APPLICATION/REGISTRATION FOR SERVICES

VBH #:_____

Client Information

Client Legal Name: _____ Client Preferred Name:_____

Prior Names:_____ DOB: _____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Primary Language: ☐ English ☐ Spanish ☐ Other_____ Religious preference: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Race: ☐ Alaska Native ☐ Asian ☐ Black/African-American ☐ Native American ☐ White
☐ Pacific Islander or Native Hawaiian ☐ Other single race ☐ 2 or more races ☐ Decline to answer

Ethnicity: ☐ Dominican ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Assigned Gender: ☐ Male ☐ Female

Gender Identity: ☐ Agender ☐ Female ☐ Male ☐ Genderqueer ☐ Non-binary ☐ Transgender ☐ Other
☐ Don't know ☐ Decline to answer

Sexual Orientation: ☐ Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Don't know ☐ Other
☐ Decline to answer

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other ☐ Decline to answer

Currently in the U.S. Military: ☐ Yes ☐ No

Prior experience in the U.S. Military: ☐ Yes ☐ No

Are you homeless: ☐ Yes ☐ No

Parent (if client is a minor), Guardian, or Spouse Information Is the client a minor? ☐ Yes ☐ No

Parent/Guardian/Spouse Name: _____Date of Birth: _____SS:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Emergency Contact

Next of kin:

Name: _____Relationship to Client:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Other emergency contact:

Name: _____Relationship to Client:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Insurance Do you have Insurance: ☐ Yes ☐ No

Name of Insurance: _____Phone #:_____

Subscriber Name: _____Subscriber Date of Birth:_____

Subscriber (Policy) ID#:_____Relation to Client:_____

Primary Care Physician Do you have a Primary Care Physician: ☐ Yes ☐ No

Name:_____Specialty:_____

Address:_____City:_____State:_____Zip:_____

Office #:_____

Referral Source ____ Family _____ Friend ___ Hospital ____ Other: _____

Name:_____ Relationship to Client:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Email:_____

Acknowledgements

- I have received a copy of Valley's Notice of Privacy Practices.
- I have received a copy of Valley's Client Rights & Responsibilities.
- I have received a copy of the Advance Healthcare Directive brochure.

  ☐ I have an Advanced Care Directive ☐ I do not have an Advanced Care Directive
- I will: ☐ Request a copy of the Medicaid Handbook ☐ Download a copy of the Medicaid Handbook
- I understand all medications given to clients by Valley through medication monitoring are filled by or transferred to ValleyRx.
- I understand if I am placed on medication monitoring as part of my treatment, all medications prescribed from all non-Valley providers must be given to Valley to monitor, and Valley assumes the final responsibility for medication refills. If my treatment does not include medication monitoring, I am responsible for all medication refills that are not prescribed by Valley.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Valley Behavioral Health.
- I understand that if I have a grievance, I have the right to file a complaint with Valley's Client Advocate at 801-263-7135 and/or DHS Licensing at 801-538-4242/dhslicensing@utah.gov.

_____ (initial) I accept and understand the above acknowledgements.

_____ (initial) ***Abuse or Violence***: I acknowledge and understand that Valley may have a legal obligation to report or make referrals in instances of abuse of children and elderly or vulnerable adults to appropriate governmental or law enforcement agencies, and, further, that Valley may have a legal obligation to report or make referrals in instances of family violence or threatened crimes to appropriate governmental or law enforcement agencies. I further consent to such reports and/or referrals by Valley.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I certify that I understand the above information and that it is accurate and complete.

_____ _____

Signature of Client or Legal Representative Date

_____ _____

Printed Name of Client or Legal Representative Relation to Client

_____ _____

Valley Staff Signature Date

CONSENT TO TREATMENT

Client Name: _____
VBH #:_____
DOB: _____

CONSENTS/AUTHORIZATIONS

☐ Yes ☐ No I voluntarily consent (or I voluntarily provide consent for my child or the individual who I am legally responsible for) to receive treatment from Valley Behavioral Health. I have completed the Application/Registration form and reviewed the Privacy Practices statement and Fee Agreement. I fully understand these documents and agree to their terms.

