Client Name: _____

CHILD FOCUS
Strong families. Thriving communities.

Adult Outpatient Registration

Office Use Only (Registration Worker)						
Date Submitted to Office:		1st Appointment Offered:				
		Fee Code (Medicaid, Private Insurance Company, Fee):				
911/DI Worker:	DATE:	Case #:				
			Group:			Individual

Please Print. Please read and complete ALL sections.

Client's Information		
Legal Name (last, first, middle):		Preferred/Chosen Name:
Pronouns:	Gender:	Sex assigned at birth:
SS#:	Date of Birth:	
Address:	County of Residence:	
City:	State:	Zip:
Home Phone:	Work Phone:	
Email Address:		
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive		
Primary language if other than English:		

Person to Contact in case of an Emergency	
Name	Pronouns:
Relationship:	Phone #:

Current Living Situation (check all that apply)			
	Own Home		Friend's Home
	Relative's Home		Experiencing Homelessness

	Client's Race: (Check All that apply):		Client's Ethnicity: (Check All that apply):
	Alaskan Native		Cuban
	Asian		Mexican
	Black/African American		Puerto Rican
	Native American/American Indian		Other Hispanic
	Native Hawaiian/Other Pacific Islander		Not Hispanic or Latino
	White		
	Biracial:		

Names and Ages of Your Children:				
Full Name:	Age:	Relation:	Does this child live with you?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Client Name: _____

Other Community and Human Service Providers Involved (check all that apply):		Contact Name and Phone Number
	Children's/Job and Family Services	
	Domestic Relations Court / Other Court	
	Mental Health or other Health	
	Adult probation/parole	
	County DD	
	Other (specify):	

Are a person living with disabilities (check all that apply):			
	Communication Disorder		Service Animal Assistance Needs
	Visually Impaired		Other (specify)
	Hearing Impaired		None
	Physical Disability		

Name and Phone Number of Person or Agency that Referred you to Child Focus:
If self-referred, how did you hear about Adult Services at Child Focus?

What is bringing you here today? Please identify your current needs in writing. Your service provider will review what you have written so a detailed description is most helpful in assuring your needs are met.

_____

_____

_____

_____

Are you currently suicidal: ☐ No ☐ Yes *Are you currently homicidal* ☐ No ☐ Yes

If yes, please explain_____

At this time, I prefer ☐ In person services ☐ Telehealth services (via secure video conferencing)

☐ No preference, either is fine

Severity of Current Needs:

1	2	3	4	5	6	7	8	9	10

Very little impact on functioning Extreme impact on functioning

Please rate environmental supports for change

1	2	3	4	5	6	7	8	9	10

Very little support Much support

Client motivation to change

1	2	3	4	5	6	7	8	9	10

Very little motivation Very high motivation

_____ _____

Signature Date

Client Name: _____

Office Use Only for Crisis Services and/or Diagnostic Testing (Clinician)

Action taken if client is suicidal/homicidal:

	ICD 10 Code	DSM V Diagnosis
Dx1		
Dx 2		
Date Ongoing Appt. Offered:	Date Ongoing Appt. Scheduled:	Entered into Catt ☐ Offered ☐ Seen

CHILD FOCUS
Strong families. Thriving communities.

MEDICAL HISTORY

Name of Client		Date	
DOB		Age	
Name of Person Completing this form		Relation to Client	

PRIMARY CARE PHYSICIAN	Check if None ☐
Practice	
Name	
Address	
Phone #	
Date of last physical	

OTHER PHYSICIAN/MENTAL HEALTH PROVIDER	Check if None ☐
Practice	
Name	
Specialty	
Address	
Phone #	
Date of last appointment	

DENTIST	Check if None ☐
Practice	
Name	
Address	
Phone #	
Date of last cleaning	

PLEASE DESCRIBE ANY CURRENT HEALTH / MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

HAVE YOU EVER HAD ANY HISTORY OF MEDICAL CONCERNS INCLUDING BROKEN BONES, INJURIES REQUIRING MEDICAL ATTENTION, SURGERIES OR HOSPITALIZATIONS? *IF SO, PLEASE PROVIDE DETAILS BELOW*
Check if None ☐

