Arubah
RESTORATION to SOUND HEALTH

INTAKE FORM

Phone: (612) 284-8115 Email: intake@arubahemotionalhealth.com

Client Name:
Date of Birth:
Social Security Number:
Ethnicity:
Gender:
Sexuality:

Home Address:

Email Address:
Phone Number:

Parent/Guardian/Emergency Contact #1
Name:
Contact Number:
Email Address:
Relationship to client:
Legal Custody Status:
Yes ☐ No ☐ N/A ☐

Parent/Guardian/Emergency Contact #2
Name:
Contact Number:
Email Address:
Relationship to client:
Legal Custody Status: Legal Custody Status:
Yes ☐ No ☐ N/A ☐

Referral Source:

Partnership Site:

Primary Insurance
Name of Insurance:
Type of Insurance - Commercial ☐ **State** ☐
Subscriber ID:
Group Number:
Policy Number:

Secondary Insurance
Name of Insurance:
Type of Insurance - Commercial ☐ State ☐
Subscriber ID:
Group Number:
Policy Number:

Tertiary Insurance
Name of Insurance:
Type of Insurance - Commercial State
Subscriber ID:
Group Number:
Policy Number:

Reason for seeking treatment:

Expectations from therapy:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

Describe your current mental health symptoms:

Please rank the three biggest concerns:

Are you currently taking prescription medication?

Please List Medications:

Signature:

Date:

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THIS DOCUMENT IS FOR CONSENT FOR TREATMENT
PLEASE SIGN AFTER EACH SECTION.

CONSENT FOR TREATMENT

This is a general consent for treatment at Arubah Emotional Health Services.
I give my consent for services at Arubah Emotional Health Services and by associated profession staff. This consent will include
evaluation, therapy, medication management or testing (if indicated).
A treatment plan will be designed between you and your assigned therapist(s). This consent is an agreement to be involved in the
treatment planning process.
I understand that I may decline a specific treatment recommendation.

Signature

Guardian Signature

Witness Signature

Date

Arubah
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THIS DOCUMENT IS FOR CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF CLIENT RIGHTS and NOTICE OF PRIVACY PRACTICES. PLEASE SIGN AFTER EACH SECTION.

ACKNOWLEDGMENT OF RECEIPT OF CLIENTS RIGHTS BROCHURE
I have received and read Arubah Emotional Health Service's description of my rights as a receipt of service, entitled "Clients Rights
and Responsibilities."

I understand that I may receive another copy of this statement at any time and that I may direct any complaints about my service to the
agency Director or owner

Signature

Guardian Signature

Witness Signature

Date

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES
Consistent with the Health Insurance Portability and Accountability Act (1996), I have been provided with a copy of the Notice of Privacy Practices.

My signature below indicates that I have received a copy of the Notice of Privacy Practices.
Arubah Emotional Health Services strongly encourages all clients to carefully read this document.

Signature

Guardian Signature

Witness Signature

Date

Arubah

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OUR FINANCIAL POLICY

We appreciate you for choosing Arubah Emotional Health Services as your mental health provider. We have committed ourselves to ensuring the best quality service for your treatment. Our financial policy is a part of our agreement for services. The statement should be read and signed prior to treatment. By signing this form you are agreeing to the terms of this financial policy.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash or check. All outstanding balances are the responsibility of the client, regardless of whether or not insurance covers the services. It is imperative that client notify us of any insurance changes. Failure to do so can cause billing inaccuracies that could result in full payment responsibility to the client.

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. This assignment can only happen with a client's signed authorization. Further, if the insurance company requires a referral, the client must obtain the referral prior to receipt of any care. Fees not covered by insurance after 45 days become the responsibility of the client.

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage.

Reduced Fees/Sliding scale fees - We may be able to reduce fees in certain circumstances. Please speak with your therapist. Payment plans may also be arranged.

Missed Appointments – A 24-hour notice for cancellations is required. This enables us to arrange care for another client. Failure to cancel **24-hours ahead** of a scheduled appointment will **automatically** result in charges (outlined below) regardless of reason. Your treatment provider will not be able to prevent or reverse charges for missed appointments.

Suspension of Services – Any client with an out-of-pocket balance of $500 or more will be placed on a suspension of services. This is a temporary pausing of services for up to 30 days to allow the client to bring the balance under $500. If the balance remains for more than 30 days their account will be closed. No client is banned from Arubah and payment plans are available.

Fees for Missed Appointment and Late Cancellation:
Individual, Couples and Family Sessions: $ 50.00
Group Sessions Any Length $ 50.00
PLEASE NOTE: FAILURE TO ATTEND A GROUP - is an automatic charge, regardless of notice. This is because another client cannot fill the vacancy of an absent group member.

My signature below is authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Arubah Emotional Health Services. I acknowledge that I have read, understand, and agree to the above Financial Policy.

Client Name: _____ DATE: _____

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S2	Taking care of your household responsibilities?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S3	Learning a new task, for example, learning how to get to a new place?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S5	How much have you been emotionally affected by your health problems?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐

Please continue to next page...

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S7	Walking a long distance such as a kilometre [or equivalent]?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S8	Washing your whole body?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S9	Getting dressed?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S10	Dealing with people you do not know?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S11	Maintaining a friendship?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S12	Your day-to-day work?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ☐☐
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ☐☐
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ☐☐

This completes the questionnaire. Thank you.

Arubah Emotional Health Services
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client Name (Last, first, middle initial)

Street Address | City | State | Zip

Date of Birth | Day Phone # | Evening Phone #

INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH
Name (Program / Individual) **Arubah Emotional Health Services**	Name (Program / Individual)
Street Address	Street Address
City State Zip	City State Zip
Telephone: Fax:	Telephone: Fax:

AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING: FROM: _____ TO _____

☐ Admission / Intake Summary ☐ Diagnosis & Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ Psychiatric Assessment ☐ Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment ☐ Psychological Assessment
☐ Prior Treatment Records ☐ Medication Management Records ☐ Medical/Physical History ☐ Education Records

☐ Progress Review ☐ HIV History ☐ Billing Records/Statements (date)_____

☐ Other _____

-OR-

☐ **The entire record** (including, if applicable, chemical dependency/drug or alcohol abuse treatment records)

AND ☐ ***including*** billing records ☐ ***excluding*** billing records ☐ ***excluding*** records from other facilities ☐ ***excluding*** HIV records

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THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

☐ Insurance Payment ☐ Third Party Authorization and Payment ☐ Communication regarding legal issues
☐ Coordination of Care ☐ Litigation ☐ Other _____

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Arubah Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Arubah Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released from any and all liability resulting from re-disclosure.

Client / Legal Representative Signature _____ Dated _____

If you are the client's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative. **You are entitled to a copy of this document**