☐ Yes ☐ No I understand that I may stop my treatment with Valley Behavioral Health at any time. The only thing I will be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court-ordered, I will have to answer to the court).

☐ Yes ☐ No I authorize Valley Behavioral Health to use my picture as part of my electronic medical record. Images will be stored in a secure location and only authorized staff will have access to them.

☐ Yes ☐ No *Emergency Medical Care*: I consent to receive first aid and emergency medical treatment. This consent would apply if I have an accident, injury, illness, or other medical emergency. I understand this applies only during treatment with Valley Behavioral Health (Valley). This also applies to minors admitted by a parent or guardian.

☐ Yes ☐ No *Electronic Communication*: I consent to receive electronic communications from Valley staff via email and/or text messages regarding my medical care and treatment, including communications about my prescriptions, appointments, and billing. I understand that there is a risk with electronic communication of being intercepted by third parties or transmitted to unintended parties. I understand that any email and/or text communications between Valley and myself regarding my medical care and treatment may be printed out and made a part of my medical record. I understand that in an urgent or emergency situation, I should not rely on electronic communication and call my provider or go to the Emergency Room. I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

☐ Yes ☐ No *Treatment*: I consent to treatment and testing/assessment by Valley whether face-to-face or via Telehealth. I understand testing includes, but is not limited to, intellectual, cognitive, developmental, and functional testing. I understand further informed consents may be required as treatment needs progress.

☐ Yes ☐ No *Treatment*: I consent to have blood drawn, urine samples tested, and/or other specimen testing if requested by my provider. I understand further informed consents may be required as treatment needs progress.

☐ Yes ☐ No *Primary Care Provider*: I authorize release of my treatment information to my Primary Care Provider for the purposes of continuity of care. If I have substance use diagnoses, I understand I am required to fill out a Release of Information form to release those specific records.

CONSENTS/AUTHORIZATIONS *(conrinued)* VBH #:_____

☐ Yes ☐ No ***Transfer/Discharge from Valley***: I authorize release of my treatment information in the event I am discharged or transferred from Valley services to the receiving clinician and/or program for the purposes of continuity of care. If I have substance use diagnoses, I understand I am required to fill out a Release of Information form to release those specific records.

I certify that I have read the above Consent to Treatment and that I fully understand and agree with its terms. I understand this consent is valid for one year and I have the right to withdraw consent at any time and for any reason.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I further understand I will be asked for consent and re-signature annually.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Printed Name of Client or Legal Representative Relation to Client

_____ _____
Valley Staff Signature Date

CLIENT FEE AGREEMENT

Fee Effective Date:	Client #:	Unit #:	Date of Birth:
Client Name:		SSN:	
Address:		Email:	
City:	State:	Zip:	
Home:	Cell:	Insurance:	

BY SIGNING THIS PAGE, I AGREE TO THE FOLLOWING ASSIGNMENT OF BENEFITS:

- I am a client with county funding or am unfunded □ Yes □ No - If yes, I agree to pay the corresponding fee/co-pay on a sliding fee scale based on my current income verification and dependents for clinical services. This fee is applicable to Outpatient or Residential services.
- Medicaid members do not have to pay for covered services received when they have Medicaid coverage.
- I accept responsibility for payments due for all services received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of Valley's contract with your insurance company.
- I understand that my insurance may not cover all services provided, and that I will be expected to pay for all uncovered services at the self-pay rates.
- I understand that Valley will bill my health insurance or other payor the full cost of services for all covered treatment and services that I receive.
- I understand that I will be expected to pay a discounted self-pay rate for services provided when I choose not to use my insurance or other funding.
- I understand that I must notify Valley of any changes to my insurance or coverage, and that by failing to do so I will be liable for the self-pay rate for all services provided.
- I understand that if my insurance is terminated and I am not covered on the date of service, I will be charged self-pay rates for all services performed.
- I agree to send Valley all payments from insurance or third-party payors that I receive directly, and that failure to do so will result in my being liable for such payments.
- I understand that a $25.00 service fee will be charged for each returned check.
- I understand that after 90 days of non-payment, Valley has the right to refuse to provide additional services, and to send my account to a collection agency for resolution.
- If my account is sent to a collection agency, I understand that I am liable for all costs including court filings, constable fees, attorney fees and interest accumulated at the legal rate on the unpaid balance until the balance is PAID IN FULL.

