with the consumer to evaluate appropriateness for continued participation in the program.

At times, the Director may have to exercise discretion in following this procedure to protect the safety of consumers and the program.

Signature ____ Date______________________

WESTERN MONTANA MENTAL HEALTH CENTER
CLIENT GRIEVANCE PROCESS

The Center has established a grievance procedure for consumers/clients who believe his/her rights have been violated by the Center or one of its employees.

Step 1: Informal Resolution

Any consumer/client who believes his/her rights have been ignored, violated or in some manner he/she has been treated inappropriately by the staff or programs of the Mental Health Center is encouraged to discuss the problem area with the staff person concerned. Often times open and frank discussion between the two parties can lead to a clarification of perspectives and a clearing of the air.

Step 2: Formal Grievance Process

If an individual consumer/client of the Western Montana Mental Health Center believes that his/her rights have been violated, and an informal resolution has not resolved the situation or was judged inappropriate, they are entitled to an impartial hearing on this matter. The request for a hearing should be in writing and should clearly state the nature of the grievance, which right have been violated and what action the consumer/client would recommend as a means to address the concern. Grievances shall normally be filed within 30 days of the alleged infraction. The Step 2 Grievance Hearing shall be conducted by the respective Office/Program manager of the Center. If the Office/Program Manager is directly involved in the grievance (i.e., the person against whom the grievance is filed), then the Executive Director will appoint an impartial Step 2 Grievance Hearing Officer. The Step 2 Hearing Officer shall normally conduct a hearing on the concerns presented within 10 working days of the receipt of a written grievance. The Hearing Officer shall issue a response to the grievant within 7 days of the hearing.

Step 3: Request for Hearing

If the Grievant is not satisfied that his/her concern has been adequately responded to through the Step 2 process, the grievant may file a Step 3 request in order to rehear the issue(s). The request for a Step 3 Hearing shall be in writing and shall be filed within 10 days of the receipt of a Step 2 decision by the grievant. The Executive Director of the Mental Health Center, or his or her designee, shall conduct a hearing on the concerns presented by the grievant. The hearing shall normally be within 10 working days of the receipt of a written grievance request and a written decision shall be given to the grievant within 7 working days of the hearing.

BOARD OF DIRECTORS INFORMED/REVIEW OPTIONAL

The board of directors of the Western Montana Mental Health Center shall be informed of all Step 3 grievance decisions. To the greatest extent possible, client confidentiality concerns will be preserved in the disclosure of this information to the Board. The Board may elect to conduct a full review of any Step 3 decision where it has concerns or questions.

Step 4: State Review

If the grievant is not satisfied with the decision of the Mental Health Center under this process, he/she may appeal the decision regarding his/her grievance to the Independent Committee established by the State Department of Corrections and Human Services for further redress. The Center will assist the grievant in providing names and addresses of state personnel to whom further concerns may be addressed. There are no time limits on violations of client right which may be grieved to the State's Independent Review Committee. The Client/Consumer may elect at any point during this grievance procedure to have the issues resolved by a Federal or State Court of Law or any Federal or State agency with appropriate jurisdiction.

Signature ____ DATE ____________________

WESTERN MONTANA MENTAL HEALTH CENTER
Individual Consent

____
CLIENT NAME (LAST, FIRST)

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Options

I understand that as a part of my health care, Western Montana Mental Health Center (WMMHC) receives, originates, maintains, discloses and uses individually identifiable health information including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment plans, and billing and health insurance information. I understand that WMMHC and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

1. Diagnose any medical/psychiatric condition.
2. Plan my care and treatment.
3. Communicate with other health professionals concerning my care.
4. Document services for payment/reimbursement.
5. Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided.) and peer review (the process of monitoring the effectiveness of health care personnel.)