Client's Name: _____

CURRENT PRESCRIPTIONS MEDICATIONS *(include dose and frequency)*	PRESCRIBED BY

CURRENT OVER-THE-COUNTER MEDICATIONS *(include dose and frequency)*	CURRENT VITAMINS *(include dose and frequency)*	CURRENT SUPPLEMENTS *(e.g., Melatonin, Glucosamine, etc.) (include dose and frequency)*

PLEASE IDENTIFY ANY FAMILY MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY CONCERNS RELATED TO

Concern	Present	Past	Details
Vision	☐	☐	
Hearing	☐	☐	
Speech	☐	☐	
Dental	☐	☐	
Allergies	☐	☐	
Head Injury	☐	☐	
Eating	☐	☐	
Sleeping	☐	☐	
Weight Loss or Weight Gain	☐	☐	
Dietary Needs	☐	☐	
Learning / Education Concerns	☐	☐	
Reading / Literacy	☐	☐	

HEALTH HABITS	
Are you on a special diet?	☐ No ☐ Yes Explain:

Client's Name: _____

IS THERE ANYTHING ELSE YOU THINK WE NEED TO KNOW ABOUT YOUR HEALTH?

The information contained within this document is accurate and complete to the best of my knowledge. I understand that it is my responsibility, to notify Child Focus of any changes in medical history that may affect my treatment.

PRINT NAME OF PERSON COMPLETING FORM	RELATIONSHIP	SIGNATURE	DATE

(For office use only)

This Medical History has been reviewed by a nurse or physician. A review of the information provided by the parent/guardian ☐ does ☐ does not contain sufficient information to contraindicate use of Physical Crisis Intervention Hold (restraint).

If not contraindicated, Child Focus authorized staff may use a Physical Crisis Intervention Hold (restraint) only as a time-limited protective measure in a life-or safety-threatening situation, and only when de-escalation has failed or is not possible. A physical hold is only used until the client regains behavioral control, or until the appropriate law enforcement, safety, or other emergency service providers arrive on site, whichever is sooner. Parent/guardian is responsible for notifying Child Focus of any changes in medical history that may cause restraint to be contraindicated.

☐ I have requested the above person's health history of skin, eyes, ears and throat, respiratory system, circulatory system, endocrine system, GI, elimination, GU, neurological, musculoskeletal, surgeries and immunizations.

_____ _____

Signature Date

Diagnostic Impressions and/or Recommendations, if any:

_____

_____

_____

CHILD FOCUS
Strong families. Thriving communities.

Consent for Treatment

Client Name: _____ Date of Birth:_____

I give my consent to receive services from Child Focus

I understand that I have the right to be informed of the risks and benefits of each of the proposed services, of alternative treatments, and of no treatment.

- *Benefits* of services may include: Improvement in behavior, mood, work performance, and/or overall functioning. *Benefits* associated with refusal of services may include: Natural resolution of the problem with little or no effort on the part of the client and/or family.

- *Risks* associated with participation in services are possible, although rare. Risks associated with services may include: Worsening of behavior, mood, work performance, and/or overall functioning. *Risks* associated with refusal of services may include: Worsening of behavior, mood, and/or work performance.

I understand that my consent for treatment includes permission for the exchange of mental health information with other treatment and health services providers, both within and outside of this agency. If I wish to restrict releases relating to my health information, I have the right to request that Child Focus limit specified disclosures of information, including disclosures for treatment information.

I understand that I have the right to consent to, or refuse, any service treatment at any time upon full explanation of the expected consequences of such consent or refusal.

I understand that my provider will evaluate my symptoms to make a diagnosis, or to rule out possible diagnoses, based on clinical evidence.

I understand that I have the right to consult with independent treatment specialists at my own expense.

I understand that I have the right to be informed (in advance) of the reason(s) for discontinuance of service provision, and to be involved in planning for the discontinuance of service provision whenever possible.

I give consent to receive services from Child Focus

_____ _____
Signature Date

I refuse to give my consent to receive services from Child Focus I understand the risks associated with this refusal.

_____ _____
Signature Date

CHILD FOCUS
Strong families. Thriving communities.

Behavioral Health Services Orientation

Client Name: _____ Case Number: _____

If you have questions about any of the documents you receive today, please ask us!

