Compass Health Network

WELCOME
We are here to help

To better assist you, we ask that you answer the following questions along with the other questionnaires in this packet. If you need assistance, please ask the receptionist staff or the staff member that you meet with for the screening.

1. Are you currently feeling like harming yourself or anyone else? ☐ Yes ☐ No
2. Are you here to complete SATOP services? ☐ Yes ☐ No

Are you seeking opioid treatment? ☐ Yes ☐ No If you answered YES are you in Clinton, Warsaw, Warrensburg, Higginsville, or Sedalia, please STOP completing this form and inform the front desk.

Client Name: _____ Alias/Preferred Name: _____

Sex (Assigned at Birth) ☐ Female ☐ Male ☐ Unknown Client Date of Birth : _____

How were you referred to Compass Health Network? _____

Client Social Security Number: _____*(required for Medicaid or other state funding programs)*

Client Address: _____ City, State, Zip : _____

Mailing Address (if different): _____ City, State, Zip : _____

County: _____ Country of Residence, if other than US: _____

Client Home Number: _____ Client Cell Phone: _____

Client Work Phone: _____ Client Email Address: _____

Is it okay to contact you? ☐Yes ☐ No

What is your communication preference? ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text

Can we leave a voicemail message for you? (Check all numbers as appropriate)

☐ Home Phone ☐ Cell Phone ☐ Work Phone

Primary Language:_____ **Preferred Language:**_____

Do you require an interpreter? ☐Yes ☐ No

Client Race: (select all that apply):

☐ African-American or Black
☐ American Indian or Alaskan Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Decline

Ethnic Origin:

☐ Decline
☐ Hispanic Origin: Cuban
☐ Hispanic Origin: Mexican, Mexican American, Chicano/a
☐ Hispanic Origin: Puerto Rican
☐ Hispanic Origin: Other _____
☐ Not of Hispanic Origin

Have you experienced any type of homelessness in the past year?

☐ No
☐ Homeless Shelter
☐ Doubling Up (living with others, "couch surfing")
☐ Transitional Housing (small unit where people transition from a shelter)
☐ Living on the street (vehicle, outdoors, or encampment)
☐ Other (reside in hotel/motel)
☐ Unknown

Employment Status:

☐ Employed Full Time (35+ hrs/week)
☐ Employed Part Time (<35 hrs/week)
☐ Disabled
☐ Homemaker
☐ Inmate
☐ Other
☐ Preschool
☐ Retired
☐ Student
☐ Receiving Support to Seek employment
☐ Seasonal Employment
☐ Seeking Employment
☐ Sheltered Workshop
☐ Supported Employment
☐ Unemployed
☐ Unemployed-Lay off

Occupation:_____

Marital Status:

☐ Common Law
☐ Divorced
☐ Living as Married
☐ Living Together
☐ Married
☐ Never Married
☐ Remarried
☐ Separated
☐ Widowed

Highest Year of Education Completed: _____

Hearing Status:

☐ Deaf ☐ Hard of Hearing ☐ Normal ☐ Unknown

Gender Identity: (not required for patients under age 18)

☐ Choose not to disclose
☐ Female
☐ Male
☐ Non-Binary
☐ Other
☐ Transgender (FTM)
☐ Transgender (MTF)
☐ Unknown

Sexual Orientation: (not required for patients under age 18)

☐ Asexual
☐ Bisexual
☐ Chose not to Disclose
☐ Lesbian, gay or homosexual
☐ Other
☐ Pansexual
☐ Queer
☐ Questioning
☐ Straight or heterosexual
☐ Unknown

Preferred Pronouns:

☐ She, Her, Hers
☐ He, Him, His
☐ They, Them, Theirs
☐ Other, Please describe _____

Tobacco Use

☐ Daily use of tobacco products
☐ Never used tobacco products
☐ Occasional use of tobacco products
☐ Previous use of tobacco products, with no use in the past 90 days
☐ Unknown

Are you planning to quit nicotine/tobacco?

