~VMH~
Valley Mental Health

821 Saginaw St. S.
Salem, OR 97302
503-589-4046

Patient Information

DATE: ____________________

LAST NAME: ____________________ FIRST NAME: ____________ MIDDLE INITIAL: ________

MAIDEN OR OTHER NAMES USED: ____________________ GENDER: ☐ M ☐ F ☐ OTHER

ETHNICITY: __________ DOB (MM/DD/YYYY): _____ /_____/_____ Age: ____ SSN: _______-_____-______

HOME ADDRESS: ____

MAILING ADDRESS (IF DIFFERENT): ____

HOME PHONE: (_____) __________- ______________ MESSAGE OK? ☐ YES ☐ NO

CELL PHONE : (_____) __________- ______________ MESSAGE OK? ☐ YES ☐ NO

PLACE OF EMPLOYMENT OR SCHOOL ATTENDING: ____

WORK PHONE: (_____) __________- ______________ MESSAGE OK? ☐ YES ☐ NO

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Re-Married ☐ Living as married MILITARY STATUS: ________

☐ PARENT AND/OR ☐ GUARDIAN: ____

HOME ADDRESS (IF DIFFERENT): ____

PRIMARY CARE PHYSICIAN: ______________________________ PHONE: ______________

ADDRESS: ____

EMERGENCY CONTACT: ______________________________ PHONE: ______________

ADDRESS: ____

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: ____

Revised 3/2011

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

LAST NAME: ______________________________FIRST NAME:_________________________MIDDLE INITIAL: ____

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

____________ (initial) By my signature below, I am giving my consent to enter into treatment under the conditions listed below.

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 Individual Service and Support Plan. If you have any questions about the nature of your treatment, talk directly to your therapist as soon as the question arises.

____________ (initial) I have received a copy of the VMH Fee Schedule. It has been explained to me that OHP members will not be billed for any services. Other insurances will be billed as appropriate.

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

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

____________ (initial) I was offered and/or completed a Declaration of Mental Health.

____________ (initial) I was instructed about my right to have a Medical Advance Directive.

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.

Revised 3/2011