I have been provided a ***Notice of Privacy Practices*** that fully explains the uses and disclosures that WMMHC will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. WMMHC has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that WMMHC cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however; that WMMHC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent the use or disclosure of my individually identifiable health information for treatment, payment, and health care options, but that if I do not consent, WMMHC may refuse to provide my health care services unless applicable state or federal law requires WMMHC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that WMMHC is not required to agree to the requested restriction but that, if it does agree, it must honor the restrictions unless I request that it stop doing so or WMMHC notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information: ____

____

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home. I further understand that WMMHC may not ask me why I want the alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for the facility directories and to family members.

I object to uses and disclosures as follows: ______________________________________

____

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that WMMHC has already taken action in reliance on my earlier effective consent.

_______________________________________   ____________________
Signature of Patient or Legal Representative   Date

_______________________________________   ____________________
Signature of Witness   Date

WESTERN MONTANA MENTAL HEALTH CENTER
MISSOULA COUNTY ADULT SERVICES

CONTRACT FOR PAYMENT OF SERVICES

Client Name: ____

The Western Montana Mental Health Center is a private, non-profit corporation financed largely by the collection of client fees. Please refer to the posted fee schedule.

1. Medicaid coverage or eligibility through the Mental Health Services Plan

☐ I am Medicaid eligible. I agree to furnish the Center with copies of my Medicaid card, and provide information regarding changes in my eligibility.

☐ I am eligible for coverage through the Mental Health Services Plan (MHSP). In the event of a co-pay requirement, I agree to promptly notify the Center of the monthly co-payment amount determined by the state, and I agree to pay that amount.

Should I lose Medicaid or MHSP eligibility and fail to inform the Center, I understand that I am responsible for my bill in full.

2. Insurance / Medicare coverage.

I understand that I am responsible for payment of all services at the Center. After I complete and sign an insurance information card, the Center will submit a claim to my insurance company for services rendered. Payment from the insurance or Medicare will be sent directly to the Center. If my insurance / Medicare notifies me that they will deny payment or make only partial payment, a copy of the notice must be furnished to the Center before any adjustments will be made on my account. If I receive a payment and do not remit to the Center in a timely manner, I understand that I will be billed for the full amount of services.

☐ I agree to pay the full difference between what my insurance / Medicare pays and the full fee.

☐ I agree to pay the negotiated rate of what my insurance / Medicare does not pay. My negotiated rate is ______________.

☐ I have secondary coverage through Medicaid or the MHSP, and I agree to pay the co-payment amount determined by the state, if any.

☐ I have coverage through the Veterans Administration.

3. No third party coverage.

☐ I agree to pay full fee for all Center services.

☐ I agree to pay my negotiated fee due to my special circumstances. My negotiated rate is _________.

4. Cancellations / Broken appointments

I agree to be responsible for notifying the Center at least 24 hours in advance if I am unable to keep my appointment. If I break two appointments without advance notice the Center will not schedule a third appointment. I understand that I may be responsible for a charge of $25 if I fail to keep my scheduled appointment.

5. I understand that should I fail to make the payments agreed above the Western Montana Mental Health Center may submit my full account to a collection agency and services may be terminated.

If there are changes in Medicaid, Medicare, MHSP, or Insurance eligibility, it is my responsibility to notify the Center promptly.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS, AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE AND ACCURATE, AND I AGREE TO THIS PAYMENT CONTRACT AND ITS TERMS.

Signature of client or responsible person: ____

Signature of staff: ____ Date: ____________________

WESTERN MONTANA MENTAL HEALTH CENTER

Consent to Treatment

I consent to mental health treatment. Treatment shall be rendered by professional staff of the Mental Health Center.

In most circumstances, information will not be released to persons no employed by the Mental Health Center without written permission. Information may be released in an emergency to protect my life or that of another person. The courts may subpoena records from the Mental Health Center.

I understand I may revoke this consent to treatment at any time, if I have admitted to treatment voluntarily.

Dated this ______________________ day of ___________________________, 20_______

____
Client Signature

____
Witness