☐ Yes, actively quitting
☐ Yes, plan to quit today
☐ Yes, plan to quit within 30 days
☐ Yes, plan to quit within 6 months
☐ Not sure
☐ No, not planning to quit at this time
☐ NA – previously quit

Living Arrangements:

☐ 18+ and Alone
☐ 18+ and Homeless
☐ 18+ in Homeless Shelter
☐ 18+ in Jail/Correctional Facility
☐ 18+ with Adult Foster Care
☐ 18+ with Family
☐ 18+ in Nursing Home
☐ 18+ with Other
☐ 18+ with Parent/Siblings
☐ 18+ with Transitional
☐ 18+ with Unrelated Person
☐ 18+ with Spouse only
☐ CSTAR Residential
☐ CSTAR Supported Housing
☐ Oxford House
☐ Residential Care Facility
☐ Under 18 with both parents
☐ Under 18 with foster home
☐ Under 18 and homeless
☐ Under 18 with independent living
☐ Under 18 with other relatives
☐ Under 18 with other
☐ Under 18 with Private care facility
☐ Under 18 with Public care facility
☐ Under 18 with Single parent
☐ Under 18 with Parent/step-parent
☐ Refuse to Answer

Migrant Worker Status:

Are you or a family member a current or former migratory or seasonal agricultural worker? ☐ Yes ☐ No

Military Services

What is your Military Service? ☐ Active Duty/Reserves/Guard ☐ Veteran ☐ N/A

Do you have a loved one who is a service member or veteran? ☐ Yes ☐ No

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐No
Branch:_____ From/To Dates:_____
Have you ever served in the U.S. Armed Forces? ☐ Yes ☐ No
Are you currently serving in the U.S. Armed Forces? ☐ Yes ☐No
Are you currently serving in the National Guard? ☐ Yes ☐ No
Is the family member currently serving in the National Guard? ☐ Yes ☐No
Is the family member currently serving federal active duty? ☐ Yes ☐No

Is the patient their own guardian? ☐ Yes ☐No If not, complete the table below. If yes, skip to Emergency Contact section.

Parent/Guardian (s)	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship:		
Address:		
Phone		

Emergency Contact Name: _____

Emergency Contact Relationship to Client:_____

Address: _____

Phone Number: _____

Annual Family Income: $_____ Number in Household: _____

PLEASE PRESENT YOUR INSURANCE CARD TO FRONT DESK STAFF

Insurance: _____

Subscriber Information – *If someone other than the patient*

Subscriber Name: _____

Date of Birth: _____SSN: _____ Sex: ☐Male ☐Female

Relationship to Patient: _____

Address (if different than patient's): _____

Primary Phone: _____Alternate Phone: _____

Presenting Concerns:

☐ Anger	☐ Anxiety	☐ Behavioral Issues	☐ Bipolar Disorder
☐ Depression	☐ Relationship issues	☐ Employment Issues	☐ Family Issues
☐ Financial Issues	☐ Gambling addiction	☐ Housing Issues	☐ Parenting Issues
☐ Internet misuse	☐ Legal Issues	☐ Marriage	☐ PTSD
☐ Stress	☐ Schizophrenia	☐ Substance Abuse	☐ Decline in Grades
☐ Grief/Loss	☐ Physical/Sexual Abuse	☐ Domestic Violence	☐ Other _____

Are you satisfied with your eating patterns? ☐ Yes ☐ No

Do you ever eat in secret? ☐ Yes ☐ No

Would you like Compass to collaborate (exchange records) with your primary care provider? ☐ Yes ☐ No

MINI HEALTH SCREEN

Do you have a Primary Care Physician/Pediatrician? ☐ Yes ☐ No

Physician Name: _____ Physician Phone Number: _____

Physician Address: _____

Street City State Zip

Have you had a physical exam in the last year? ☐ Yes ☐ No

Do you have a Dentist ☐ Yes ☐ No

Have you seen a dentist in the past year? ☐ Yes ☐ No

Have you or close family members (parents/grandparents) been diagnosed with any of the following conditions?

	Self	**Parent/Grandparent**
Diabetes/Pre-Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Hyperlipidemia (high cholesterol)	☐ Yes ☐ No	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	☐ Yes ☐ No
Hypertension (high blood pressure)	☐ Yes ☐ No	☐ Yes ☐ No
Cardiovascular (heart) Disease	☐ Yes ☐ No	☐ Yes ☐ No

Do you use tobacco or nicotine products (Vape, Juul, cigarettes, cigars, chewing tobacco, etc)?

