Pawnee Mental Health

Child Client Registration Form

Client Information

Name: _____ Nickname: _____ Email: _____

Birth Date: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Race: _____

Ethnicity: Hispanic or Latino Yes _____ No _____

Is the client in Foster-Care? Yes _____ No _____

Has the client ever served in the military? Yes _____ No _____

Please Check here _____ if you do not want text /email appointment reminders.

Please Check here _____ if you do not want phone call reminders.

Please Check here _____ if we may leave agency name on voicemails

Client Gender Assigned at Birth:	Client Pronouns:
Male Female Intersex	He/Him/His She/Her/Hers They/Them/Their Other

Sexual Orientation: _____ Gender Identity: _____

What type of service(s) are you seeking? _____

In a few words, tell us why you are seeking treatment: _____

_____

_____

_____

Emergency Contact Information:

_____	_____	_____
Name	Phone	Relationship

Court Ordered: Yes No

Name/Location of Court: _____

Name of Attorney/PO/CSO: _____

Court Date: _____

Type of Court Order: _____

Primary Care Physician, Address & Phone: _____

Financial Agreement

☐ Yes, I have Insurance.

The amount dictated by insurance will be applied to the client's account upon receipt of the Explanation of Benefits from the insurance company. Payment of copay/deductible/coinsurance amounts are due at time of service.

Primary Insurance:	_____	Secondary Insurance:	_____
Policy Number:	_____	Policy Number:	_____
Group Number:	_____	Group Number:	_____
Subscriber Name:	_____	Subscriber Name:	_____
Subscriber SS#:	_____	Subscriber SS#:	_____
Subscriber Date of Birth:	_____	Subscriber Date of Birth:	_____

Authorization and Release:

I give permission to Pawnee Mental Health to bill my insurance. I allow Pawnee Mental Health to obtain and release any information, including diagnosis to my insurance company to allow for the processing of insurance claims. I further acknowledge that I am financially responsible for all charges not covered by my insurance.

☐ No, I Do Not Have Insurance.

Pawnee Mental Health provides a sliding fee scale based on gross annual income and number of dependents for clients without insurance. **An admissions representative will reach out to you with more information to get you on the sliding fee scale.**

We accept the following documents as verification of income:

- Income Tax Return
- Paycheck Stub(s)
- Retirement/Pension (SSI/SSDI)
- Social Security Benefits
- Unemployment Stubs
- Child Support / Alimony
- Student Loans / Grants
- Letter from the Department of Children and Families
- Letter of Support
- Other

_____ _____

Printed Name of Client or Legal Representative Financially Responsible *Date*

_____ _____

Signature of Client or Legal Representative Financially Responsible *Date*

_____ _____

Signature of Witness *Date*

For questions about your account please contact the Pawnee Mental Health billing department at (785) 587-4344 or (866) 337-3353.

FORM # FN202301F
06/12/2023

Pawnee Mental Health

CLIENT RIGHTS CHECKLIST

Client/Legal Guardian, please **initial** on each applicable line**.** If not applicable, please put NA.

_____I **hereby acknowledge a written receipt of the following information, or I can have the information verbally explained to me**:

- List of my rights as a client of Pawnee
- List of my responsibilities as a client
- Description of Pawnee services.
- Information about HIV/TB screening and education for all consumers, with risk-based testing and referral; enhanced focus in SUD services
- How to obtain services during regular hours of operation
- How to obtain services after-hours or in an emergency
- Information about confidentiality practices and exceptions.
- Copy of Notice of Privacy Practices
- Information about billing and payment
- Information regarding fees and co-payments
- Information about treatment of minors
- Process for submitting a complaint or suggestion
- Information about satisfaction surveys

Consent for Treatment by a Legal Guardian:

_____As legal guardian of _____, I authorize and give legal consent to treatment at Pawnee Mental Health Services.

Informed Consent:

_____I am initiating treatment with a Community Mental Health Provider that holds one or more degrees and/or licensures from MD/DO, APRN, PHD, LSCSW, LMLP, LMSW, LCP, LAC, LCMFT, LMFT, LPC, LMAC, LCAC, BS, AD, CMA Pawnee Mental Health Services employs student interns who are completing a requirement for a Clinical Degree. Clinical work provided by Student Interns is supervised by Supervisors in their respective program.

Primary Care Provider Collaboration: **If yes, please initial.**

_____At this time, I would like my primary care provider contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care. *Separate Authorization Required*.

_____ At this time, I would not like my primary care provider contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care.

Marketing Communication: If yes please initial and provide contact information.

_____I consent to receive general agency updates and wellness-related information from Pawnee Mental Health by email, text message, or both. These communications will not include personal or health-related information.

