

Open Access New Client Intake Package

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Pre-Admission Screening Form for Open Access

Last Name:		First Name:		MI:	
Address:			City:	State:	Zip:
DOB:	SSN:		Age:	Phone:	
Gender Assigned at Birth:		Gender Identity:		Preferred Pronouns:	

DATE: _____

What services are you interested in? Individual Therapy Family/Couples Therapy
 Community Support Groups Outpatient Group Therapy Residential Services
 Case Management

What type of insurance do you have? _____

Are you currently receiving therapy or psychiatric services? Yes No

If yes, please list: _____

Do you currently use substances (such as Alcohol, Cocaine or Marijuana)? Yes No

If yes, please list substance(s) and frequency: _____

Are you taking any psychiatric medication? Yes No

If yes, please list: _____

Are you currently having thoughts about hurting yourself? Yes No

If yes, please explain: _____

Are you currently having thoughts about hurting other people? Yes No

If yes, please explain: _____

Do you feel that you are in psychiatric crisis and need to speak to a crisis worker immediately?

Yes No

Have you had any recent psychiatric hospitalizations? Yes No

If yes, please explain (including dates): _____

How did you hear about Turning Point? My doctor A current or past TP client

Friends or family Heartland Health Care Referral Researching online

Another organization (please specify) _____ Other (please specify) _____

Please Note that Turning Point does not offer services for the following Emergency Housing, Psychological Testing, Substance Abuse, Eating Disorders, Vocational Services, Psychiatry, and Domestic Violence. We do not provide services to children under the age of 6.

FOR STAFF USE ONLY:

- If client answered yes to SI/II/Crisis questions, was EST (or TLR) called? Yes No
If no, please indicated reason: _____
- Open Access clinician client was assigned to: _____
- Was client seen by the OA clinician on the schedule for that day? Yes No
- If bonus email was sent asking for coverage volunteers, please indicate why (too many clients called, scheduled clinician called in sick, etc.):

If client was NOT sent on to a clinician for an Open Access Assessment, please indicate the reason below:

- Not appropriate for services/looking for services we don't provide
- Turning Point is not paneled with client's insurance
- Referred to EST/The Living Room
- Waiting list
- Other: _____

Please indicate the plan for the client (given resources, seen by Crisis staff, directed to come back another day, etc.):

NOTES:

Turning Point BHCC Client Information Profile

Date: _____
 Name (First, Middle Initial, Last): _____
 DOB: _____ Family size: _____ Household Annual Income: _____
 Client's Mother's Maiden Name ("Unknown" if not known): _____
 Emergency Contact: _____ Phone Number: _____
 Legal Guardian (if not self): _____
 Interpreter (please circle one): 0 Not Needed 1 American Sign 2 Foreign Language (Language _____)

For the following questions, please circle the correct response.

SEX: F—Female M—Male

LANGUAGE:

- 10 English
- 20 Spanish
- 90 Other
- 99 Unknown

RACE (If Hispanic, choose 90):

- 10 White
- 20 Black/African-American
- 30 Asian
- 40 American Indian
- 50 Pacific Islander
- 90 Other
- 99 Unknown

HISPANIC ORIGIN (If not Hispanic, choose 00):

- 00 Not Hispanic
- 11 Mexican/Mexican American
- 12 Puerto Rican
- 13 Cuban
- 14 Central or South American
- 18 Other Hispanic
- 19 Unspecified Hispanic
- 99 Unknown

MARITAL STATUS:

- 1 Never Married
- 2 Married
- 3 Widowed
- 4 Divorced
- 5 Separated
- 9 Unknown

EDUCATION LEVEL:

- 00 Never Attended School
- ___ Appropriate grade level (01-12)
- 20 Preschool/Kindergarten
- 30 High School Diploma
- 31 GED

- 32 Spec Ed Certificate
- 40 Post-Secondary Training
- 41 One year college
- 42 Two year college
- 43 Three year college
- 50 College Degree
- 60 Post Graduate
- 99 Unknown

EMPLOYMENT STATUS:

- 10 Employed (Including vacation/sick)
- 11 Full-Time
- 12 Part-Time
- 13 Full/Part-Time Subsidized
- 14 Vocational
- 20 Unemployed
- 30 Retired, Student, Homemaker
- 90 Other
- 99 Unknown

SSI/SSDI ELIGIBILITY:

- 0 Not applicable
- 1 Eligible, Receives Payment
- 2 Eligible, No Payment
- 3 Eligible, Pending
- 4 Eligible, Not Applied
- 5 Not Eligible
- 9 Unknown

CITIZENSHIP:

- Y U.S. Citizen
- N Not U.S. Citizen
- U Unknown

COURT/FORENSIC:

- 00 Not Applicable
- 01 Dept. of Corrections
- 02 Unable to Stand Trial
- 03 Unable to Stand Trial—Extended Term
- 04 Unable to Stand Trial—G2