☐ Daily Use ☐ Never Used ☐ Occasional Use ☐ Previous Use, no use in past 90 days ☐ Unknown

Have you received mental health or substance use treatment in the past? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently receiving behavioral health services from another agency? _____

If so, which agency, and for what purpose? _____

Have you been hospitalized or gone to the emergency department in the last year? ☐ Yes ☐ No

Psychiatric reasons _____

Medical reasons _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

If yes, are you receiving prenatal care? ☐ Yes ☐ No

If yes, name of provider or clinic _____

How many times in the past year have you had
Men- 5 or more drinks per day
Women or all adults older than 65 years- 4 or more drinks per day

- ☐ 0-1 times
- ☐ 2-3 times
- ☐ 4-5 times
- ☐ 6+ times

Please list all Prescription medications you are taking _____

_____

_____

_____

_____

Please mark any prescribed medications below that you are taking:

☐ Pain Medications ☐ Anxiety Medications ☐ Muscle Relaxants

Please list all Over the Counter medications you are taking _____

_____

_____

Inspire Hope. Promote Wellness.
compasshealthnetwork.org

Compass Health Network

ACCESS TO CARE - ADULT

PATIENT NAME: _____ DATE: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly Every Day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Having a poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down in some way	0	1	2	3
7.	Trouble concentrating on activities, such as reading, playing games, computer activities, or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? – or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or wanting to hurt yourself in some way	0	1	2	3
				PHQ9 SCORE:	

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely Difficult

I made plans to end my life in the last 2 weeks? ☐ Yes ☐ No

ACCESS TO CARE - YOUTH

PATIENT NAME: _____ DATE: _____

PHQ-A

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.		Not at all 0	Several days 1	More than half the days 2	Nearly Every Day 3
1.	Feeling down, depressed, irritable, or hopeless?				
2.	Little interest or pleasure in doing things?				
3.	Trouble falling asleep, staying asleep, or sleeping too much?				
4.	Poor appetite, weight loss, or overeating?				
5.	Feeling tired, or having little energy?				
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?				
7.	Trouble concentrating on things like school work, reading, or watching TV?				
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?				
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?				
				TOTAL SCORE:	

CAGE-AID Substance Abuse Screening Tool

1. Have you ever felt you ought to cut down on your drinking or drug use?

YES NO

2. Have people annoyed you by criticizing your drinking or drug use?

YES NO

3. Have you felt bad or guilty about your drinking or drug use?

YES NO

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

YES NO

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

Compass Health Network

Consent to Treatment

Client Name:	Client ID#:	Date of Birth:
Episode	Admissions Date:	Date:

CLIENTS EXPERIENCING CRISIS MAY CONTACT OUR CRISIS HOTLINE AT ANY TIME.

Missouri: Crisis# 1-800-833-3915

CONFIDENTIALITY

I acknowledge by my signature below that I have received a copy of Compass Health Network's Notice of Privacy Practices. I understand that if I have any questions regarding confidentiality, I may contact the Privacy Officer at (660) 885-8131.

CONDITIONS OF TREATMENT

I understand that it is my responsibility to call the 24-hour crisis line should I consider harming others or myself. I understand that when I am seen for medications by Compass Health Network's physicians, they may require I receive services with a clinician/case manager as part of my treatment. Failure to honor the physician's request may prevent me from receiving further medication services.

I agree to follow my clinician/physician's instructions or to notify them if I am not willing to do so. This includes taking medications as prescribed. Failure to comply with treatment as mutually agreed may results in my termination from care.

I understand that I must call for medication refills four (4) working days before I am out of medications. Telephone refills will not be provided to those missing their appointment except in emergencies.

I understand that my case will be closed when there are no services delivered for 60 days or more, unless I make special arrangements with my clinician for less frequent care. I further understand that I may reopen my case at any time.

I understand that when I repeatedly fail to notify this office at least 24 hours in advance of my inability to keep an appointment, I will be subject to possible termination of my services and/or loss of my privilege to schedule specific appointment times.

APPOINTMENT POLICY

For Compass Health Network to make effective use of outpatient staff time, the following appointment policy will be strictly followed:

I understand that I must call the Compass Health office to cancel my appointment where I receive services at least 24 hours in advance if I am unable to keep my scheduled appointments, otherwise, the missed appointment will be treated as a no-show. In emergency situations, I am requested to call as soon as possible.

I understand that following the first no-show, all future scheduled appointments with that specific clinician/psychiatrist shall be cancelled by the support staff (in consultation with the professional). In order to make another appointment, I will contact my case manager or the support staff to determine what date I may be worked into the schedule.

I understand that a no-show is considered to have occurred when the Compass Health Network office is not notified of a cancellation at least 24 hours in advance.