*Email*_____*Cell phone number*_____

Continue to next page

Photograph: If yes, please initial.

_____I agree to have my photo taken by Pawnee Mental Health staff. I understand it will be used only for identification and placed in my health record.

Payment Authorization:

_____I hereby authorize Pawnee Mental Health Services to disclose diagnosis, dates of service, and type of service as well as any other additional information required by my insurance carrier to process insurance claims for p a y m e n t . I further authorize the payment of insurance benefits directly to Pawnee Mental Health Services for services provided.

Client/Legal Guardian Signature	Date	Witness Signature	Date

Client/Legal Guardian Name (printed)	Client Date of Birth

To report suspected abuse, neglect or exploitation, please telephone the Kansas Protection Report Center at 1-800-922-5330. Every call is taken seriously. Telephone lines are staffed 24 hours a day.

Pawnee Mental Health Services Informed Consent for Telehealth Services Prior to

starting telehealth services, I acknowledge the following:

• There are potential benefits and risks of telehealth services (e.g. limits to patient confidentiality) that differ from in-person sessions.

• Confidentiality still applies for telehealth services, and neither Pawnee nor I will record the session without the permission from the others person(s).

• It is important to be in a quiet, private space that is free of distractions during the appointment. I will be appropriately dressed, awake and ready to participate on time in a space prepared to engage therapeutically. I agree to provide my undivided attention to the session including turning off or silencing all distractions including cell phones, tv, video games, etc.

• I will not attempt to conduct my appointment in a public setting, while driving a vehicle or while being a passenger in someone else's vehicle. I understand that if I am unable to provide a private space, I can reschedule my appointment to take place via telehealth at my nearest Pawnee office in accordance with their hours of operation. I will notify my provider of all persons present in the space that our session is being conducted even if they are not within camera view of the therapist to ensure confidentiality.

• I will abstain from using substances prior to and during my appointment.

• I understand that if I attempt to conduct my appointment in a place that is not free of distraction, in a public space or while performing dangerous tasks such as driving a vehicle, partaking in drug use, etc. my provider has the right to cancel or end our session early.

• It is important to be on time. If I need to cancel or change my telehealth appointment, I will notify Pawnee as soon as possible. I understand that if I am late to my appointment and I do not notify Pawnee, my provider will attempt to call me. If I do not answer, I understand that my provider may not be present on zoom by the time I am ready to start my appointment.

• Due to licensing requirements set by the appropriate Licensing Board, I understand that I am required to be in the state of Kansas at the time of and for the duration of my appointment.

• In the event of technical problems (i.e., dropped call) My provider will attempt to reopen the zoom room. If I cannot reconnect my provider will attempt to call me one time to either continue via phone(if allowed by payor source) or reschedule. If my provider cannot reconnect, my provider or a representative will call to attempt to reschedule for a later date. If we cannot reconnect via phone I will be expected to call back at a later time to reschedule my appointment.

• In the event of a crisis, Pawnee will provide me with the information for Pawnee's crisis department.

• If I am a minor, Pawnee needs the permission of my parent or legal guardian (and their contact information) for me to participate in telehealth sessions.

• I understand my provider is a mandated reporter and will report any suspicions of abuse and/or neglect of a child or vulnerable adult to the proper authorities.

• I understand that there will not be a Customer Service Representative present for telehealth appointments and that it is my responsibility to make payments for all appointments. I understand that I can make payments by going to my nearest Pawnee Mental Health office, through Pawnee's website or by calling Pawnee to make a payment over the phone.

• My provider may determine that due to certain circumstances telehealth treatment is no longer appropriate and at that time, we will discuss alternative options for me.

My signature below indicates that I agree to this informed consent and agree to telehealth services.

Client Name Printed/Typed:	Client Date of Birth
Client Signature/Legal Representative	Date
Legal Representative Name Printed/Typed	
Client Phone Number	Client Email Address

FORM: CO201925F

UPDATED: 4/14/25

REQUEST AND AUTHORIZATION FOR ALTERNATIVE COMMUNICATION ACCOMMODATION

E-Mail Informed Consent Form

Pawnee Mental Health Services (PMHS) respects your wishes to communicate with our mental health providers, billing staff or other administrative service personnel by E-mail. Transmitting confidential client information by E-mail has a variety of risks that must be considered and acknowledged before using this technology.

