Rehabilitative Health Services

Patient Registration Form

Today's Date:_____

Patient Information

Full Name: Last: _____ First: _____ M. I.: ____
Physical Address: _____ City: _____ State: ____ Zip: _____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Phone: Home:_____ ☑ Okay to Call Work:_____ ☐ Okay to Call
Cell:_____ ☐ Okay to Call Phone Carrier:_____
Best Time to Call: (Circle One) Anytime Mornings Daytime Afternoons Evenings Weekdays (M-F) Evenings & Weekends
Date of Birth: _____ Sex: M F SSN: _____ Drivers License #: _____
E-mail: _____ Status: Married Single Divorced Widowed
Communication Preference: Letter Phone Call E-mail Appointment Reminder: E-mail Text Message
Employed: Y N Employer Name: _____ Phone: _____
Student: Y N School: _____ Phone: _____
Spouse Employer (if applicable) _____
Race: American Indian or Alaska Native:__ Asian: __ Black or African American:__ Native Hawaiian or Other Pacific Islander:__
White:__ Decline to Answer:__ Preferred Language Spoken: _____
Ethnicity: Hispanic or Latino:__ Not Hispanic or Latino:__ Decline to Answer:__
Primary Care Provider: _____ Phone: _____

Parent/Guardian Information

Full Name: Last: _____ First: _____ M. I.: ____
Mailing Address: Street/Box: _____ City: _____ State: ____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Best Time to Call: (Circle One) Anytime Mornings Daytime Afternoons Evenings Weekdays (M-F) Evenings & Weekends
E-mail: _____ Contact Type: Mother Father Other: _____

Full Name: Last: _____ First: _____ M. I.: ____
Mailing Address: Street/Box: _____ City: _____ State: ____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Best Time to Call: (Circle One) Anytime Mornings Daytime Afternoons Evenings Weekdays (M-F) Evenings & Weekends
E-mail: _____ Contact Type: Mother Father Other: _____

Insurance Information

Primary Insurance
Insurance Carrier Name: _____ Insured Name: _____
Address: _____ DOB: _____
City, State, Zip: _____ Phone: _____
Relationship to Patient: Self Spouse Parent Other:_____
Policy #: _____ Group #: _____
SSN#/ID#: _____

Secondary Insurance
Insurance Carrier Name: _____ Insured Name: _____
Address: _____ DOB: _____
City, State, Zip: _____ Phone: _____
Relationship to Patient: Self Spouse Parent Other:_____
Policy #: _____ Group #: _____
SSN#/ID#: _____

Emergency Contact

Contact Information of an emergency contact not living with you.
Full Name: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____

Pharmacy Information

Pharmacy Name: _____ Phone: _____
Pharmacy Address: _____

Rehabilitative Health Services (RHS) **Addiction & Trauma Recovery Services at RHS**
RHS PHONE: (208)523-5319 RHS FAX: (208)-523-5627 ATRS PHONE: (208) 932-0668 ATRS FAX: (208) 932-0809
1675 Curlew Dr. Ammon ID. 83406

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Notice of Privacy Practices (HIPAA)

Client/Patient Name:		Date of Birth:	
Phone:			

RECORDS TO COME FROM: (authorization to REQUEST my protected health information FROM...)

Facility/Provider Name:					
Phone:		FAX:		City:	

Reason for Request:
- ☐ Changing ☐ Medical Services ☐ Behavioral Health Services
- ☐ Adding Additional ☐ Medical Services ☐ Behavioral Health Services
- ☐ Acquiring information for
  - ☐ Coordination of Care ☐ Diagnosis ☐ Assessment ☐ Testing ☐ Other: _____

Requested Records:

☐ Health and Physical (H&P)	☐ Social/Medical History	☐ Imaging	☐ Probation/Parole Progress
☐ Comprehensive Diagnostic	☐ Physical Health History	☐ Physician Notes	☐ Psychological Testing/Reports
☐ GAIN Assessment	☐ Diagnosis	☐ Discharge Summary	☐ Educational Testing/Reports
☐ Psychiatric Evaluation	☐ Medication List	☐ Treatment Plan(s) : _____	☐ Other _____
	☐ Lab Reports	☐ Case Management Plans	☐ Other _____

RECORDS TO BE RELEASED TO: (*Authorization to: RELEASE my protected health information TO... may include family members, significant others, or other as specified in which RHS staff can release info or speak to about your treatment)*

1) Name:				Relationship:	
Phone:		FAX:		City:	
2) Name:				Relationship:	
Phone:		FAX:		City:	
3) Name:				Relationship:	
Phone:		FAX:		City:	

☐ Records Request for Self Physical Copy ☐ in Person ☐ Mail	Requested Records:	

Notice of Privacy Practices (HIPPA)

I understand the my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days after discharge.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment, or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization. **I have been offered a copy of HIPAA regulations.**

This release will remain effective for one year from the signature date, unless revoked by member in writing.