- 05 Not Guilty by Reason of Insanity
- 06 Civil Court Ordered
- 07 Criminal Court Ordered Treatment
- 08 Court Ordered Evaluation
- 99 Unknown

MILITARY STATUS:

- 0 Not Veteran
- 1 Veteran
- 2 Active Duty
- 9 Unknown

HOUSEHOLD COMPOSITION:

- 10 Lives Alone
- 20 Lives W/One or More Relatives
- 30 Lives W/Non-Related Person
- 99 Unknown

RESIDENTIAL TYPE:

- 10 Homeless
- 21 Private Resident (Patient Supervised)
- 22 Private Resident (Patient Unsupervised)
- 31 Other Resident (Patient Supervised)
- 32 Other Resident (Patient Unsupervised)
- 40 Stated Operated Facility
- 50 Jail or Correction Facility
- 60 Other Institution Setting
- 80 Boarding School
- 90 Other
- 99 Unknown

**Turning Point Behavioral Health Care Center
Client Fee Agreement**

Please complete all sections:

Client Name:

Name of person to be billed:

Relationship to client:

Insurance Coverage: (Please check all that apply)

Self-Pay: _____

Private Ins: _____ Name of Private Ins: _____

Medicare: _____ Medicaid: _____

Medicaid Managed Care: _____ Name of Medicaid Managed Care Insurance: _____

Medicare Medicaid Alignment Initiative (MMAI): _____ Name of MMAI Insurance: _____

Other Coverage Type:

IF CLIENT WANTS TO RECEIVE A SLIDING SCALE COMPLETE THE FOLLOWING QUESTIONS
(ANSWER ALL THAT APPLY)

Proof of Income: (please enter the numbers for all that apply and instruct client to submit the forms)

IRS Form (1040)- Including spouse and dependents: _____

Pay Stub-reflecting current and year round earning: _____

Unemployment Benefit Statement: _____

Copy of SSDI check or bank statement showing SSDI: _____

Letter from SSDI stating Award Amount: _____

Bank Statement reflecting Direct Deposit of Income: _____

Letter From Employer Verifying Income Paid in Cash: _____

Letter of No Income from Client or Family Member: _____

Total Household Income:

Service Fee Schedule:

Per Hour:

Therapy (Individual/Family/Couples):	\$160
Group Therapy:	\$ 35
CSG Group:	\$ 35
Case Management:	

\$140

Client Fees (Based on household income):

Per Hour:

Therapy (Individual/Family/Couples):	\$ _____
Group Therapy:	\$ _____
CSG Group:	\$ _____
Case Management:	\$ _____

Private Insurance Deductible/Copay Information:

Please note that you will be billed at the time of your appointment only your estimated co-insurance or copay amount. Any additional charges, including deductible charges, will be applied to your account based on the explanation of benefits (EOB) sent back to Turning Point from your insurance company after claims have been submitted, and are your responsibility to pay. Please be advised that if your policy has a fixed number of visits allowed per calendar year, you will automatically be billed your self-pay fee when you have maximized your benefits. Self-pay fees are based on income and household size, so it is essential to present income verification. If proof of income is not presented, you will be charged the full fees for services.

General Insurance Information for All Clients:

Turning Point Behavioral Health Care Center offers a sliding fee scale to persons deemed eligible for a fee reduction, or those who do not have insurance benefits. The client must provide evidence of household income at the time of their initial appointment(s) to apply for this benefit. If the client doesn't provide evidence of household income, the client will be set at full fee of \$160.

The standard rate is expected from those who are determined to have the financial capacity to pay the actual cost of services. Fees are reviewed annually or as required. Clients are responsible for notifying Turning Point of all insurance coverage changes (including Medicaid coverage becoming inactive) as soon as possible so we may verify coverage and inform you if we accept your new insurance. If you are no longer covered by any type of insurance, an appointment should be made with a member of our Billing Team to reconfigure your fees based on your income level. This should be done in a timely manner so that you are not being back billed for services received after your insurance has been terminated.

Insurance Acknowledgements:

- Payment is due at time of service. If payment is not made at the time of service, you will not be seen for your appointment.
- Turning Point reserves the right to suspend services if the account balance exceeds two times the individual therapy fee.
- Telephone contacts with the clinician lasting more than five minutes may be charged on a prorated basis according to the individual treatment (IT) fee.
- Fees are based upon treatment offered and provided, not upon outcome.
- If you have a Medicaid spenddown, you will be responsible for paying the client rate for all services provided until you have met your spenddown and your Medicaid is active. If you do not meet your spenddown and lose your Medicaid, Turning Point will bill you your self-pay fee for all dates of services not covered by Medicaid.
- Case Management and Community Support Services (Individual and Group) are not covered by private insurance or Medicare.
- I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Turning Point Behavioral Health Care Center. A photocopy is to be considered as valid as the original.
- I hereby authorize Turning Point Behavioral Health Care Center to release any information acquired during my examination or treatment to my insurance carrier. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original.