I understand that two no-shows with a psychiatric provider in a twelve-month period will result in a warning letter being sent. If I receive a third no-show in a twelve-month period, I will no longer be allowed to schedule

appointments with any Compass Health Network psychiatric providers for twelve months and I will be required to sit and wait to be fit into a psychiatric provider's schedule.

FEES FOR SERVICE

I understand that there may be a fee for my service and that payment is required at the time of service.

I understand that state funded medications are only available to those qualifying both clinically and financially.

I understand that if I fail to pay for services received, that not only may my services be terminated, but in addition all billing I information including name, address, place of employment, dates of service(s) received, etc., may be given to a professional collection agency to use in their process of collection. I further understand that if my account is placed for collection, I will be responsible for the fee charged by the collection agency and any attorney or court fees assessed.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Compass Health Network and I recognize my responsibility to pay for all non-covered services including any additional cost incurred in collecting these amounts. I also authorize Compass Health Network to release any and all information regarding pre-admission data, assessments, diagnosis, prognosis and treatment for physical and/or emotional illness, including treatment of alcohol or drug use, to any and all of my insurance companies or their legal representatives for policies that I have in force during the dates of my treatment, any such disclosure shall be limited to information that is reasonably necessary to legal or contractual obligations of the insurance companies.

I understand the information obtained by use of this authorization will be used by the utilization review organizations to determine continued stay eligibility under an existing episode of care.

RELEASE OF LIABILITY ON AUTHORIZED RELEASES OF INFORMATION

I am aware this authorization constitutes a waiver of all claims against Compass Health Network, its agents, servants, or employees, as a result of their compliance with this authorization, and that neither Compass Health Network nor any of its agents, servants or employees will have any responsibility for the acts of the recipients of this information with respect to said records, after they are made available, as I have authorized and requested.

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

I have received a statement of my rights as a client of the Compass Health Network, including proper grievance procedures should I be dissatisfied with any of the policies and procedures or my treatment at Compass Health Network.

You are entitled to the following rights and privileges:

1. To receive prompt evaluation, care and treatment;
2. To receive these services in the least restrictive environment;
3. To receive these services in a clean and safe setting;
4. To not be denied admission or services because of race, gender, sexual preference, marital status, national origin, disability or age;
5. To confidentiality of information and records in accordance with federal and state law and regulation;
6. To be treated with dignity and addressed in a respectful, age appropriate manner;
7. To be free from abuse, neglect, physical punishment and other mistreatment, such as humiliation, threats or exploitation;
8. To be the subject of an experiment or research only with my informed written consent, or the consent of a person legally authorized to act;
9. To the extent that the facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;
10. To refuse treatment unless ordered by the Court or authorized by my guardian, except in an emergency;

11. To consult with a private practitioner at my own expense.

CONSENT FOR TREATMENT AND FOLLOW-UP

I understand all the preceding statements and will adhere to these policies during my services with Compass Health Network. I am requesting the services of Compass Health Network and agree to be contacted by a facility representative during or after my services, to ascertain the results of my treatment and my satisfaction with the services I received through Compass Health Network.

I understand that Compass Health Network serves as a clinical training site for mental health professionals with advanced degrees that have not yet obtained full licensure. In some cases, these individuals may be a part of the care I receive, and my participation is closely monitored and supervised by a fully licensed Professional. I have the right to decline the participation of these individuals from my care by informing the front desk or admissions staff of this decision. Compass Health Network considers the training of tomorrow's Professionals an important mission along with providing quality healthcare services to me.

Guardian Name:		
Witness Name:		
Signature and Credentials:		**Date:**

Compass Health Network

Delegation of Another Person to Consent for Treatment of a Minor or Incapacitated/Disabled Adult

Patient Name: _____ Date of Birth:_____

***Fill out this form if the patient is a minor and you (the guardian) would like other adults to be able to bring the child/ward to his/her appointments. ***

I, _____ (parent/legal guardian), cannot accompany my child,

_____ (patient name name) to Compass Health Network. Therefore, I give permission to the following adult(s) to bring my child/ward to his/her appointments:

*Person bringing child must be 18 years or older. *

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____(initials) I give permission for this person to seek treatment for my child/ward including any type of medical care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a physician, nurse practitioner, or dentist, to be necessary for the welfare of my child/ward and provide consent **without having to contact me**.