NEW CHOICES WAIVER (*IF APPLICABLE*)

- I and/or my designee agree to the following regarding payments for my Medicaid Liability:
  Rules and Regulations for Medicaid:
  - I understand that I am responsible to stay financially eligible for Medicaid. I am responsible to pay the Medicaid Liability, if applicable, to the Department of Workforce Services each month to remain in compliance with the rules and regulations of Medicaid.
  - I understand that the amount I pay is determined by the information I have given to my Department of Workforce Services Medicaid Worker.
  - I understand that failure to pay this amount can result in a loss of benefits and I may be disenrolled from FlexCare and the Medicaid New Choices Waiver Program.

CLIENT FEE AGREEMENT

- In signing as Financial Designee, along with this full agreement, I also agree I will assist this New Choices Waiver client in notifying Medicaid of all changes financially or otherwise applicable and assist the client in staying eligible for Medicaid during times of annual reviews and any documentation needed for verifications throughout the year.

- I also understand that I am responsible for the following while on the New Choices Waiver Program:
  - I understand that I am responsible to pay my Room & Board to the facility I reside in.
  - I understand that I will be financially responsible for items not covered by Medicaid, such as over-the-counter pharmacy products, co-pays on medical visits and hospital stays, and items used that may not be included with room and board agreement.
- I certify that the above information is accurate and complete. I agree to pay the full cost of services if I should become disenrolled from the New Choices Waiver Medicaid Program. I agree to notify my Department of Workforce Services Medicaid Worker of any and all changes to my income, including any medical deductions and/or insurance premiums.

AUTHORIZATIONS

- I authorize my insurance company or third-party payor to make payments, otherwise payable to me, directly to Valley. In the event that benefits paid exceed the total cost of services, Valley will be responsible for issuing a refund.
- I authorize Valley to pre-authorize with my insurance company, and to appeal on my behalf, any decision made by the insurance company regarding payment.
- I authorize Valley to disclose protected health information (PHI) to my insurance company, or any entity responsible for payment for my treatment, in order to obtain reimbursement.

This fee agreement covers all services provided by Valley Behavioral Health including both mental health and substance abuse.

I certify that the above information is accurate and complete.

Applicant's Signature:_____Date:_____

Authorized Representative Signature:_____Date:_____

Printed Name of Authorized Representative:_____Relationship:_____

Valley Staff Signature:_____Date:_____

Client No-Show and Late Cancellation Procedure

Valley Behavioral Health (Valley) prioritizes effective and personalized care. Clients are expected to attend each scheduled session on time. A cancelled or delayed appointment can negatively impact other clients. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without 24 hours' notice, we are often unable to fill the time slot.

Definition of No-Show: Missing an appointment, providing less than 24 hours' notice that you will miss an appointment, or being more than 15 minutes late to an appointment

By signing below, I understand and acknowledge the following:

____ I have read and understand the definition of No-Show.

____ If I miss an appointment without providing adequate notice, any recurring appointments may be canceled, and someone from my treatment team will reach out to reschedule the missed appointment.

____ If I have 2 no-shows/late cancellations within 90 days, a member of my treatment team will reach out to me to discuss barriers with engaging in treatment, create an engagement plan, and to reschedule the missed appointment if appropriate.

____ I may be offered a temporary scheduling plan as part of the engagement plan, which may include same-day appointments only, a change to in-person or telehealth appointments, or alternative appointment times.

___ I am responsible for attending scheduled services. I can, at any point, reach out to my treatment team to discuss barriers with attending treatment services and create an alternate scheduling plan.

____ If I have 3 or more no-shows within 90 days, I will be discharged from Valley Behavioral Health.

____ Valley will excuse no-shows for emergencies if I communicate the emergency as soon as possible. Emergencies include any of the following, whether it be the client or the client's immediate family: serious or contagious illness, car accidents, or death. Work issues do not constitute emergencies. In the event of bad weather or some emergencies, appointments can be changed to telehealth appointments.

____I understand the importance of communicating with my therapist and my treatment team.

Client Signature: _____ Date: _____

Printed Name: _____