VIEW POINT Health

Welcome to View Point Health.

We are honored to partner with you on your recovery journey.

Please give us your Name:_____

Please check the documents below that you have with you today:

- ☐ Proof of address (a recent utility bill, rent receipt, or lease agreement in your name).
- ☐ Proof of income (paycheck stub, letter from Social Security, DFCS or Earning Statement from the Department of Labor.)
- ☐ Identification card/document which has your picture on it (driver's license or photo ID).
- ☐ Medicaid or Medicare card if you will be using that for payment.
- ☐ Verification of lawful presence in the U.S.

(It's ok, if you don't have all the documents, just let the front office know.)

Here's what you can expect to happen today:

1. You will complete a brief screening to identify your needs (next few pages)
2. You will meet with a front office staff to enroll in services
3. You will meet with a counselor for an initial assessment

At the end of your session you will have the following:

1. A plan of care
2. An appointment with a doctor and nurse if needed
3. An appointment with a counselor
4. A referral to other supportive services and resources if needed

Please start by telling us one of the most important things we can help you with today,

View Point Health
Access to Services

Thank you for coming in today and for choosing View Point Health for your behavioral healthcare

Date of Referral: _____ Time Arrived: _____

Individual's Name: _____ DOB: ___/____/____ Age: _____ SSN: _____

Individual's Home Address: _____ City: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____ Primary Language: _____

Emergency Contact Name: _____Phone: _____ May VPH contact? Y ☐ N ☐

For Children Services Only: Are you the legal guardian? Y ☐ N ☐ (If N, Guardian Name: _____)

Are you currently a VPH client? Y ☐ N ☐ (If Y, which services are you receiving _____)

Are you having problems with your medication(s)? Y ☐ N ☐ Do you need a refill on your medication? Y ☐ N ☐

Do you have insurance? Y ☐ N ☐ (If Y, name of your insurance _____)

For New Clients: How did you hear about us?

☐ Family/Friend	☐ DBHDD	☐ Crisis Stabilization Unit
☐ County Jail	☐ Court	☐ Another Client
☐ Probation/Parole Office	☐ GCAL	☐ Another VPH program
☐ Public Defender's Office	☐ Inpatient Hospital	☐ Other: _____

Please tell us why you are here today (check all that apply)

☐ To being mental health treatment ☐ To begin substance abuse treatment ☐ Recently released from jail/prison
☐ Open DFCS case ☐ Referred by primary doctor ☐ Involved with adult probation or juvenile justice
☐ To be assessed for crisis; inpatient hospitalization or detox ☐ Other _____
☐ Hospital Discharge *(past 2 weeks)* Hospital _____ Admit Date _____ Discharge Date _____

Please tell us what problems you have had in the past three days (check all that apply):

☐ Depression	☐ Problems in relationships	☐ Domestic violence
☐ Anger/Aggression	☐ Work/school problems	☐ Court mandated/legal issues
☐ Paranoia	☐ Family recommended services	☐ Change in sleep patterns
☐ Anxiety	☐ Thoughts of killing myself	☐ Alcohol and drug use
☐ Seeing/hearing things others do not	☐ Thoughts of killing others	☐ Other: _____

Do you own a weapon? Y ☐ N ☐ Have access to a weapon? Y ☐ N ☐ Are you carrying a weapon? Y ☐ N ☐

Please select any applicable paperwork you are seeking for your job

☐ FMLA	☐ SSI/SSDI
☐ Work Assessment	☐ Other _____

Please know that View Point Health no longer prescribes controlled substances such as Xanax, Valium, Klonopin, Ativan or medication for adult attention/deficit hyperactivity disorder.

Note for SSI Disability Information Requests

If you have applied for social security benefits under Social Security Disability Insurance Program or Supplemental Security Income program (SSI), please know View Point Health will not complete SSI questionnaires or similar forms about your treatment unless you (1) have been in services with View Point Health for a minimum of 90 consecutive days and (2) have been examined by a View Point Health doctor at least once during that time period. Please know that if these conditions are met, View Point Health reserves the right not to complete SSI documentation.