Initials	Orientation to Child Focus Part I
	I am aware that the Client Handbook is on the Child Focus website in the "Mental Health" and then "Registration and Fees" section. I understand I may request a paper copy of this handbook at any time and this will be provided free of charge. I am aware that the Client Handbook contains: • Client Rights • Client Responsibilities • Explanation of Available Services • Agency Ethical Standards • Privacy Practices • Client Grievance Policy and Procedure
	I understand that I may be contacted by telephone or e-mail during and after services as part of Child Focus quality improvement efforts. If you do not wish to be contacted write NO in the space provided
	I understand that Child Focus facilities are smoke-free and drug-free. Underage persons are **not** permitted to smoke or use other tobacco products, including vape, on Child Focus grounds or at agency sponsored activities at any time. Adults age 21 and over are permitted to smoke outside of the building in a designated smoking area that is out of the view of minor children. Cigarette butts are to be disposed of in a container provided at the side of the building. Child Focus buildings are designated **smoke free**. Child Focus does not ask individuals to disclose their medications however we do ask that individuals take precautions when bringing medication to Child Focus facilities. Any prescription medication or over the counter drugs should be kept in a safe space out of reach from children. Over the counter and prescription medications need to be kept on their person at all times. Individuals are asked to ensure that medication containers are closed tightly after use, put in a safe place like a purse or some other personal space out of sight and reach and only handled when a dose is needed. Medications should be taken only as prescribed by a physician or according to the directions provided on the over-the-counter drug packaging.
	I understand that **no weapon of any kind is permitted** in the facilities or on the grounds of Child Focus, regardless of any permit held by an individual.
	I understand it is my responsibility to notify Child Focus of any address or phone number changes.
	Medicaid recipients: I have received a Financial Responsibility Notice.

_____ _____

Client Name Signature Dat

CHILD FOCUS
Strong families. Thriving communities.

GOSH RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult: ☐ Yes ☐ No If yes, complete the following information.	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Client Signature	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify):
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone number of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

CHILD FOCUS
Strong families. Thriving communities.

Permission to Disclose Personal Health Information to: Information System (GOSH) and Ohio Behavioral Health Information System (OBHIS)

In order for your services to be paid for--in part or in full--by the Community Mental Health, or Alcohol and Drug Addiction Services Boards, and/or Job and Family Services, and/or Medicaid it is necessary to enroll you (the client) in the GOSH and OBHIS shared database systems.

The information entered into the database is used to:

- Enroll the client in the Great Office Solution Helper (GOSH)
- Enroll the client in the Ohio Behavioral Health Information System (OBHIS)
- To determine eligibility for publicly funded services.
- To pay claims for services received.
- To report information required by the CMH/ADAMH Board and/or OhioMHAS regarding characteristics of individual seeking services and the types of services provided. The Boards and/or OMHAS use the information in aggregate form for service planning and evaluation purposes.
- To report information required by the CMH/ADAMH Board and/or the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to measure effectiveness of services and evaluate treatment outcomes in my case and other similar cases.
- To report information to the CMH/ADAMH Board and OhioMHAS, as required by Ohio law, about reportable incidents that may occur while I am receiving services.

Child Focus may disclose information necessary to be paid for mental health services even if I do not authorize disclosure.

Treatment cannot be conditioned upon my signing this authorization.

I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment with Child Focus ends.

I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that Child Focus cannot control the use of this information once it has been disclosed.

By signing below, I am indicating that I understand all of the above. I authorize Child Focus to disclose information necessary to the Great Office Solution Helper and Ohio Behavioral Health Information System.

Client: _____ Client D.O.B.: _____

Signature of Parent/Guardian: _____

Relationship to Client: _____ Today's Date: _____

CHILD FOCUS
Strong families. Thriving communities.

Consent to Phone or Text Usage for Appointment Reminders and Other Healthcare Communications

Client Name: _____ Client Account Number: _____

Persons served at Child Focus may be contacted via phone or text messaging to remind you of an appointment, to obtain feedback on your experience with our service providers, and to provide general reminders/information.

_____ I consent to receive phone or text messages from Child Focus at my cell phone and/or any number forwarded or transferred to that number to receive communication as stated above. I understand that this request to receive phone and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Child Focus does not charge for this service, but standard call and text messaging rates may apply as provided in your wireless carrier plan (contact your carrier for pricing plans and details).

Please choose a preferred contact method below for appointment reminders.

