BEAR RIVER MENTAL HEALTH SERVICES, INC. **CLIENT ADMISSION FORM**

Client Legal Name: _____ Date of Birth: _____ Account #: _____
Client Preferred Name: _____ Client Preferred Pronoun: _____
Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Alternate Phone Number: _____ SS#_____

**Court document proving legal custody if divorce, separation, or unmarried parent OR proof of guardianship apply. Received: No ___ Yes___

**Does client have an Advance Directive? No _____ Yes_____ If yes, ask client to bring a copy to their appointment.

INSURANCE POLICY HOLDER'S (Attach a copy of the front and back of the insurance card.) Insurance Co._____

SERVICE CHARGES AND CO-PAYMENTS - Bear River Mental Health Services, Inc. (BRMH) is a not-for-profit company. Charges are based on real cost of services, which occasionally change. Payment for services may depend on the following: 1) All services for clients who are on Medicaid are paid for by Medicaid. 2) Clients who meet the State of Utah severity criteria may have a lower fee (sliding-fee) based on monthly household income. 3) Clients with private insurance, pay co-pays and deductibles decided by the insurance company. 4) Private pay clients who do not meet the State's severity, pay the full cost of services. The Center may help in billing your insurance company. **Your payment, co-payment, or Medicaid card is expected before you receive services.** At no time will your co-payment or insurance payments be greater than the full amount of service charges. Also, you will be charged the full amount if: 1) You do not live in Cache, Box Elder, or Rich counties; 2) Your insurance does not cover the services you receive; 3) You do not allow us to bill your insurance company; or 4) You do not meet State of Utah severity criteria. We cannot always set your payment status before you receive services. Therefore, ***you are responsible for the full cost of services***, which may or may not be offset through Medicaid eligibility, private insurance, or Center sliding-fee. I understand that my account can be given to an outside collection company if it is over 60 days past due. I may have to pay for all charges, collection costs, attorney costs (as well as those of BRMH), and court costs if action is taken to recover past due payments. **I may be charged for missed appointments unless I give notice 24-hours before my appointment.** I hereby allow payment of benefits directly to BRMH, otherwise to be paid to me, but not more than the full amount of the charges for service.

CLIENT DROP-OUT - More than 180 days of complete service inactivity will be considered as discontinuation of services and will result in case closure. Service may be re-established any time upon request.

MEDICAID LIABILITY WAIVER - BRMH does not hold Medicaid clients liable for: (1) BRMH debts in the event of insolvency, (2) covered services provided to the client for which the State does not pay, (3) covered services provided to the client for which the State or BRMH does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement, and (4) payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the client would owe if BRMH provided the services directly.

ACKNOWLEDGEMENTS -You should receive a copy of the ***Medicaid Member Handbook*** by mail. If not, please inform the receptionist. This handbook describes your mental health plan services and your rights and responsibilities. Pay close attention to the following parts: Emergency services (page 9), transportation (page 5), choice of therapist (page 8), grievances (page 18), and filing appeals (page 16).

I have received a copy of the Medicaid Handbook and a ***Notice of Privacy Practices***. _____
Client or Legal Guardian Signature

CLIENT'S RIGHTS - You have the right to get the best health care possible that agrees with YOUR own values. You have the right to:

1. Receive information on BRMH in easily understood prevalent languages and in alternative formats.
2. Be treated with respect, dignity and privacy, including privacy of current and closed records.
3. Be free from discrimination, abuse, neglect, mistreatment, exploitation, fraud, potential harm or acts of violence, and from any form of restraint or seclusion used other than for reasons of safety (e.g., to punish).
4. Receive information on other possible treatment choices, and a copy of preferred practice guidelines upon request.
5. Take part in treatment planning, as well as the right to refuse to be treated.
6. Make a written request to get a copy of your record, and if appropriate, to ask that it be corrected.
7. Receive timely health care services that meet BRMH quality standards for amount, duration and scope.
8. Communicate w/family, attorney, clergy, physician, counselor or case manager unless therapeutically contraindicated or court restricted.
9. Be informed of agency policies/procedures that affect client/guardian's ability to make informed decisions regarding client care:

Client rights are taken into account in the service delivery process. You may exercise your rights, without adverse effect by staff or providers.

BRMH is defined by Utah law as a "Secure Area." I will not bring weapons onto the premises, even though I may carry a concealed weapons permit.

Telehealth services may be provided as an option for treatment, which allows communication by two-way video technology. You may need equipment that allows web based video conferencing. There may be no technical support available to you if there are problems with the technology. Clinical material will be kept confidential. You or your provider may choose to end telehealth services at any time. I AGREE : 1) that the service provider determines whether telehealth treatment is appropriate; 2) to not record sessions for sharing in public forums/social media; 3) to hold BRMH harmless for information that is lost due to technical failures. I consent to the delivery of services via telehealth technology.
I understand all information listed above. I agree that I am responsible for the cost of services. ***I request and agree to be treated*** by BRMH, which may include appointment reminders via phone or text messaging.

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

_____ _____
Responsible Party Signature Date Responsible Party Date of Birth

_____
Print Name