Client/Patient Signature:		Date:	
Parent/Guardian Signature:		Date:	

If the client/patient is a minor or adult with a guardian, I acknowledge that: (a) I am the parent, legal guardian, or authorized representative of the client/patient; (b) I have the legal right to make medical decisions on their behalf; and (c) hereby give informed and voluntary consent on their behalf.

Name:_____ Date:_____

Depression Screener (PHQ-9)

	None	Several Days =1	Most Days =2	Nearly Daily=3
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling/staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about self, that you're a failure or have let others down				
Trouble concentrating (reading/tv)				
Moving/speaking so slow that other people notice? Or the opposite- being so fidgety or restless, moving around a lot more than usual.				
Thoughts that you're better off dead or of hurting yourself				
If you marked yes on any above, how difficult is it for you to take care of things or get along with other?	Not At All	Somewhat Difficult	Very Difficult	Extremely Difficult
Total Score:				
0-4 = Minimal Depression	**5-9 = Mild**	**10-14 = Moderate**	**15-19 = Moderately Severe**	**20-27 = Severe**

REHABILITATIVE HEALTH SERVICES

COMPREHENSIVE HEALTH HISTORY

Member's Name:		Date:	

Medical Information

Diagnosis	You		Mother Side	Father Side	Surgery	You		Mother Side	Father Side
	Past	Present				Past	Present		
Acid Reflux	☐	☐	☐	☐	Knee	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Eye	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Spleen	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Bladder	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	Appendectomy	☐	☐	☐	☐
COPD	☐	☐	☐	☐	Shoulder	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Hysterectomy	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	Back	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	Prostate	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Colon	☐	☐	☐	☐
Hepatitis (A,B,C)	☐	☐	☐	☐	Heart	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	Gallbladder	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	Hip	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	Stomach	☐	☐	☐	☐
Insulin Resistance	☐	☐	☐	☐	Foot	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	Brain	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	Electric Shock Therapy	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Other:	☐	☐	☐	☐
TBI	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	No Major Surgeries ☐				

Behavioral Health Information

Diagnosis	You		Mother Side	Father Side	Diagnosis	You		Mother Side	Father Side
	Past	Present				Past	Present		
Aggression/Anger	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	Indecisiveness	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Irritability	☐	☐	☐	☐
Isolation	☐	☐	☐	☐	Loneliness	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Memory Problems	☐	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	Racing Thoughts	☐	☐	☐	☐
Mania	☐	☐	☐	☐	Sleeping Problems	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Suicidal Thoughts	☐	☐	☐	☐
Helpless/Hopeless	☐	☐	☐	☐	Worrying	☐	☐	☐	☐
Distractibility	☐	☐	☐	☐	Muscle Tension	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	Other:	☐	☐	☐	☐

Substance Abuse Information

Substance Used	You		Mother Side	Father Side	Substance Used	You		Mother Side	Father Side
	Past	Present				Past	Present		
Tobacco	☐	☐	☐	☐	LSD/Hallucinogens	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	Ecstasy	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	Inhalants	☐	☐	☐	☐
Methamphetamine	☐	☐	☐	☐	IV Drug Use	☐	☐	☐	☐
Cocaine/Crack	☐	☐	☐	☐	Rx Drugs	☐	☐	☐	☐
Heroin	☐	☐	☐	☐	Other:	☐	☐	☐	☐

Rehabilitative Health Services Clinical History Form

Date: _____

Patient Name: _____ Date of Birth: _____

An accurate medical, social and family history is very important for us to know in order to better assess your current medical health and influences on future health and well-being.

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING:

GENERAL	**EYES**	**ENT**	**CARDIOVASCULAR**	**RESPIRATORY**	**GASTROINTESTINAL**	**GENITOURINARY**
Fatigue	Blurred Vision	Hearing Problems	Chest Pan/Pressure	Cough-Acute	Abdominal Pain	Painful Urination
Fever	Eye Drainage	Ear Ringing	Dizziness	Cough-Chronic	Diarrhea	Blood in Urine
Night Sweats	Light Sensitivity	Nosebleeds	Palpitations	Short of Breath	Blood in Stool	Frequent Urination
Weight Gain	Double vision	Hoarseness	Feet Swelling	Blood-Sputum	Nausea	Incontinence
Weight Loss	Eye Pain	Sore Throat	Varicose Veins	Wheezing	Vomiting	Flank Pain
Musculoskeletal	**Skin/Breasts**	**Neurological**	**Hematologic/ Lymph**	**Endocrine**	**Male**	**Psychologic**
Joint Pain	Lesions/Moles	Fainting	Easy Bruising	Hair Loss	ED	Depression
Back Pain	Itching	Headaches	Excess Bleeding	Heat/cold Intol	Impotence	Anxiety
Joint Stiffness	Rash	Confusion/Memory loss	Lymph Node Swelling	Excess Thirst		Severe Stress
Extremity Pain	Breast Mass	Numbness/Tingling	Anemia	Excess Sweat		Sleep Disturbance
Muscle Pain	Breast Tender	Seizure	Autoimmune			