This form will remain in effect until revoked by me. Please notify the office at any time if you would like to revoke this permission.

This form is **ONLY VALID** during the following timeframe:

Effective date: _____ Expiration date: _____

_____

Signature of Parent/Guardian Relationship Date

_____

Signature of Witness Date

Compass Health Network

Consent for Telehealth Services

Client Name_____MRN_____Date_____

To serve the needs of the people in the community/hospital, health care services are now available by interactive video communication and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management, and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth". This means that you may be evaluated and treated by a health care provider from a distant location. Since this may be different from the type of treatment with which you are familiar, it is important that you carefully review and understand the following statements.

1. I understand that my health care provider at Compass Health Network recommends that I engage in telehealth treatment.
2. I understand that the provider will be at a different location from me. An additional health care provider may be present with me in the room to assist in the treatment.
3. I will be informed if any additional personnel are to be present with me in the room or in the room at the location from which the provider is providing telehealth services. I will give my verbal permission prior to the entry of the additional personnel, and I can exclude anyone from being present at any time during the consultation.
4. I understand that I have the option to refuse telehealth service at any time without affecting my right to future care or treatment and, if applicable, without risking the loss of or withdrawing from my participation in the MO HealthNet program.
5. I understand that there are alternatives to the telehealth treatment service. I may have the option to travel to see the provider, or I may refuse to see the provider. Compass has fully explained the alternatives to me.
6. I understand that I have the right to access my medical history, examination, e-rays, tests, photographs or other images ("my medical information") related to this treatment.
7. The provider may store or retain my medical information to comply with any applicable state or federal records retention requirements, but may not store or retain my medical information beyond these limits without my written permission.
8. I understand that I have the right to be informed of and to object to the videotaping or other recording of this treatment.

I acknowledge that Compass has explained the telehealth treatment service in a satisfactory manner and that all questions that I have asked about the telehealth treatment services have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth services described above.

Signature of Client/Guardian:_____Date_____

Signature of Witness: _____Date_____

Consent to Receive Text Messages

1.) I hereby authorize Compass Health to contact me by Text Message to serve me better. Compass will send me text messages for the options selected below. Appointment Reminders text messages will provide information on upcoming appointments and Caring Contact text messages are in addition to your current treatment to offer you extra care and hope while you work through your recovery process.

2.) I understand that message/data rates may apply to the messages that I receive to my cell phone.

3.) I know that I am under no obligation to authorize Compass Health Systems to send text messages.

4.) This consent is valid for one year unless I wish to revoke it. I may revoke or opt-out of receiving these communications from Compass Health at any time by contact the Compass Health Information Management Office.

5.) It is important to note that text communication is not always secure. Text message can be intercepted and for this reason, we do not communicate personal health information through this method.

I agree to receive text messages. Client Cell Number: _____

☐ Yes ☐ No

Message Types

Appointment reminder messages ☐

Caring Contact Messages ☐

6.) I consent to participate in surveys from Compass Health. Surveys may include questions regarding my treatment or services rendered. I understand I may opt out of surveys at anytime by notifying my local office.

I agree to receive Compass Health Network Surveys.

☐ Yes ☐ No

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Guardian (if applicable) Date

_____ _____

Witness Signature Date

Inspire Hope. Promote Wellness.
compasshealthnetwork.org

Compass Health Network

Name: _____ Date of Birth: _____

Compass Health Network
Financial Policy

Welcome

Thank you for choosing Compass Health Network. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important. We have provided the following information to help you understand your financial responsibility for services received:

If You Have….	You Are Responsible For…
Commercial Insurance or Medicare HMO with which we have a contract	***If the services you receive are not covered by the plan:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at the time of visit. *
	If you have commercial insurance as primary and have secondary insurance or Medicaid: No payment is necessary at the time of visit.
	If you have commercial insurance as primary, but no secondary insurance: All applicable copays, coinsurance, and deductibles are requested at the time of the office visit.
Medicare	***If the services you receive are not covered by Medicare:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at time of visit. *
	If you have Regular Medicare, and have not met your $100 deductible, we ask that it be paid at the time of service.
	If you have Medicare as primary and have secondary insurance or Medigap or Medicaid: No payment is necessary at the time of visit
	If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% coinsurance is requested at the time of visit.
Medicaid or Managed Care Medicaid	***If the services you receive are not covered by Medicaid:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at the time of visit. *
	If you have a Medicaid Spend Down: Payment for services is requested at the time of the visit until the Medicaid Spend Down has been met. No payment is necessary when Spend Down has been met.
	If you have Medicaid without a Spend Down: No payment is necessary at the time of visit.
Commercial Insurance or Medicare HMO – No Compass Contract	Payment in full is requested at the time of service. We can provide you with the necessary information for you to file a claim with your insurance company directly.
No Insurance	Payment in full is requested at the time of service. * Please ask front desk staff for information on applying for Medicaid, CHIP, financial assistance, sliding fee or Department of Mental Health funding.

