Valley Mental Health

821 Saginaw St South
Salem, OR 97302
phone 503 589-4046
fax 503 480-0484
www.valleymental.com

Patient Information

DATE: _____

LAST NAME: _____ _____**FIRST NAME:**_____**MIDDLE INITIAL:** _____

MAIDEN OR OTHER NAMES USED: _____ **GENDER M F RACE:** _____

DOB (MM/DD/YYYY): _____ /_____/_____ **Age:** _____ **SSN:** _____-_____-_____

STREET ADDRESS: _____ **APARTMENT #**_____

CITY_____**STATE**_____**ZIP**_____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): _____

CITY_____**STATE**_____**ZIP**_____

HOME PHONE: (_____) _____- _____ **MESSAGE OK? ___YES___NO**

CELL PHONE : (_____) _____- _____ **MESSAGE OK? ___YES___NO**

HOUSEHOLD INCOME/MONTH $ _____ **SOURCE** _____

PLACE OF EMPLOYMENT or SCHOOL ATTENDING: _____

WORK PHONE: (_____) _____- _____ **MESSAGE OK? ___YES___NO**

MARITAL STATUS (circle) Single Married Divorced Separated Re-Married Living as married

NAME OF SPOUSE/SIGNFICANTOTHER/GUARDIAN_____

EMERGENCY CONTACT: _____ **PHONE:** _____ **ROI** _____

PRIMARY CARE PHYSICIAN:_____ **PHONE:** _____

REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE._____

EMPLOYER:_____

SUBSCRIBER/MEMBER NAME: _____ **DOB:** _____

SUBSCRIBER ID # _____ **GROUP/POLICY #** _____

RELATIONSHIP TO PATIENT/CLIENT: _____

SECONDARY INSURANCE: _____

EMPLOYER: _____

SUBSCRIBER/MEMBER NAME: _____ **DOB:** _____

SUBSCRIBER ID # _____ **GROUP/POLICY #** _____

RELATIONSHIP TO PATIENT/CLIENT: _____

COMPLETE FOR ADULT RESPONSIBLE FOR PAYMENT OF CHARGES NOT COVERED BY INSURANCE

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LAST NAME: _____FIRST NAME:_____MIDDLE INITIAL: ____

DOB (MM/DD/YYYY): _____ /_____/_____ SSN: _____-_____-_____

_____ By my signature below, I am giving my consent to enter into treatment under the conditions listed below which is a copy of the consent on the Registration sheet.
(initial)

As a client of Valley Mental Health, your treatment may be provided by a subcontracted therapist and/or at a satellite office. As such, any physician or therapist associated with Valley Mental Health may review your records in part or in whole. Otherwise, clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be released to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as VMH employees and subcontractors are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse and evidence of past or current elder abuse. Additionally, confidentiality may be broken in the event that the information we have could help save your life in a life-threatening emergency. If you have questions about confidentiality, please feel free to discuss them with your therapist.

Entering mental health treatment is a courageous step. You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. Your therapist may ask you to participate in activities or ask you to do tasks outside the "therapy hour". While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You will be involved in the process of designing and implementing, and the periodic review, of your treatment plan. You have the right to be informed of your mental health diagnosis after the mental health assessment is completed and the purpose of any prescribed medications and potential side effects. You also have the right to withdraw consent and file a grievance or request a hearing at any time. If you have any questions about the nature of your treatment, talk directly to your therapist as soon as the question arises.

_____ I have received a copy a fee schedule.
(initial)

My signature below indicates that I have read the above information and am requesting mental health treatment from Valley Mental Health or its subcontracted providers. I hereby consent to treatment and take responsibility to pay for treatment. I understand that the established fee for services at Valley Mental Health includes office visits, client telephone contacts, and professional consultations on the client's behalf. The established fees for services is _____ per hour, including assessment, individual/family services, or group services. I understand and agree to make payment directly to Valley Mental Health for any fees or copays due. I understand that if I do not follow this agreement, Valley Mental Health reserves the right to deny services. I have received and read a copy of the office policies. I understand that I will be charged for appointments that are missed or canceled with less than 24 hours notice and that my insurance will not be billed. I also understand that if I miss three or more appointments, my therapist has the option of discharging me. I authorize this office to release any information necessary to expedite insurance claims to the insurance companies listed above or to any subsequent insurers, should my health insurance change. This includes information about psychiatric treatment and/or drug and alcohol treatment. This will include my diagnosis and for some insurers may also include my treatment plan or the full text of my chart.

_____ I have received a copy of my Rights and Responsibilities.
(initial)

_____ I have received a copy the Grievance Procedure.
(initial)

SIGNATURE:_____

DATE:_____

I am the Patient _____ the Parent_____ the Guardian_____

NOTE: Clients with Medicaid funding will not be charged for services and will not be responsible to pay for missed appointments.