Allergies

□ None □ Medications □ Latex □ Food □ Other

List Allergies and Reactions: _____ _____

_____ _____

Prescription/ Non-prescription Medications/Vitamins/Supplements

1. _____ **5.** _____ **10.** _____
2. _____ **6.** _____ **11.** _____
3. _____ **7.** _____ **12.** _____
4. _____ **8.** _____ **13.** _____
5. _____ **9.** _____ **14.** _____

Past Medical History- Check all that apply

□ Arthritis □ Asthma □ Bleeding Difficulties □ Depression □ Diabetes Mellitus □ Emphysema

□ Heart Disease □ Hepatitis □ High BP □ High Cholesterol □ HIV □ Insomnia □ Kidney Disease/Stones

□ Migraines □ Osteoporosis □ Seizure Disorder □ STD □ Stroke □TB □ Thyroid Disease

□ Cancer: (Type/Treatments) _____

Patient Name: _____ Date of Birth: _____

Assigned Sex (Optional)

Assigned sex at birth: Male Female

Gender Identity: Male Female

Gynecologic/Obstetric History

Date of last menstrual cycle: _____ Age at onset of periods: _____ Age at onset of menopause: _____
Problems with menstrual cycles:
_____None _____ Irregular frequency/duration _____ Dysmenorrhea _____ Heavy Bleeding _____ Other
Number of pregnancies: _____ Problems with pregnancies: _____
Number of live births: _____ Number of miscarriages: _____ Number of Abortions: _____
Current birth control: _____
Date of last pap smear: _____ History of abnormal pap smears? ☐ No ☐ Yes Abnormalities: _____

Prevention

If over age 30, have you had your cholesterol level checked in the past 5 years? ☐ No ☐ Yes
Have you ever had a mammogram? ☐ No ☐ Yes If yes, date of last mammogram: _____
Any abnormalities noted? ☐ No ☐ Yes _____
Have you ever had a colonoscopy? ☐ No ☐ Yes If yes, date of last colonoscopy: _____
Any abnormalities noted? ☐ No ☐ Yes _____
Have you ever had a bone density or DEXA test? ☐ No ☐ Yes If yes, date of last screening: _____
Any abnormalities noted? ☐ No ☐ Yes _____
Date of last dental exam: _____ How often do you brush teeth? _____
Date of last eye exam: _____
Do you have any current health goals? _____

Immunizations

☐ Tetanus/Yr _____ ☐ Influenza/Yr _____ ☐ Pneumonia/Yr _____ ☐ Shingles/Yr _____ ☐

HPV vaccine: #1 _____ #2 _____ #3 _____ ☐ Other/Yr

Surgical History

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ Date of Birth: _____

Family History

Illness Which Family Members? Illness Which Family Members?

Key: MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather

Cancer/Type?_____
Hypertension _____ Heart Disease _____
Diabetes _____ Stroke_____
Mental Disease _____ Thyroid Disease_____
Glaucoma _____ Bleeding Disorder_____
Osteoporosis _____ Alcohol Abuse _____
Illicit Drug abuse _____
Other _____

Father: Living / Deceased Age ____ Cause of Death _____Brothers: # Alive ___ # Deceased___ Age___ Cause of Death _____
Mother: Living / Deceased Age ____ Cause of Death _____Sisters: # Alive ___ # Deceased___ Age___ Cause of Death _____

Social History

Spiritual and/or Religious Preference (optional): _____
Education Background: High School College – 2 yr College – 4 yr Post-Graduate
Occupation/Duties: _____
Marital Status: Single Married Separated Divorced Widowed
Number of Children: _____
Who lives in your current household? _____
Do you feel safe at home? _____ If not, what makes you fearful? _____
Has anyone ever hit, kicked, pushed or verbally intimidated you? _____
Do you have any current major home, work, social or financial stressors affecting your life and/or well-being?
_____
Do you have difficulty sleeping? _____ How many hours of sleep do you get each day? _____
Hobbies/Recreation _____
Exercise: ☐ None Type of Exercise: _____
Frequency: Days per week/Time per session _____
Nutrition:
Are you happy with your current weight? Yes No If no, why not? _____
Are you currently on a special diet? Yes No If yes, what kind? _____
Do you eat 1-2 servings of fruit and 3-6 servings of vegetables each day? Yes No
How many glasses of water do you drink each day? _____
How would you rate your overall nutrition? Terrific Good Fair Poor Terrible

