New Horizons of the Treasure Coast, Inc.
Outpatient services
Client Registration Instructions

1. Please complete the packet using **black ink.**

2. **Do Not sign** or have any forms witnessed prior to returning your completed packet into a New Horizons staff member. We will review the forms for completeness and have you sign the forms in our presence.

3. Please bring in a form of valid photo identification. **We Can't** process your request for services without it.

4. You must provide proof of household income (all members that are blood related that live in the same household) when applying for any sliding scale services. Any of the following documentation will be acceptable:
    i. Most Recent Federal Income Tax Return
    ii. Copy of your SSI, SSD ,retirement checks, Alimony or child support (electronic bank deposit acceptable).
    iii. You can log into www.ssa.gov to obtain proof of income or no income from the social security office.
    iv. Food stamp benefit letter

5. You must provide proof of residency through any one of the following ways. (full name and address). This is **ONY** required if you are applying for sliding scale services.
    i. Light bill, Phone bill or any bill or piece of mail with name and address on it.

6. If you have insurance a copy of your insurance card will be needed at time of registration.

7. If you are the legal guardian of an adult, or are not the biological parent of a minor, you must bring proof of custody and/or plenary guardianship papers in order for services to be provided. No adult or child will be registered and/or seen without the proper documentation. The biological parent or the guardian must be present at time of services.

If you need assistance completing your registration packets, please feel free to ask for help and someone will assist you.

If you are requesting a Court Ordered Evaluation, please provide a copy of the order when you turn in your registration packet.
Thank you,

If you are a new consumer requesting services with New Horizons for the first time, please take a minute and complete our New Consumer Survey conveniently located in each Outpatient Services Office.

NEW HORIZONS OF OKEECHOBEE AND THE TREASURE COAST, INC.
CLIENT REGISTRATION FORM

Office Staff Only ☐ New Client ☐ Readmission
MR#: _____ **Registration Date**: _____

_____
Client's Last Name **First Name** **Middle Name**

_____
Other Last Name (AKA) **Other First Name (AKA)**

_____
Street Address

_____
City **State** **Zip Code** **County**

Day Phone: ( ) _____ OK to call? ☐ Y ☐ N

Cell Phone: ( ) _____ OK to call? ☐ Y ☐ N

Soc. Sec. #: _____ - _____- _____ **Date of Birth** (mm/dd/yyyy**)**: _____/_____/_____

If client is a **child**, please provide the following information:

Mother's Name:_____ **Father's Name:**_____

For adults with a **plenary guardian**, and for all **children**, please provide the following information:
Guardian's Name: _____

Who is to be contacted regarding services? ☐Mother ☐Father ☐Either ☐Guardian

Are the contact numbers above for the person to be contacted? ☐ Yes ☐ No, use this #:_____

CLIENT DEMOGRAPHICS

Marital Status: ☐1 Single/Never Married ☐2 Married ☐3 Widowed ☐4 Divorced ☐5 Separated (not legally)
☐6 Unknown ☐7 Registered Domestic Partner ☐8 Legally Separated

Race: ☐1 White ☐2 Black ☐3 American Indian ☐7 Asian ☐8 Native Hawaiian/Pacific Islander ☐9 Multi-racial

Ethnicity: ☐1 Puerto Rican ☐2 Mexican ☐3 Cuban ☐4 Other Hispanic ☐5 Haitian ☐6 None of these

Education Level <u>Completed</u>: _____ **Gender:** ☐ Male ☐ Female

Primary Language: ☐01 English ☐02 Spanish ☐03 French ☐04 Creole ☐05 Combination ☐06 Other_____

Religion: ☐1 Protestant ☐2 Amish ☐3 Jewish ☐4 Buddhist ☐5 Moslem ☐6 Catholic ☐7 Other ☐8 Unknown

LGBT Status: ☐(L) Lesbian ☐(G) Gay ☐ (B) Bisexual ☐(T) Transgender ☐(N) Non-LGBT

Primary Care Physician: _____ **PCP Phone Number**: _____

NEW HORIZONS OF THE TREASURE COAST, INC.

CLIENT REGISTRATION FORM – Page 2

Employment Status: Are you employed? If so, which one of these categories applies?

☐10 Active Military, Overseas ☐20 Active Military, USA ☐30 Full Time ☐40 Part Time

☐50 On leave of absence from my job

If you are not currently employed, which one of these applies?