I acknowledge and accept the above conditions:

Client Signature:

Date:

Staff Signature:

Date:

**Turning Point Behavioral Health Care Center
Communication Permission Form**

Name: _____

Date: _____

There will be times when we need to reach you regarding scheduling or other non-clinical issues. In order to ensure that we maintain confidentiality, please indicate which methods you will allow us to contact you, and if messages can be left if you are not available when we call.

If this information changes at any time, it will be your responsibility to contact us with the updated information.

When contacting you, can we:

1. Call: _____ Yes _____ No

Preferred Phone Number: (_____) _____ (Home/Cell/Work-circle one)

2. Leave a Message (identifying Turning Point) _____ Yes _____ No

3. Send Text Reminders for appointments: _____ Yes _____ No

Cell # (for text message reminders): (_____) _____

Cell Phone Carrier (must be completed for text message reminders): _____
Standard message data may apply

4. Send emails: _____ Yes _____ No

Email: _____ *Please Print Clearly*

I consent for my treatment providers at Turning Point to communicate with me in the formats indicated above. I understand that there are risks with electronic communication, and that if my digital device(s) does not have a security code, others who have access to them might be able to view my email/text messages/call log/voicemail. I also understand that the preferred way to communicate with my treatment providers is through face-to-face sessions or the telephone. In an emergency, I will call 911 or go to the emergency room for immediate assistance. I will call the Emergency Services Team at Turning Point at 847.933.0051 at any time if I am experiencing a crisis. This consent is valid for my length of treatment. I understand that I can revoke this consent at any time.

CLIENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

CLIENT SERVICES STAFF SIGNATURE

DATE

Turning Point Behavioral Health Care Center
No Show Policy for Clients
March 2022

1. Clients of Turning Point must attend at least one individual appointment with a therapist or case manager a month in order to stay open to services. If a client fails to follow this rule, services may be terminated.
2. If a client checks in at reception (or fails to answer a phone or video call) **more than 10 minutes** after the start of their appointment time, they will not be seen for that appointment and it will be **considered a no show**.
3. When there are attendance issues, clients can expect the therapist or case manager to be in touch regarding any possible barriers to treatment and to close clients when necessary.
4. Clients are to be placed on an attendance contract if any of the following missed appointment patterns emerge:
 - a. A client no-show/late cancels 3 appointments over a 90-day period,
 - b. A client has two no-show/late cancellations in a row,
 - c. A client cancels (with 24 hour notice) 4 appointments over a 90-day period.

At this point, the therapist or case manager may initiate phone outreach to the client. If the client cannot be reached by phone, the therapist or case manager will send a letter giving details about attending an appointment within the time frame given. The letter may also list the details of an attendance contract. If the client does not attend the appointment, then the client's case will automatically be closed. If the client attends the appointment, then the client will remain open and the client must abide by an attendance contract.

Missing any appointments (regardless of the reason) while engaged in an attendance contract will result in the immediate termination of services unless the clinician calls for an exception.

5. If a client successfully abides by the attendance contract for at least four appointments in a row, they can return to the regular scheduling procedure.
6. If a client is closed due to an engagement issue, the client will not be opened to the agency for **45 days from the deadline listed in the letter or the date of a failed attendance contract**. The therapist or case manager will put an alert in the client's electronic medical record notifying the clinician and support staff that the client cannot access services during this window of time.
7. Upon the 3rd violation of this policy in an episode of care, services will automatically be terminated. The client will not be allowed to re-enroll for 6 months following termination of services.

No Show Policy Acknowledgement

My signature below indicates that I have received a copy of Turning Point's No Show Policy.

The document has been reviewed with me by staff and I understand the content. I agree to follow these policies and procedures while participating in Individual Therapy and/or Case Management.

Client Signature, **Date**

Client Printed Name

Parent/Guardian Signature, **Date**

Parent/Guardian Printed Name

Staff Signature, **Date**

Staff Printed Name



ORIENTATION CHECKLIST

- Explanation of financial obligations, fees, and financial arrangements for services provided:
 - Copy of Client Agreements and Authorizations from CIS
 - Copy of Fee Agreement from CIS
 - Copy of Client Income Information Form from CIS (if applicable)

- Client Orientation Information (mail_____ or client will access online_____):
 - Turning Point Client Orientation Handbook, which includes:
 - Agency Map
 - Mission Statement
 - Contact Information, Office Days/Hours, and Services we Offer
 - Guidelines, Procedures and Client Expectations
 - Privacy Practices
 - Client Rights
 - Grievance Policy
 - Client Responsibilities
 - No Show Policy (and Acknowledgment)
 - Communication Permission Form (completed by client)

- Handouts (mail_____ or client will access online_____):
 - Code of Ethics
 - Mental Health Crisis information
 - Crisis Programs Brochure
 - Client Input and Quality Assurance
 - Advance Directives
 - Consumer Family Choice Handbook

CLIENT NAME (PRINT)

CLIENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

CLIENT SERVICES STAFF SIGNATURE

DATE

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