NewPoint Behavioral Health Care

APPLICATION FOR SERVICES – ADULT

FOR CENTER USE ONLY

CLIENT NUMBER: _____

CHECK ONE		*COMPLETE*
__ Outpatient	__ PACT	Fee: _____
__ Screening	__ APC	Medicaid #: _____
__ ICMS	__ PATH	Intake Date: _____
		Staff/Degree: _____

Date: _____ Date of Birth: _____

Your Name: _____ SS#_____-_____-_____

Last First Middle

Address: _____

Number & Street Town State Zip Code

County: _____ Highest Grade Completed _____

Phone: _____ Emergency Phone # _____ Gender_____ Race _____ Marital Status _____

Maiden Name (if married female) _____Occupation: _____

Place of Employment: _____Phone #: _____

Annual Household Income: $_____ Total # of persons dependent on income _____

PEOPLE LIVING IN YOUR HOME

NAME	RELATIONSHIP	BIRTHDATE	OCCUPATION	EDUCATION

Name and address of family doctor: _____

Who suggested that you come to the Center? _____

What problem brought you to the center? (be somewhat specific): _____

_____

_____

How long has the problem been going on: _____

Have you ever been to this Center before? __ yes __ no. If yes, when? _____

Has a member of your family ever been to this Center? ☐ yes ☐ no. If yes, when? _____

Have you ever sought mental health services from a hospital, clinic or private source before? ☐ yes ☐ no

If yes, please give the name(s) and location(s):

_____
_____
_____

Have you ever received services for substance abuse (drugs and/or alcohol) before? __ yes __ no

If yes, please provide information as to where and when: _____
_____

Are you taking any medication at this time? If so, please indicate name of medication, dosage and frequency:

_____
_____
_____

Do you have any significant medical problems? If yes, please specify: _____
_____

Any additional information you would like us to know?_____
_____
_____
_____
_____

NOTE: Fees for service are based on a sliding scale. Since the cost of providing services exceeds public funding, the difference must be covered as fully as possible by the applicant.

HMO MAY NOT COVER CENTER SERVICES. SOME COVERAGES MAY REQUIRE A CO-PAY

What health insurance do you have? _____
Company Name and Phone number, if known

Insurance ID number: _____

I have received copies of "Client Rights" and "How to Report a Complaint" and have had an opportunity to discuss them.

_____
Parent/Guardian or Client (if age 14 or older) Signature

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Please use this space for updating client information such as change of address, phone number, etc.

_____
New Address # and Street City State Zip

_____
New telephone # Other updated information