Choose only one:

_____ I prefer to receive phone calls. I understand messages may be left on voicemail. Please use this number for reminder calls: _____

_____ I prefer to receive text messaging. The cell phone number that I authorize to receive text messages for reminder calls is: _____

_____. I prefer not to receive reminder calls.

_____ _____
Client signature Date

CHILD FOCUS
Strong families. Thriving communities.

Child Focus Consent for Telehealth

Client Name: _____ Date of Birth:_____

I give consent for the above named client to receive **Telehealth** services at Child Focus Telehealth service is provided real-time through audio and video telecommunication technology in which the client and treating service provider are at different locations. I understand that telehealth secure videoconferencing may be used intermittently when I am unable to get to the appointment or at regularly scheduled intervals.

I understand I have the right to be informed of the risks and benefits of the proposed service, of alternative treatments, and of no treatment.

- *Benefits* of Telehealth may include: Increased access to mental health services, less wait time and distance travel required for appointments, improved care coordination with mental health providers, access to expertise from a distant specialist. There are no *Benefits* associated with refusal of Telehealth service.
- *Risks* associated with Telehealth may include: There is a small risk that equipment failure may result in broken communication with the service provider or the experience of poor video or audio quality. There is a slight risk that a delay in evaluation or treatment could result from a deficiency or equipment failure. There is a minuscule risk that security protocols could fail, causing a breach of privacy of personal health information. *Alternative Treatment*: Includes face-to-face therapy service. The *Risk* associated with refusing Telehealth service may include worsening of mental health symptoms and functioning.

I understand I have the right to be oriented to telecommunication secure video software.

I understand that federal and state laws which protect privacy and confidentiality of my medical information also apply to Telehealth. As such, I understand I will be required to verify and authenticate my child's and my own identity during sessions.

I understand that I have the right to consent to, or refuse, or withdraw my consent for Telehealth at any time upon full explanation of the expected consequences of such consent, refusal or withdraw.

I understand that I have the right to be informed (in advance) of the reason(s) for discontinuance of service provision, and to be involved in planning for the discontinuance of service provision whenever possible.

I give consent to receive services from Child Focus

_____ _____
Client Signature Date

I refuse to give my consent for services from Child Focus I understand the risks associated with this refusal.

_____ _____
Client Signature Date

CHILD FOCUS
Strong families. Thriving communities.

Telehealth Expectations

You may receive mental health services via Telehealth. This means that you and your provider will be connected through electronic devices, rather than together in person.

We ask that you treat telehealth in the same way you would an in-office appointment. Expectations include:

- Dress appropriately during telehealth sessions, as you would if you were attending a session at the office.
- Be seated on a chair or couch (sessions will not be conducted with clients or family members on a bed or floor).
- Be located in an area that is safe, has good lighting and provides privacy/confidentiality.
- Be located in a room that is appropriate. No session will be conducted with anyone participating in a bathroom.
- Have the camera on your device turned on and facing you.
- Stay in the room and remain awake, alert and engaged with the provider for the full session.
- Please do not have anyone else in the room unless it has first been discussed and agreed upon with your provider.
- Please do not conduct other activities while in session, such as driving a vehicle, shopping, engaging in recreation activities, engaging in salon activities, etc.
- In general, you should not engage in activities that you would not engage in during in person sessions such as using drugs or alcohol, watching tv, texting, playing video games, etc.
- Please be ready for the start of your session. Providers are on tight schedules.
- Please do not record sessions without first obtaining the provider's approval.
- If you have not received a SecureVideo link 15 minutes prior to your scheduled appointment, please call the office to let them know.

For families choosing primarily Telehealth services, at least one in person contact is required each year.

Licensure laws of our service providers prohibit them from practicing outside of the state of Ohio. Therefore, if the client is out of state, sessions cannot occur.

Failure to comply may result in discontinuation of the session, a no show being charged, and a need for further appointments to be scheduled in the office.

I understand and will comply with the above expectations.

Client _____ Date _____

Parent/Guardian *(*if client is a minor) _____ Date _____

CHILD FOCUS
Strong families. Thriving communities.

Financial Responsibility Notice

- You have stated that you have Medicaid coverage.
- There is no co-pay for those clients who have Medicaid coverage.
- If you should lose Medicaid coverage for any reason, we will need to complete a fee agreement with you. In order to do so, you will need to present:
    - Proof of household income (i.e. wages, child support, disability, social security)
    - Proof of insurance, if applicable

Please notify the receptionist if you have any questions about this Notice.