☐60 Retired ☐70 Recently Terminated/Unemployed ☐81 Homemaker ☐82 Student

☐83 Disabled ☐84 Criminal Inmate (Jail, Prison) ☐85 Other Inmate (Psychiatric Institution)

Disabilities/	☐ Yes	☐ No	Physically Impaired	☐ Yes	☐ No	Hearing Impaired
Limitations:	☐ Yes	☐ No	Visually Impaired	☐ Yes	☐ No	Non-Ambulatory
	☐ Yes	☐ No	Developmental Disability	☐ Yes	☐ No	Extreme Limited English

BRIEF HISTORY:

Who referred you to New Horizons, or how did you learn about us? _____

Have you ever received services at New Horizons before? ☐ No ☐ Yes

If so, when?_____

Please describe briefly why you are seeking services at this time:_____

_____

_____

How long has this been a problem? _____

What have you attempted to do about this so far? _____

_____

RELEASE FOR EMERGENCY CONTACT

New Horizons will need to be able to contact someone on your behalf should you have a medical/psychiatric emergency while receiving services at our facilities. Please tell us who to contact in the event of an emergency:

Name: _____

Address: _____

City: _____ **State:** _____ **ZipCode**: _____

Telephone: ( ) _____ **Relationship to you**: _____

Is this your legal guardian: ☐ Yes ☐ No

Client Signature:_____ Date:_____

Staff Signature:_____ Date:_____

NEW HORIZONS OF OKEECHOBEE AND THE TREASURE COAST, INC.
CLIENT REGISTRATION FORM

Office Staff Only ☐ New Client ☐ Readmission
MR#: _____ **Registration Date**: _____

_____
Client's Last Name **First Name** **Middle Name**

_____
Other Last Name (AKA) **Other First Name (AKA)**

_____
Street Address

_____
City **State** **Zip Code** **County**

Day Phone: ( ) _____ OK to call? ☐ Y ☐ N

Cell Phone: ( ) _____ OK to call? ☐ Y ☐ N

Soc. Sec. #: _____ - _____- _____ **Date of Birth** (mm/dd/yyyy**)**: _____/_____/_____

If client is a **child**, please provide the following information:

Mother's Name:_____ **Father's Name:**_____

For adults with a **plenary guardian**, and for all **children**, please provide the following information:
Guardian's Name: _____

Who is to be contacted regarding services? ☐Mother ☐Father ☐Either ☐Guardian

Are the contact numbers above for the person to be contacted? ☐ Yes ☐ No, use this #:_____

CLIENT DEMOGRAPHICS

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Race: ☐1 White ☐2 Black ☐3 American Indian ☐7 Asian ☐8 Native Hawaiian/Pacific Islander ☐9 Multi-racial

Ethnicity: ☐1 Puerto Rican ☐2 Mexican ☐3 Cuban ☐4 Other Hispanic ☐5 Haitian ☐6 None of these

Education Level <u>Completed</u>: _____ **Gender:** ☐ Male ☐ Female

Primary Language: ☐01 English ☐02 Spanish ☐03 French ☐04 Creole ☐05 Combination ☐06 Other_____

Religion: ☐1 Protestant ☐2 Amish ☐3 Jewish ☐4 Buddhist ☐5 Moslem ☐6 Catholic ☐7 Other ☐8 Unknown

LGBT Status: ☐(L) Lesbian ☐(G) Gay ☐ (B) Bisexual ☐(T) Transgender ☐(N) Non-LGBT

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NEW HORIZONS OF THE TREASURE COAST, INC.

CLIENT REGISTRATION FORM – Page 2

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Disabilities/	☐ Yes	☐ No	Physically Impaired	☐ Yes	☐ No	Hearing Impaired
Limitations:	☐ Yes	☐ No	Visually Impaired	☐ Yes	☐ No	Non-Ambulatory
	☐ Yes	☐ No	Developmental Disability	☐ Yes	☐ No	Extreme Limited English

BRIEF HISTORY:

Who referred you to New Horizons, or how did you learn about us? _____

Have you ever received services at New Horizons before? ☐ No ☐ Yes

If so, when?_____

Please describe briefly why you are seeking services at this time:_____

_____

_____

How long has this been a problem? _____

What have you attempted to do about this so far? _____

_____

RELEASE FOR EMERGENCY CONTACT

New Horizons will need to be able to contact someone on your behalf should you have a medical/psychiatric emergency while receiving services at our facilities. Please tell us who to contact in the event of an emergency:

Name: _____

Address: _____

City: _____ **State:** _____ **ZipCode**: _____

Telephone: ( ) _____ **Relationship to you**: _____

Is this your legal guardian: ☐ Yes ☐ No

Client Signature:_____ Date:_____

Staff Signature:_____ Date:_____

NEW HORIZONS OF THE TREASURE COAST, INC.