Tobacco, Alcohol, Caffeine

Tobacco Never smoked _____ Past Smoker: Cigarettes Quit Date _____ # Packs/Day _____
Cigars Quit Date _____ # Packs/Day _____
Current Smoker: ____ Every Day Smoker ____ Intermittent Smoker # Cigarettes/Cigars Per Day _____
Smokeless Tobacco: ____ Current Use # Cans/Pouches per Day _____ Vape: _____

Alcohol None _____ Frequency: ____ Rare ____ Social ____ Regular Use ____ Binges
Quantity: # Drinks per Day _____ # Drinks per Week _____ # Drinks per Month _____
Types of Alcohol: _____ Previous attempt to quit? _____

Caffeine None ___ Coffee Tea Soda # Servings per Day ____

Illicit Drug Use: Current Use: ____ No ____ Yes Type: _____
Prior Use: ____ No ____ Yes Type: _____ Quit Date: _____

Member Printed Name:	

Rehabilitative Health Services
Statement of Member Rights and Grievance Procedure

As a member of the above specified agency the following specifies <u>member rights:</u>

As a Consumer of Rehabilitative Health Services, the following Statement of Consumer Rights is applicable to services received from before said agency. The following specifies consumer's rights for a consumer of Rehabilitative Health Services:

1. Rehabilitative Health Services assumes that the consumer is legally competent unless he/she has otherwise been determined by a court of law.
2. Consumer will not lose any legal rights as a result of becoming involved with Rehabilitative Health Services.
3. Consumer has the right to adequate and humane services and care in the least restrictive environment. Treatment plan(s) will be developed in a plan approved by the Department of its designee. These services will be consumer specific.
4. Consumer has the right to help develop and review any service plan. A qualified staff member of Rehabilitative Health Services will ensure that the service plan(s) is/are implemented, and will be reviewed for quality assurance by designated staff.
5. Consumer has the right to refuse services and request a new service provider.
6. Consumer has the right to not be physically, verbally, or emotionally abused, punished, or neglected.
7. Consumer will not be discriminated against due to race, religion, gender, age, disability type, socioeconomic status or any other type of prejudice.
8. Consumer has the right to emergency medical services.
9. Consumer has the right to receive quality services from any professional unless services are not beneficial to the treatment of consumer and have been determined to not be beneficial through a review by designated staff at Rehabilitative Health Services.
10. Consumer has the right to privacy in regard to his/her file with Rehabilitative Health Services. Information about consumer will not be released to personnel outside of Rehabilitative Health Services without consumer consent, consent of guardian, or in the best interest of the consumer's treatment as determined by designated staff.
11. If consumer has reason to believe that his/her rights have been breached or violated, the consumer has the right to utilize Consumer Grievance Procedures, which provides
12. The ability to have concerns of violation reported and reviewed in a timely matter. Reviews of complaints occur weekly, with follow up to consumer within one week, if not sooner. (This is to make sure that we can gather all information of both sides to resolve the matter).
13. Consumer is aware that RHS facility supports certified pet and therapy animals in the building.

As a member of the above specified agency the following specifies <u>grievance procedures:</u>

1) A member should address problems and concerns with his/her CBRS Worker, Case Manager, Peer Support Specialist, Nurse, Therapist, or Partial Care Worker. (Staff member)

2) If the problem or concern is not resolved with the staff member then member should then speak to the staff member's supervisor. The staff member should provide or offer the opportunity for the member to speak to the staff member's supervisor. The supervisor or worker should report the problem or concern to an owner of the agency.

3) Problems or concerns are recorded in a log that is reviewed weekly by agency quality assurance team which includes agency owners. Problems and concerns are also addressed during supervisors meeting.

4) If the problem or concern is not resolved with the supervisor and through the quality assurance team the member has the right to contact the appropriate authorities that govern the area of concern including consumer advocacy groups, adult protection, authorities that govern HIPAA or any governing authority that best fits the problem or concern in which the member has a need. The above said agency can assist the member in finding a new agency that would better fit the needs of the member.