***** Compass Health Network offers a sliding scale discounted price based on income and household size for which you may be eligible.

_____ (patient/guardian initials) I acknowledge and understand the above financial policy.

Created 3.15.2021
Revised 3.28.23, Effective 4.5.23

Name: _____ Date of Birth: _____

Insurance

Before your visit, contact your insurance company to verify that Compass Network is a participant in your plan and the services you intend to receive and provider of those services are covered. Not all services or providers are covered by all policies. Services not covered by your insurance plan will be your responsibility.

For us to file a claim, you must present a CURRENT copy of your insurance card at each visit and communicate changes in your personal information.

Information Required at Check In

The following information is required at check in at each visit:

1. Verification of personal contact information
2. Current copy of insurance card
3. Payment of any outstanding balance
4. Payment of Today's visit

Payment can be made via cash, check or card unless service is provided in the field or school, in which you will be expected to come into the nearest office to make payment.

Labs and Prescriptions

Any labs or prescriptions ordered by the physician are not covered by this financial notice and your financial responsibility will be dependent on lab or pharmacy.

I have read, understand, and agree to the above Financial Declaration. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, and deductibles are my responsibility.

_____ _____

Signature of Client or Guardian Date

_____ _____

Witness Signature Date

Open Access Initial Assessment
Client Notice of Cost

During the Open Access visit, a Compass Health provider will be performing an initial assessment for the client to help identify what services the client may need. The client may be charged a fee for this assessment based on the following:

Category	Income Level	Fee
Medicaid or Priority Population	n/a	No Fee ($0) OR amount due according to SMT (whichever is greater)
Insurance – If a Covered Service	n/a	Amount due according to Insurance policy/plan
No Insurance Coverage for this service and/or provider **AND** Income no more than 100% of the federal poverty level ***Note: must complete appropriate financial assistance packet and provide all required documentation.***	Family Size: 1 – Annual Income of up to $15,060 2 – Annual Income up to $20,440 3 – Annual Income up to $25,820 4 – Annual Income up to $31,200 5 – Annual Income up to $36,580 6 – Annual Income up to $41,960 7 – Annual Income up to $47,340 8 – Annual Income up to $52,720 Each addn. person add $5,380	No Fee ($0)
No Insurance Coverage for this service and/or provider **AND** Income over 100% but no more than 200% of the federal poverty level ***Note: must complete appropriate financial assistance packet and provide all required documentation.***	Family Size: 1 – Annual Income of up to $30,120 2 – Annual Income up to $40,880 3 – Annual Income up to $51,640 4 – Annual Income up to $62,400 5 – Annual Income up to $73,160 6 – Annual Income up to $83,920 7 – Annual Income up to $94,680 8 – Annual Income up to $105,440 Each addn. person add $10,760	$5 fee
No Insurance Coverage for this service and/or provider *And* Income over 200% of the federal poverty level	Annual Income greater than above amount	$25 if pay the same day $300 if do not pay same day

If a client sees an open access clinical staff, but the assessment is not completed due to the client not needing services, the client will not be charged.

If a client receives additional services on this day, there may be additional charges applied.

_____ _____

Signature of Client or Guardian Date

Compass Health Network

HIE Authorization and Consent Form

Who is this form for?

It is for patients who want to join the Velatura health information network.

What are you agreeing to by signing this form?

- To give consent that allows your health care providers to share your health records electronically, through their computers, to better care for you.
- That you have received information about sharing your health records through the Velatura Network.

Please read the statements below.