INFORMED CONSENT FOR FOLLOW-UP

Client's Name:	MR#:

We are asking for your permission to contact you after discharge in order to obtain feedback on the quality and effectiveness of the services you received. You may be contacted by staff at New Horizons, and/or if you received substance abuse services, a representative of the University of Florida (UF) may contact you by phone and conduct a brief survey. New Horizons utilizes the information internally for quality assurance and assistance in improving services. The University of Florida acts on behalf of the Department of Children and Families (DCF) and generates a summary report of findings, without identifying individual information, which is then submitted to DCF. All client information is protected by New Horizons, DCF and its representatives/agents to ensure confidentiality.

Please check the appropriate box and sign below:

☐ **I DO** **OR** ☐ **I DO NOT**

give permission to New Horizons of the Treasure Coast, Inc. (NHTC) and the Department of Children and Families or its affiliates to contact me for purposes of obtaining follow-up information concerning my progress since receiving services from NHTC. This information is used to determine if mental health and/or substance abuse services have been effective.

If you do give consent, please provide the following information:

Primary Phone # where I may be reached: ( ) _____

Secondary Phone # where I may be reached: ( ) _____

If the program is unable to reach me at this phone number, I **DO** give permission to speak with the following person listed below to inquire about any forwarding phone numbers or addresses where I may be reached. If follow-up personnel cannot reach me, I give permission for the person(s) named below to answer questions about my progress since leaving treatment/services by answering the questions in the follow-up survey. **(NOTE TO STAFF: A separate Authorization for Release of Information form must be completed.)**

Name:_____ Relationship:_____

Phone #'s:( )_____ ( ) _____

I understand that I have the right to revoke this authorization for Follow-Up Survey in writing at any time. This consent for Follow-Up expires 18 months after date signed unless cancelled by me.

I have read and fully understand the above Consent for Follow-Up.

Client/Patient Signature:_____ Date:_____

Parent/Guardian/GA Signature:_____ Date:_____

Staff Signature:_____ Date:_____

NEW HORIZONS OF OKEECHOBEE AND THE TREASURE COAST

ORIENTATION AND RECEIPT OF OUTPATIENT SERVICES HANDBOOK

Client: _____ MR#_____

The following items were provided in the Outpatient Services Handbook:

Mission/Vision Statements
About New Horizons
Non-Discrimination
Recovery & Resiliency
Code of Ethics
Client Rights: Mental Health and Substance Abuse
Notice of Privacy Practices
Advance Directives
Primary Care Physicians
Client and Family Responsibilities
Parental Consent/Legal Guardianship
Program Rules/Loss of Privileges/Regaining Privileges
Safe Environment
Weapons/Contraband Policy
Infection Control
Smoking
Grievance Procedures
Abuse Reporting
Charges for Services
No-Show and Cancellation Policy
Medical Staff
Description of New Horizon's Services
Outpatient Services Office Directory

My signature below indicates that I received and reviewed a copy of the Outpatient Services Handbook. I understand that I may ask questions about New Horizon's policies, procedures and services and at any time.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

NEW HORIZONS OF THE TREASURE COAST, INC.

FINANCIAL INTAKE FORM

Client Name:_____ MR #:_____

Financial Responsible Party:_____

EMPLOYMENT HISTORY

Employer:_____ Annual Income: $_____

Other Employer:_____ Annual Income: $:_____

Number of Days Worked in the Past 30 Days:_____ Income for the Past 30 Days: $_____

SSI/SSDI INFORMATION

SSI/SSDI Eligible: ☐1-Current Recipient ☐2- Past Recipient ☐3- Applicant ☐4- Not Applicable ☐5- Unknown

SSI/SSDI Monthly Income: $_____ SSI/SSDI Annual Income: $_____

Reason for SSI/SSDI: ☐ Medical ☐ Psychiatric (Explain):_____

OTHER INCOME INFORMATION

(1)Other Income Amount: $_____

Source of Other Income: ☐1-AFDC/TCA ☐2- Child Support ☐3- Alimony ☐4- Rental Income

☐5- Retirement Income ☐6- Workman's Comp. ☐7- Employment ☐8- Other

(2) Other Income Amount: $_____

Source of Other Income: ☐1-AFDC/TCA ☐2- Child Support ☐3- Alimony ☐4- Rental Income