Member or Parent/Guardian Signature:		Date:	

RHS
Mental Health Solutions
Changing Lives Together
EST. 1998
Rehabilitative Health Services
PHONE: (208) 523-5319 FAX: (208) 523-5627
ADDRESS: 1675 Curlew Dr. Ammon, ID 83406

Addiction and Trauma Recovery Services at RHS
EXPERIENCE. STRENGTH. HOPE.
PHONE: (208) 932-0668 FAX: (208) 932-0809
ADDRESS: 1675 Curlew Dr. Ammon, ID 83406

Services - Benefits/Risks - Consent to Treat - Financial Responsibility

Client/Patient Name:		Date of Birth:	

RHS Services >Checkmark boxes for requested services<

- ☐ Family Medical Clinic (Patient Centered Medical Home – PCMH recognition through NCQA)
- ☐ Behavioral Health Clinic
  - ☐ Medication Management
  - ☐ Psychological Testing
  - ☐ Counseling/Therapy - Individual and/or Group
  - ☐ Addiction and Trauma Recovery Services - Individual and/or Group – Case Management-Recovery Support
  - ☐ CBRS (Community Based Rehabilitative Services) – Medicaid or Cash Pay
  - ☐ Case Management – Medicaid or Cash Pay
  - ☐ Peer Support Services – Medicaid or Cash Pay
  - ☐ Family Support Services – Medicaid or Cash Pay

Statement of Benefits and Risk >Checkmark as read<

RHS strives to provide quality standard of care practice in all delivered services in adherence to Federal and State Code and Rules, Medicaid Optum Level of Care Guidelines, PCMH NCQA guidelines, ethical standards, and current standard of care practices.

☐ **BENEFITS of *behavioral health services* can include...**

- Improved quality of life and satisfying lifestyle including achieving individual objectives/goals
- Gain and/or maintain independent living, housing or employment
- Gain or/maintain main connected healthy family and social relationships
- Gain knowledge, skills, & attitudes supportive of a mental health and or/addiction management including sobriety and/or recovery
- More likely to avoid psychiatric hospitalization, incarceration, substance use or other addictions, homelessness, unemployment and loss of family and social relationships.
- Receive diagnosis, assessment, or testing allowing for targeted services

☐ **BENEFITS of *medical care and establishing a medical home* can include...**

- Detect potentially life-threatening health conditions or diseases early
- Reduce your risk of illness
- Increase chances for diagnosis, treatment, and cure and/or disease management
- Limit risk of complications by closely monitoring existing conditions
- Increase lifespan and improve health
- Reduce healthcare costs over time by avoiding costly medical services
- Form a partnership with the doctor for treatment efficiency with access to updated or new medical information

☐ **Reasonably foreseen RISKS of *behavioral health services* can include...**

- Emotional energy and time for recovery work
- Side effects of medications
- Strain in family relationships from open discussion of issues, past traumas,
- Stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, time spent in recovery and completing assignments, working on goal on treatment plans

- Emotional stress from requirements of group interaction self-disclosure or negative reactions by group members
- Facing underlying problems that may surface during assessment
- Loss of some familiar, but unhealthy relationships that influence behavioral health issues including addiction

☐ **Reasonably foreseen RISKS of *medical care* can include**...

- Side effects of medications or discomforts of medical treatment
- Undesired treatment outcomes that may occur even with quality standard of care
- Stress of gaining knowledge of long term health issues

Financial Agreement >Checkmark as read<

☐ **Financial Agreement:** I, the undersigned, agree, whether I sign as the guarantor (for minor or guardianship) or as patient, in consideration of the services rendered to the patient, I hereby obligate myself to pay this account to Rehabilitative Health Services (RHS).

- With the exception of Medicare and Medicaid patients, payment is collected when you arrive for your appointment, including deductibles, co-pays, and co-insurances unless prior financial arrangements have been made in advance.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company does not pay your claim within 60 days of submission, the balance becomes your responsibility. Please be aware that some services provided may not be covered by your insurance company and/or considered unreasonable or unnecessary by your insurance company, thereby, leaving you responsible for full payment of the denied charges.
- RHS offers a sliding scale fee discount program to patients/clients/responsible party to all who are uninsured, are underinsured, need behavioral health services not covered by insurance, have needs for cash pay only, or experiencing financial difficulty paying for RHS requested and provided services. RHS bases program eligibility on a patient's or client's ability to pay and does not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, creed, or gender identity.

☐ **Assignment of Insurance Benefits**: I, the undersigned, hereby authorize RHS to receive assignment of all insurance payments otherwise payable to me for services rendered by RHS and they are hereby authorized to release medical information for treatment, payment and operation purposes.

☐ **Patient Certification, Authorization to release Medical Information**: I, the undersigned, authorize Rehabilitative Health Services to release any medical information that may be necessary for treatment, payment and operations and to release credit information to appropriate information gathering agencies.

