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

View Point Health
Access to Services

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

Date:_____ 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	☐ School
☐ Probation/Parole Office	☐ GCAL	☐ Physicians' office
☐ Public Defender's Office	☐ Hospital	☐ Other: _____

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

☐ To begin mental health treatment ☐ To begin substance abuse treatment ☐ Recently released from jail/prison
☐ Referred by DFCS ☐ 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:

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

Before going any further, please know that:

- **View Point Health does *not* complete paperwork for Disability (SSA/SSI), or employment related forms such as FMLA or return to work, or Emotional Support Animals, etc.**
- **View Point Health *will* provide educational/school related paperwork for children (ex, IEP). Requests must be made in advance; turnaround time is up to 3 weeks.**
- **View Point Health does *not* prescribe controlled substances such as Xanax, Valium, Klonopin, Ativan *or* stimulant medications for adult ADHD.**

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

View Point Health

Informed Consents

The following are informed consents that you'll be asked to sign at your initial appointment. The 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 services 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 databases to gather information on current or previously prescribed medications for the purpose of enhancing quality of care. Prescribed databases include those which monitor prescribed controlled substances. The information gained from prescription databases provides an accurate history of prescribed medications and may reduce the misuse of these medications.

Testing for Blood Borne Pathogens

Georgia law (OCGA 31-22-9.2) allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS/Hep C. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. (3) For all other patients, if my physician recommends an HIV or Hep C test, he or she will notify me and I will have the right to refuse the test at that time.

Family Involvement Consent / Denial

I consent to have the family members listed 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.

Follow-Up Contact Consent

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.

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 substance use 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.

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 pre- caution 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 Consent

- I affirm that the information provided regarding insurance coverage for me and/or my dependents (if applicable) is true and accurately reflects my current 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 the services I have requested may not be covered by my 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.