Collaborative Care Program Application (Intake)

Name:		Today's Date:
Street Address:		City:
State:		Postal Code:
Phone: (home)		(Cell) (Work)
Email Address:		Preferred Method of Contact:
Name of Parent/Guardian (if under 18):		
Gender *(circle)*: M F Gender Identity:	Date of Birth: Social Security #:	
Family Doctor:		
Referring Doctor:		
Emergency Contact:		Phone:
How did you discover this clinic? *(please circle)*	Family Doctor | Specialist | Friend/Family | Yellow Pages | Website | Facebook | Other *(please specify)*:	

Health Insurance

Insurance company:
Policy Number:
ID Number:
Policy Holder Name: ☐ Same as above ☐ Other:
If the patient is not the policy holder, please indicate relationship: Spouse Child
Policy Holder's Date of Birth:

Income-Based Information (*client must provide proof of income to be eligible for discounted services*)

Current Monthly Household Income (all persons)	
# of People in Household (Include yourself)	
Rent or Mortgage	
Loans (Auto, Student)	
Credit Card Payments	
Insurance (Home, Life, Auto)	

Acceptable forms of documentation include (please provide one of the following)

- Pay Stubs representing 4 consecutive weeks of wages paid within the last 6 months; or
- Federal tax return for the prior tax year; or
- A letter of means of support (i.e. food stamps, housing assistance, social security, etc.); or
- Statement from the IRS stating the client does not file a tax return.

Debt to Income Ratio will be considered for this program as long as the client enrolls and successfully completes Horizons Budget/Debt Management Counseling Program. Failure to complete the debt management program will terminate all income-based services through the Collaborative Care Program.

To be considered for the Collaborative Care Program all applicants must be referred by a physician in order to receive care and discounted services. A referral form will be provided to have your PCP sign. If you do not have a PCP you will be referred to a free clinic for approval.

MEDICAL INFORMATION

List current medications:
____
____
____

List present or previous health problems:

____
____
____

GENERAL INFORMATION

Age: ________

Occupation: ___________________

Are you… Working?
On Disability?
Retired?
On Unemployment?

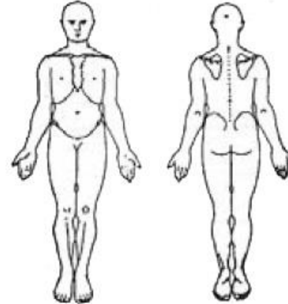
Race:
____

Family Status/Who lives with you?
____
____

Children and Ages:
____
____

What do you hope to gain from your treatment?
____
____
____

INDICATE THE LOCATION OF YOUR PAIN ON THE DIAGRAM:



GENERAL HEALTH

Do you have any of the following?

Diabetes?	Y	N
Heart Trouble?	Y	N
Epilepsy?	Y	N
High Blood pressure	Y	N
Circulation problems?	Y	N
Osteoporosis?	Y	N
Bowel/Bladder Problems?	Y	N
AIDS/HIV positive?	Y	N
Do you smoke?	Y	N
Have you ever had cancer?	Y	N
Have you ever experienced dizziness or blackouts?	Y	N
Sudden weight loss?	Y	N
Breathing problems?	Y	N
Are you pregnant?	Y	N
Recent surgery?	Y	N
Arthritis?	Y	N

List other healthcare professionals you are working with.
____
____

List any allergies:
____
____

Informed Consent for Treatment

We welcome you into our program, and hope that the work we do here will improve your life. The following information is important for your consideration. Your goals are more likely to be met when you understand the nature and limitations of alternative therapies. **Your signature will indicate that you voluntarily consent to entering this program through an informed decision.** You may withdraw consent at any time without risk of punitive action.

The Wellness Center is a 501(c)(3) non-profit organization who has dedicated a certain amount of funds to be used for services through our network of professionals in Linn County, Iowa. Funds are available for those facing financial hardship and those who suffer from serious chronic illness or pain. All service providers have been certified and are insured, if applicable. We are not a medical establishment, nor do we diagnose disease. It is a requirement of the program to have a medical referral from a physician before your application will be approved.

Benefits and Risks

Generally, alternative therapies are most useful for helping individuals help themselves to improve their quality of life by changing lifestyle behaviors. The client determines the nature and amount of change they wish to make. Most people experience improvement of concerns that brought them into this program, but of course, there are no guarantees; and there are some risks. For example, this program can open new levels of awareness that may cause discomfort. If after the intake session you decide to enter this program, your provider will review the plan with you and describe the determined course of action, specific procedures to be followed, the risks associated with participating or not participating in therapies, and alternative treatments if available.

Length of Program

The length of time enrolled in this program will vary depending on the current complaint; however, as a rule we work to resolve issues in the fewest possible visits. Upon acceptance into the program there will be a re-evaluation period every 3 months and a renewal application will be required each year. If you do decide to withdraw from this program, you should discuss this decision with your care coordinator. Due to the nature of this clinic, if a file goes 60 days with no activity, it will be closed. If you wish to apply again in the future, the file may be reopened.

Confidentiality

We understand that the information you share during your time in the program can be very personal and that by signing this Informed Consent for Treatment, you acknowledge receipt of the Client Rights and Responsibilities document. That document describes your rights and obligations.

Billing and Fees

Each provider will accept payment at time of service depending on the discount granted to your application. When requested, each provider can assist you in seeking payment from your insurance by providing necessary information to your insurance carrier. Please note, not all providers can accept insurance. If a health insurance will be covering your therapies you are required to pay your co-payment at each session. If you qualify to free services The Wellness Center will repay the co-payment to you as needed or pay for your appointment completely if insurance is not accepted by the provider. If insurance denies coverage or payment for any reason, you remain responsible for paying any outstanding balance.

Cancellation of Appointments

If you need to change or cancel an appointment, as a courtesy to your provider and the office please notify THAT specific provider at least 24 hours in advance. Please do not call your Care Coordinator to cancel an appointment as they might not get the information in time. Each provider has their own cancellation policy that they will enforce. If showing up for appointments becomes a recurring issue you may be terminated from the program.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding this program at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

Payment arrangement is as follows: INSURANCE: YES___ NO___ CLIENT PAY: $_______

Parents of minors receiving services: I authorize____________________________ to receive services provided by The Wellness Centers' Providers. This authorizes any necessary evaluation or therapies. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following ways may be required: assessment, home/lifestyle changes or family counseling.

Signature____ Date_______________

Signature____ Date_______________

Signature____ Date_______________

Release of Information **Client Name:** **DOB:**

I, hereby authorize The Wellness Center to release verbal and/or written information to:

_______________________________________ _______________ _________________
Name of person or entity information is to be released/received Phone Fax

____
Address

For the following purposes:

☐ All of the following: ☐ Treatment and assessment ☐ Coordination of Care ☐ Referral of new or additional services
☐ Other:

Specific information to be released includes:

☐ All of the following: ☐ Assessment and diagnosis ☐ Treatment goals ☐ Session content/notes ☐ Discharge
☐ Other:

I understand that by signing this General Authorization I am authorizing The Wellness Center to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to The Wellness Center.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to The Wellness Center. I understand that my revocation of this General Authorization will not affect disclosure that The Wellness Center has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by The Wellness Centers' confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized. I understand that signing this is not a condition of receiving services. This authorization will expire on _____________ or 12 months from the date it was signed.

_________________________________ _______________________________ ____________
Printed name of client Signature Date

_________________________________ _______________________________ ____________
Printed name of Parent or Legal Guardian Signature Date

_________________________________ _______________________________ ____________
Printed name of Witness Signature Date