☐ **Collection Action**: I, the undersigned agree that if payment on this account is not made in accordance with the above mentioned terms, my account can be closed and sent to Outsource Collections and I cannot be seen at RHS until account is paid in full.

☐ **NO SHOW POLICY** – I understand I must give twenty-four hours notice if I am unable to participate in a service provided at RHS. If my service is missed without advanced notice I can be charged a sliding scale rate to cover the cost of the missed services.

☐ **SOBRIETY/BEHAVIOR** – I understand I must be sober and safe to receive services at RHS. RHS reserves the right to ask me to leave during a provided service if I am disruptive or dangerous to others around me at RHS. My worker may disengage with me in the community if I am aggressive or dangerous to my worker.

By Signing below, I acknowledge that

☐ I have been informed of the ***Benefits and Risks of Services*** (for informed consent)

☐ I have been informed of ***My Rights and Responsibility*** for **Payment** of services

☐ I give my **Informed and Voluntary Consent** for treatment, services, care, and/or testing as identified and as I request/agree. I have the right to discontinue services at any time*(Consider any probation or parole requirements for services and treatment).*

☐ I acknowledge I have received a copy of RHS service descriptions.

☐ If the client/patient is a minor or I have been appointed as an adult guardian, I acknowledge that:

(a) I am the parent, legal guardian, or legally authorized representative of the client/patient;

(b) I have the legal right to make medical decisions on their behalf; and

(c) I hereby give informed and voluntary consent on their behalf

Client/Patient Signature:		**Date:**	
Responsible Party Signature: ☐ **Parent** ☐ **Guardian**		**Date:**	
Parent/Guardian PRINTED NAME:			
Witness Signature/Title:		**Date:**	

Rehabilitative Health Services

Family Medical Clinic and Behavioral Health Service Provider

Choice of Medical Provider

RHS has a primary care team to provide services for your medical health and behavioral health needs. Please select a Primary Care Provider. If you would like to also receive mental health medication management please select a provider for these additional services. Our referral team will place you with the provider of your choice unless your chosen provider cannot meet your treatment needs or the provider does not yet have room in his/her schedule. A member of our referral team can advise you of a provider that can best fit your needs.

Primary Care Providers (PCP)

Please check mark the provider you would like to see for your medical care, sign and date below

Kathy Hemming, PA-C ☐ PCP ☐ Mental Health Medication Management Provider

Kathy provides general family medicine to all ages, addresses behavioral health needs, pain management, addiction issues, and women's health at RHS Family Medical Clinic.

Kathy is a physician's assistant certified by the National Commission of Certification of PAs. She is licensed under the Idaho Board of Medicine. Kathy began working for RHS in October 2017 and has been in practice since 1997. Kathy received her bachelor's degree in Zoology, Chemistry, and Medical technology from Idaho State University. She also studied at Ricks College and BYU Hawaii in physical therapy. Kathy received Master's of Physician Assistance Studies at Idaho State University. Kathy's practice background includes 10 years of family medical practice and 10 years pain management in the Salt Lake City area. She also provided pain management services at an Idaho Falls Clinic. One of Kathy's goal in her practice is to help promote available health care for the underserved in Eastern Idaho.

Kolt Piquet PA-C ☐ PCP ☐ Mental Health Medication Management Provider

Kolt provides general family medicine at RHS to all ages while addressing behavioral health needs.

Kolt is a physician's assistant certified by the National Commission of Certification of PAs. He is licensed under the Idaho Board of Medicine. Kolt began working for RHS in September of 2017 and began his PA practice at RHS. Kolt received his undergraduate and graduate medical training at Idaho State University and received both a Bachelor in Science and Master's of Physician Assistance Studies. Kolt worked has a psychiatric technician at the Behavioral Health Center in Idaho Falls and has particular skills in working in primary care treatment with behavioral health management. Kolt practices in general medicine practice of all ages, medication management for psychiatry, and general med management. Kolt particularly enjoys ADD/ADHD medication management, depression medication management, dermatology, and treating lung disorders. His goal in practice is to provide evidence based medical treatment particularly assisting or encouraging patients that struggle with adherence to psychiatric and medical interventions, helping find solutions to improve overall health outcomes.

Brent Ellsworth PA-C ☐ Mental Health Medication Management Provider

Brent provides mental health medication management at RHS Family Medical Clinic.