_____ Initial here

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	*N/A*
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	*N/A*	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	*N/A*	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	*N/A*	*N/A*

VIEW POINT Health
A Total Care Perspective

myviewpointhealth.org

678-209-2411

Your Informed Consents

The following are informed consents that you'll be asked to sign at your initial appointment. These consents below are provided so that you can review prior to signing. These consents are written exactly as they'll appear for your signature.

Consent for Services

I consent to such medical, psychiatric and / or other service as the staff may recommend, including diagnostic tests and counseling. I agree to cooperate in the implementation of the services including follow through with terms and conditions of services recommended by staff. I have been informed that statistical information concerning my treatment will be submitted to the Georgia Department of Behavioral Health and Developmental Disabilities for compilation of statistical information statewide. I knowingly and freely agree to assume all such risks and responsibility for any injuries or damages that I may suffer that arise from my participation.

I understand that my healthcare provider will access Prescription Drug Monitoring Programs (PDMPs) to view any current or previously prescribed controlled substance prescriptions prescribed to me. These programs can help reduce the misuse of drugs from legal, medically authorized, to illegal uses of controlled substances.

Family Involvement Consent / Denial

I consent to have the family members listed below involved in the planning and delivery of the services that I shall be receiving from the agency for this period of service. I understand that, without this consent, the agency's employees will be prohibited to acknowledge to any family member that I am a consumer of services.

Consent / Denial for Contact

I consent to agency staff contacting me within 90 days of the termination of this period of service, in order to collect information on the outcomes of that service. I further consent to such contact being made through the following persons listed below.

Payment for Services Statement

Payment for services according to your ability to pay is expected. The state purchases services for individuals who have been determined to meet the *Core Customer* eligibility requirements, and who are unable to pay the maximum rate for services. These state funds; however, are limited and can only be used for those with no other means to pay for services. You can arrange for payment for services through your health insurance policy, Medicaid, Medicare, or through self-payment. You must complete this application to determine the most appropriate payment amount for your current situation. You must provide proof of income by providing a copy of a recent pay stub or your most recent tax return. If you have health insurance, you must provide a copy of proof of insurance including the group number and policy number. You will be responsible for any co-payment required by the insurance policy. Until this information is provided, View Point Health will bill you at 100% of the State approved charges for the services you receive. To apply for mental health or addictive disease services paid in full; in part by the state or to determine your fee for services, you or your guardian must complete a financial assessment with a financial counselor.

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Your Informed Consents (continued)

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Payment for Services Statement—continued

The organization has 30 days from the day you give them this signed application to act on it. This application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. During your financial assessment, please answer these questions completely and accurately. Failure to provide accurate information may result in you being charged the full charge or in the denial of services.

Consent for Contact

There may be times when we need to contact you regarding your services here at our agency. As a precaution to protect your privacy, we would like to know the best method for communicating with you. By signing this document, I am giving permission to be contacted by the method(s) indicated above. I have the right to change the preferred method of contact and may do so by informing a clerical support staff worker at this agency. I am responsible for keeping the agency updated with current contact information.

Financial Acknowledgements and Consent

I affirm that the statements above are true and accurately reflect my current financial circumstances.

I understand and agree that I am responsible for payment for services provided to my dependents or myself.

I understand that the organization may ask me for additional information to assist in making a final determination of my ability to pay.

I further understand that the organization may verify the information provided and I give my consent for the verification by signing this application.

I understand that my financial status will be reviewed annually or as circumstances change. I also understand that I have the option to review the decision by following the review process.

I agree for this agency to release any necessary information, including Alcohol and Drug Information (if applicable), to the appropriate Medicare fiscal intermediaries/carriers, Medicaid or Health Insurance Company for the purpose of pre-certification and/or re-certification of recommended treatment services and the filing of claims for services provided. For Medicare and Insurance Company covered services rendered, I hereby authorize payments directly to this agency.

I understand that I will be responsible for deductible and co-insurance charges.

I understand that services I have requested may not be covered under the Georgia Department of Community Health Services and/or contracted affiliates, or other insurance providers as being reasonable and/or medically necessary for my care.

If these services are determined not to be reasonable and/or medically necessary, I understand that I am responsible for payment of the services I request and/or receive.

ASSIGNMENT OF RIGHTS: I hereby authorize this agency to carry forward an appeal on my behalf as permitted by law. I understand that this does not obligate or require this agency to carry forward any such appeal, unless they so choose.