(If you are a patient's legal representative, "me," "my" or "I" refer to the Patient)

By signing this form, I understand and agree that Velatura and health care providers participating in the Velatura Network:

1. Will share my health data with providers who are treating me.
2. Will be able to see all of my health records from both before and after today's date.
3. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
4. May share *all* of my health records with providers who are treating me; this includes but is not limited to:

    - illnesses or injuries (like diabetes or a broken bone)
    - test results (like X-rays or blood tests)
    - medicines I am taking or have taken

    This may also include, but is not limited to sensitive data:

    - Alcohol or substance abuse problems
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health and developmental disabilities
    - Family planning information (including abortions)
    - Sexually transmitted diseases
    - Head and spinal cord injuries

5. May copy or include my health data in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
6. Have penalties in place for anyone sharing my data in the wrong way.
7. Velatura will keep track of who views my health records to make sure they are secure. I can ask my doctor or Velatura for a list of who has looked at my records. List of Current Providers: www.velatura.org/velatura-hie

What is Velatura?

Velatura is the nonprofit, health information network for the Midwest. This secure, electronic network allows your doctors and other caregivers to share your health records quickly to provide you with the best care.

Who has access to the Velatura Network?

Only authorized health care providers/organizations and professionals involved in your treatment, coordination of care, quality improvement and activities related to management or payment of your health care. Medical record information is protected under federal and state privacy laws; access, use and disclosure of medical records will comply with the laws.

Please read and understand each of the following statements:

- Using this data for marketing or advertising purposes, or to determine insurance or employment eligibility, is strictly prohibited.
- My consent will remain in effect for one year from the date of this form.
- My consent to join Velatura is voluntary. I can cancel my consent at any-time. I can rejoin at any time.
- I may ask for a copy of this form after I sign it.
- If I suspect or learn that my data was shared or accessed in the wrong way, I may contact Velatura at: www.velatura.org/velatura-hie or PMB 270, 2000 E. Broadway, Columbia, MO 65201-6091.

Patient Information:

By signing this form, I give all Velatura participating providers the right to share all of my health records, including sensitive data, through Velatura's Network for purposes of providing care to me. Velatura has the right to contact me to do identity verification.

_____ _____/_____/_____

My Name (print please and include maiden name) Date of Birth

_____ _____

My Address City

_____ _____ _____ _____/_____/_____

State Zip Code Gender Social Security

Patient Signature:

X _____/_____/_____

Patient or Guardian Signature **Date**

If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will be automatically opted out unless he or she chooses to join the Velatura network.

Compass Health Network

AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION - Behavioral Health

Patient's Name: _____ Date of Birth: _____

Last 4 Digits of Social Security #: _____ Client #: _____

I authorize Compass Health Network to: ☐ Disclose To ☐ Receive From

Name: _____

Address: _____

City: _____State: _____ Zip:_____ Fax: _____

Date of Services for PHI to be Released:

From (date): _____ To (date):_____

Information to be Disclosed: *(check all that apply)*

☐ Discharge Summary ☐ Intake Information ☐ Treatment Plan

☐ Progress Notes ☐ Psychological Testing ☐ Psychiatric Assessments

☐ Psychological Evaluations ☐ School Records ☐ Family Assessment

☐ Medication Records ☐ Verbal/Written Communication with: _____ ☐ Other: _____

Purpose of Request: *(must check one)*

☐ To help maintain job security while in treatment ☐ To assist in my treatment ☐ At patient's request

☐ To assure coordination of treatment ☐ Aftercare ☐ Other: _____

This authorization becomes effective on _____ and will automatically expire one year from the date of request or sooner as designated. Please specify: _____.

I understand that my drug and/or alcohol treatment records are protected under the Federal Regulations governing Confidentiality and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability Act (HIPAA) of 1996 (45 C.F.R., Parts 160 and 164) and cannot be disclosed without written consent unless otherwise provided for by the regulations.

I understand that by signing this authorization, I am allowing the release of my mental behavioral health information. This may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

I understand that I have a right to revoke this authorization at any time. I must do so in writing and present my written revocation at the office where I am being seen. I further understand that actions already taken based on this authorization, prior to the revocation, will not be affected.

I understand that I have the right to a copy of this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary in most cases. I can refuse to sign this authorization. I will be refused treatment for my refusal to sign if my care is mandatory by Corrections or the Juvenile Justice System. I understand that I may request to inspect or obtain a copy of my record. I understand that any disclosure of information carries the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my protected health information, I can contact the Privacy Officer for Compass Health Network.

PROHIBITION ON REDISCLOSURE OF ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: (1) This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65; or(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

My signature below acknowledges that I have read, understand and authorize the release of my protected health information.

Client Signature Date

Parent/Legal Guardian/Representative Signature Date

Witness Signature Date