Brent is a physician's assistant certified by the National Commission of Certification of PAs. He is licensed under the Idaho Board of Medicine. Brent began working for RHS in February 2018. Brent received his undergraduate degree at Brigham Young University Idaho and his Master's of Physician Assistant Studies at Idaho State University earning a place on the dean's list. He has been practicing for 9 years and began his practice at Region 7 Behavioral Health and additional practiced with behavioral health providers Seasons of Hope and Willow Sage in Idaho Falls. Brent practices and specializes in Behavioral Health to include adult mental health and substance use disorder med management. Brent's philosophy is to use the minimum amount of medication necessary to manage negative symptoms. One of Brent's goal in his practice is to promote cohesiveness in medical and behavioral health medicine between providers treating each patient considering all aspects of their health for good outcomes.

Supervising Physicians and Supporting Medical Staff

Supervising Physicians	*Dr. Tyler Mayo, DO Family Medicine/ General Family Medicine*
	Dr. Kayne Kishiyama, DO Psychiatrist
Nursing, Medical Assistants	*Amanda Robertson RN*
	Kathrine Wardell MA, Samantha Harris MA, Lidia Gomez-Contreras
Clerical Staff	*Kayla Binggeli – Clerical*

Patient/Parent/Guardian Printed Name: _____ **DATE:** _____

Signature - Patient/Parent/Guardian: _____ **DATE:** _____

Rehabilitative Health Services

Family Medical Clinic and Behavioral Health Service Provider

Why Choose a Primary Care Provider (PCP) in a medical clinic that is national recognized as a Primary Care Medical Home (PCMH) using best practice methods? AND What is a PCP and PCMH?

A primary care provider is a specialist in family medicine, internal medicine or pediatrics who is a patient's first point of contact. Patients who use a PCP have better health outcomes, including fewer deaths from cancer, heart disease, or stroke.

The benefits of choosing and maintaining a primary care provider (PCP) include:

1. **Continuity of care.** When a doctor is a PCP, he or she is "responsible for providing a patient's comprehensive care," according to the American Academy of Family Physicians. Routine check ups with the same doctor builds a relationship beneficial to the patient. Over time, the PCP develops a comprehensive snapshot of the patient's health which helps diagnose illnesses more accurately. A PCP also collaborates with other doctors and healthcare professionals, to keep track of any specialty care a patient receives.

2. **Medication management.** A PCP can serve as gatekeeper by keeping track of all medications a patient takes, noting any changes in dosages or frequency that could cause negative side effects. Medication can be monitored for contraindications, prompting the provider to review with the patient any side effects he or she may be having. The PCP can then recommend changes to the medications or consult with the prescribing providers to better manage the patient's medication regimen.

3. **Time savings.** When a patient has an established relationship with a PCP, issues that come up in between annual check ups can often be addressed quickly. The more familiar a provider is with a patient's history, the more effective and efficiently he/she can be in deciding the best course of treatment.

4. **Prevention.** The more a provider is aware of your overall health, the more likely they will be able to identify health problems before they happen. Having your overall health profile enables the primary care provider to recommend tests that can determine your risk of developing certain diseases, such as diabetes, heart disease and cancer. If you're at high risk, your PCP can recommend lifestyle changes you may need to make to help lower that risk and prevent becoming sick.

5. **Behavioral health.** Comprehensive care under the scope of a PCP includes monitoring a patient's behavioral health. The current recommendation is to screen adults and children age 12 for depression at primary care office visits. Patients are monitoring for depression, anxiety, and other more serious behavioral health needs to include addiction related issues.

RHS Evidence Based Care

RHS uses evidence-based care in medical treatment asking these 3 questions to maintain best practice approaches for treatment; 1)Why are we practicing this way, 2) Are we adhering to best practices, and 3) Can we produce better outcomes with consistency?

RHS PCPs acquire and apply best evidence practice and knowledge gained from published medical studies and journals; continuing formal education courses; questioning other providers in the community; drawing on the knowledge from each other within the practice;, personal experience in

treatment outcomes; and seeking current information from the RHS subscription to UpToDate (a subscription-based online resource designed to provide physicians access to current clinical information that is updated on a quarterly basis)

What is a Primary Care Medical Home (PCMH)?

RHS Family Medical Care is a Patient-Centered Medical Home (PCMH) where...

- Your treatment is coordinated through your PCP and care team to ensure you receive the necessary care when and where you need it, in a clear manner.
- You are an integral part of decisions for your care to include preventative care, health education and overcome barriers to your health care.

RHS...

- Facilitates partnerships between you and your personal physicians for both physical and mental health care, and when appropriate, your family.
- Communicates with other providers through all means to also include registries, information technology, and health information exchange with hospitals and other providers to assure that you receive comprehensive indicated care when and where you need it and want it.

What does this mean for you?

