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