☐5- Retirement Income ☐6- Workman's Comp. ☐7- Employment ☐8- Other

HOUSEHOLD INFORMATION

Primary Income Source: ☐1-Salary ☐2-AFDC/TCA ☐3-Retirement/Pension/SSI ☐4-Disability

☐5-Other (Specify):_____ ☐6-None ☐7-Unknown

Total **Household** Income: $_____ Total **Personal** Income: $_____

Total Dependent Children:_____ Total **Household** Dependents (**Include Children**):_____

INSURANCE INFORMATION
(ATTACH FRONT AND BACK COPY OF ALL INSURANCE CARDS)

Insurance Type: ☐1-None ☐2-Medicare ☐3-Medicaid ☐4-Private ☐ 5-Healthy Kids ☐6-HMO ☐7-Other

Insured Name (if different from client):_____ **Insured** Social Security #:_____

Relationship to Client:_____ **Insured** Gender: ☐Male ☐Female **Insured** Date of Birth:_____/_____/_____

COMPLETE ONLY IF NO INCOME

Are you disabled? ☐Yes ☐ No Have you applied for assistance? ☐Yes ☐ No Receive Food Stamps? ☐Yes ☐No

Who pays rent or mortgage?_____ Who pays bills and buys food?_____

NEW HORIZONS OF THE TREASURE COAST, INC

FINANCIAL AGREEMENT

Client Name: _____MR#:_____

I hereby guarantee payment to New Horizons of the Treasure Coast, Inc. for all charges for services and/or treatment of the above patient.

I understand that I am responsible for any deductible and/or co-payment required by a third party payer source under which I have benefits; i.e. Medicaid, Medicare, Insurance. I acknowledge that I will be responsible for payment of the Patient Responsibility portion of the charges as dictated on the Explanation of Benefits provided by my third party payer source. **An Authorization for Release of Information is required for New Horizons to process third party claims. If I refuse to sign this release, I am aware I will be billed and am responsible for the full fee.**

Medicaid/Medicare/Insurance Payment Assignment: I authorize payment of third party benefits directly to New Horizons of the Treasure Coast, Inc. for all services rendered by New Horizons of the Treasure Coast, Inc.

Sliding Fee Scale: If services are rendered that are not covered services under the benefits of my third party payer source or if I have no third party payer, then I understand that the charges will be assessed as a percentage of the standard fee for the particular service provided. This percentage shall be determined by the household income and number of individuals in the household based on the Sliding Fee Scale in effect at the time the service is rendered. For Crisis Stabilization services, the information provided on the Financial Intake Form will be used to **estimate** the percentage of fees assessed. **I am aware I must provide proof of income within 30 days or I may be responsible for the full fee. The sliding scale fee can vary from $25 up to $675 for the Mental Health Crisis Unit and the Detox Unit and from $15 up to $550 for the Mental Health SRT Unit**. For Outpatient services, proof of household income and residency will be required to support any financial discount.

I understand that in order for you to discuss financial or billing information with anyone other than myself, an Authorization for Release of Information is required.

_____Date:_____
Guarantor Signature

_____Relationship to Patient:_____
Guarantor Name

_____Date:_____
Staff Signature

NEW HORIZONS OF THE TREASURE COAST, INC

INFORMATION REGARDING NOTICE OF PRIVACY PRACTICES

Client Name: _____ MR#:__ _____

This is to inform you that your health information is protected by federal and state privacy laws. By law, we are allowed to release your information to other providers within New Horizons in order to coordinate your care and to provide a smooth operation of our services.

We may also release your records to outside agencies (Department of Children and Families, Medicaid, and/or The Commission on Accreditation of Rehabilitation Facilities) in order to monitor the quality of the services we provide or maintain data in the number and types of people we serve. Personal information will not be made public and is used for statistical and quality assurance purposes only. Other health information will not be released to anyone without your prior authorization.

New Horizons is legally required to report incidences of communicable diseases to the Department of Health. If, during the course of your treatment, it is determined by staff that you have acquired a communicable disease, this information will be reported. This report will be made only to those individuals who are required by law to be notified.

Please see our Notice of Privacy Practices brochure for further details on how your health information is protected. You have the right to obtain a written copy of this notice, if you should so desire.

_____Date:_____
Client Signature

_____Date: _____
Parent/Guardian Advocate Signature

_____Date:_____
Staff Signature