- **Comprehensive and Coordinated Care** RHS provides services or coordinates services with other providers to meet the large majority of your **physical and mental health care** including prevention and wellness, acute care, and chronic care. Coordination of care includes specialists, hospitals, home health care, community services and supports, particularly during transitions of care such as hospital discharge with clear and open communication. Specific care management is provided to RHS patients with complex health issues assisting patients in overcoming barriers to care and facilitating coordination of care with multiple providers.

- **Patient-Centered Care** RHS primary care is relationship-based with an orientation toward the whole person understanding and respecting your unique background and experiences. RHS supports you in learning to manage and organize your own care at the level you choose. RHS recognizes that patients and families are core members of the care team, fully informed partners in establishing your individual care plan.

- **Accessible Services** RHS offers same day urgent care and, as able, same day preventative visits with your chosen provider. RHS is open for your convenience 8-6 Monday – Thursday and 8-2 Friday. RHS will be launching a secure Patient Web Portal over the next year, where you can email your provider with a medical question, request medication refills, request referrals to specialty providers, access your lab/imaging results, and access your chart notes.

- **Quality and Safety** RHS is committed to quality care and quality improvement by using evidence-based medicine and clinical decision-support tools to guide shared decision making with you and your family. RHS engages in clinic performance measurement and improvement, measuring and responding to your experiences and your satisfaction. RHS participates in population health management (analyzing patient data to manage symptoms, treatment, and diagnosis among those with similar diseases processes or health issues), uncovers gaps in care, fills care gaps for your benefit while working to improve health outcomes, aligns physician diagnosis and treatment, coordinates care, reconciles medications, and works to create efficiencies in your care.

healthy connections

Enrollment/Change Form

As a participant in Idaho Medicaid, you are required to have a Primary Care Provider (PCP)

Fill in choice of PCP below (in box following "Birth Date") or one will be selected for you

ID Number	Participant Name	Birth Date	Name of Provider or Clinic

Are any of the above family members pregnant? Yes No

If yes, Name: Due Date:

If this is a change to your current Healthy Connections enrollment, please explain why you are changing:

_____

_____

- A list of participating PCPs can be found at www.healthyconnections.idaho.gov
- To choose your PCP by phone, please contact Healthy Connections at (888) 528-5861

Person Completing this Form (Participant or Authorized Individual) Please print clearly		
Name:		
Address:		
City:	State:	Zip:
Phone Number:		E-Mail Address:

I understand I am enrolling in Healthy Connections and I have read and understand the information on both sides of the form.

Signature:_____ Date:_____

Please return the completed form to:

Molina Medicaid Solutions
Member Services
P.O. Box 70081
Boise, ID 83707-0081

Healthy Connections Contact Information		
Phone: (888) 528-5861 (English & Spanish)	Fax: (888) 532-0014	E-Mail: HCCR7@dhw.idaho.gov

healthy connections

I agree to participate in Healthy Connections

Your Responsibilities:

- Establish care with your PCP and be involved in your healthcare decisions
- Present your Medicaid card each time your visit your PCP
- Make sure your PCP has made a referral before receiving services from another provider or specialist
- Cancel in advance if you can't make an appointment

Your Rights:

- To choose your PCP/clinic
- To request referrals for services
- Change PCP should your circumstances change
- To opt out of Healthy Connections if you are receiving Medicare, foster care, adoption services or are a member of a federally recognized tribe. *Note: Your PCP may require enrollment in the Healthy Connections program

Call your PCP/clinic for:

- Medical advice-any time, day or night, including weekends and holidays
- An office visit or a wellness visit
- Follow up care after an ER or specialist visit
- A Healthy Connections referral

Contact Healthy Connections to:

- Find a Healthy Connections Provider
- Change your PCP
- Get more information about Healthy Connections

Examples of reasons for changing PCP:

- Change to/from a PCP
- Moved out of the area
- Unsatisfactory customer service
- Change due to limited PCP hours/availability
- Changed due to pregnancy and prefers OB/GYN physician
- Have other family members going to clinic

I understand that:

Medicaid will not pay other health care providers to treat Healthy Connections patients unless they have a referral from your PCP/clinic or the service does not need a referral.

Healthy Connections Problem Resolution/Grievance Process Steps:

Step 1 Contact Healthy Connections office at (888) 528-5861 to discuss the problem. They may help you resolve your issues. If you are not satisfied, continue to step two.

Step 2 Please submit a written explanation of your grievance. You will receive a written response to your grievance. If you are not satisfied with the outcome, continue on to step three.

Step 3 You have the right to file for a Hearing. You may request a Hearing by writing directly to the address on your grievance response letter. You do not contact Healthy Connections to request a Hearing.