CHILD FOCUS
Strong families. Thriving communities.

OBHIS Admissions Records Client Form

The following information is requested by OMHAS (Ohio Mental Health and Addiction Services)

Client Name _____ Date of Birth _____

Admission Type

☐ Alcohol/Other Drug ☐ Mental Health ☐ Alcohol/Drug and Mental Health

Assessment and Referral Only

☐ No ☐ Alcohol/Other Drug ☐ Mental Health ☐ Alcohol/Other Drug Alcohol/Drug and Mental Health

Paying Entity/Board: _____

Please complete this information for the registering child/adult.

Current Educational Enrollment

- ☐ K-12th Grade
- ☐ GED Classes
- ☐ College
- ☐ Other Schooling (e.g. Adult Basic, Ed; Literacy
- ☐ Vocational/Job Training
- ☐ Has not attended school in last three months
- ☐ Unknown

Education Type (If K-12 Selected)

- ☐ Has Individual Education Plan (IEP)
- ☐ Does Not Have an Individual Education Plan (IEP)
- ☐ Unknown

Highest Education Level Completed

- ☐ < 1st grade
- ☐ 1st grade
- ☐ 2nd grade
- ☐ 3rd grade
- ☐ 4th grade
- ☐ 5th grade
- ☐ 6th grade
- ☐ 7th grade
- ☐ 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ High School Diploma/GED
- ☐ Technical School
- ☐ Some College
- ☐ 2 Yr. College/Assoc. Degree
- ☐ 4 Yr. College/Bach Degree
- ☐ Graduate Degree
- ☐ Unknown

Primary Reimbursement

- ☐ Blue Cross
- ☐ Medicaid
- ☐ Medicare
- ☐ No Charge
- ☐ Other Government Payments
- ☐ Other Health Insurance
- ☐ Other payment source
- ☐ Self-Pay

Primary Source of Income/Support

- ☐ Disability (SSI/SSD/WC)
- ☐ Family Relative
- ☐ Public Assistance
- ☐ Retirement/Pension
- ☐ Wages/Salary
- ☐ None
- ☐ Other
- ☐ Workers Compensation

Living Arrangement at Admission

- ☐ Private Residence - Adult
- ☐ Private Residence –Child
- ☐ Permanent Supportive Housing
- ☐ Residential Care/Group Home/ACF
- ☐ Community Residence
- ☐ Temporary Housing
- ☐ Foster Care
- ☐ DD Licensed/Operated Facility
- ☐ Correctional Facility
- ☐ Homeless
- ☐ Other
- ☐ Unknown

Please complete both sides of this form

Please complete this information for the registering child/adult.

Does Client Use Tobacco Products
☐ Yes ☐ No ☐ Unknown

Military Status
☐ Active
☐ Discharged
☐ Disabled Veteran
☐ None

Client County of Residence: _____

Number of arrests in the past 30 days : _____

Employment at Admission
☐ Full Time
☐ Part Time
☐ Sheltered
☐ Unemployed but actively looking for work

NOT in LABOR FORCE
☐ Disabled
☐ Engaged in Residential/Hospitalization
☐ Homemaker
☐ Inmate in Jail/Prison/Corrections
☐ Retired
☐ Student
☐ Volunteer Worker
☐ Unknown

Referred by
☐ Individual (self-referral/family/friend)
☐ Alcohol/Other Drug After-Care
☐ Mental Health Provider
☐ Other Health Provider
☐ School
☐ Employer/EAP
☐ Child Welfare (CDJFS, CSBS)
☐ Ohio Family and Children First Council
☐ Other Community Provider
☐ State Psychiatric Hospital
☐ State Prison
☐ Jail
☐ Courts/Other Criminal Justice
☐ TASC: Courts/CJ – Felony
☐ TASC: Courts/CJ – Juvenile
☐ TASC: Courts/CJ – Municipal
☐ Unknown

Number of Children in Household under 18: _____

Required for Female Clients

Childbirth in the last 5 Years
☐ Yes ☐ No ☐ Unknown

Is Client Currently Pregnant
☐ Yes ☐ No ☐ Unknown

Stage of Pregnancy
☐ First Trimester
☐ Second Trimester
☐ Third Trimester
☐ Unknown
☐ N/A

Lifetime Number of Births (live and still): _____

Please complete both sides of this form