Risk Factors and Responsibilities to communicating via E-mail:

- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the signer or the recipient had deleted his or her copy.
- E-mail containing information pertaining to your diagnosis and/or treatment constitutes a part of your medical record. Thus, any individual who has access to the medical records will have access to your e-mail messages
- All e-mail may be discoverable in litigation because it will be included in the medical record.
- Employees do not have an expectation of privacy in the e-mail they send or receive at their place of employment. Thus, if you send or receive e-mail from your place of employment you risk having your employer read your e-mail.
- Pawnee cannot guarantee that electronic communications will be private. PMHS will take reasonable steps to protect the confidentiality of client e-mail but is not liable for improper disclosure of confidential information not caused by Pawnee's gross negligence or wanton misconduct.
- You have no way of anticipating how soon Pawnee staff will respond to your e-mail. Although Pawnee staff will attempt to read and respond to e-mail promptly, Pawnee cannot guarantee that any particular e-mail message will be received, read and responded to within any particular period of time. Please note that Pawnee providers rarely have time between appointments, staff meetings, meetings away from the facility, and meetings with clients and their families to continually monitor whether they have receive e-mail . THUS YOU SHOULD NOT USE E-MAIL IN AN EMERGENCY OR IF YOU EXPECT AN IMMEDIATE RESPONSE.
- If your e-mail requires or invites a response, and the recipient does not respond within a reasonable time, you are responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **clients should use extreme caution if they choose to use e-mail for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, etc. mental health or developmental disabilities; alcohol or drug abuse.**
- You are responsible for protecting your password or other means of access to e-mail sent or received from PMHS to protect confidentiality. Pawnee is not liable for breaches of confidentiality caused by the client.
- You may revoke or withdraw this consent at any time by e-mail, written or verbal notification to Pawnee, attention: the name of the treatment provider or Pawnee Privacy Officer.
- You are responsible for providing the e-mail address that you would like to be used to communicate with Pawnee. E-mails from any other address will NOT be answered due to the inability to confirm the identify of the sender.

I have read and understand the risks and responsibilities involved in communicating with Pawnee Mental Health Services' staff by e-mail. I acknowledge these risks and accept personal responsibility for the risks implicit in using this technology. I understand that I cannot hold Pawnee Mental Health Services staff liable for complications that result from my choice to communicate in this manner.

_____ _____

Client or Client's Parent/Legal Guardian Signature Date

_____ _____

Printed Name Relationship to client (if other than self)

Client Full Name: _____ Date of Birth: _____

Please Describe circumstances under which e mail will be utilized as the requested accommodation:

_____

_____

_____

_____

Approved e mail address(es) for communication with this agency: (only these e mail addresses will be acknowledged/responded to by this agency per this authorization. Changes to these e mail addresses will require notification from you in writing, or completion of a new authorization form.)*
Please also include the name of who the e-mail address is associated with

_____ _____

_____ _____

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please insure that a valid Release of Information is on file for the parties designated.

OFFICE USE ONLY:

Action: ☐ Accepted ☐ Denied

Reason if Denied: _____

_____

_____ _____

Privacy Officer Signature/ Designee Date

Forward to Privacy Officer, Forward Approval to Medical Records designee for entry into EMR

FORM: CO201923F

APPROVED: 4/9/2020

Pawnee
Mental Health

Cancellation Policy

We prioritize your wellness while you are within our care and want to be upfront regarding our policy for missed appointments.

To experience the greatest benefit through the care provided, consistent attendance will help you progress through the treatment process. The frequency of sessions prescribed will be discussed with your clinician. We understand that unexpected situations may require an adjustment to your scheduled appointments. We respectfully request that you provide at least 24 hours' notice for missed appointments to allow another client to fill the appointment slot. To respect time slots for each client throughout the day, should you arrive more than 15 minutes late for a scheduled mental health/recovery appointment or 5 minutes late for a medical appointment, we may ask that the appointment be rescheduled.

Our policy outlines that if you do not show or cancel an appointment with less than 24 hours' notice 3 appointments within 60 days, we will attempt to reengage you in services. We will make three attempts via phone. If we are not successful in reaching you and getting you rescheduled, we will assume that you are no longer interested in receiving services through our agency and will discharge you 60 days from the date of the last service. You can reinitiate services through same day access (SDA).

If you are discharged from other services, this does not impact your ability to seek Pawnee's crisis services. Licensed mental health professionals are available 24 hours a day, seven days a week. In times of crisis, you can reach out to Pawnee's crisis team at (800) 609-2002.

Client/Legal Guardian/Placement Printed Name: _____

Client DOB:_____

Client/Legal Guardian/Placement Signature:_____

Date:_____

2001 Claflin Rd.; P.O. Box 747
Manhattan, KS 66505-0747
785-587-4300
Fax 785-587-4305

814 Caroline Avenue
Junction City, KS 66441
785-762-5250
Fax 785-762-2144

210 W. 21st; P.O. Box 585
Concordia, KS 66901
785-243-8900
Fax 785-243-8933

Non-emergency: (785) 587-4302
CRISIS line: 1(800) 609-2002

The Certified Community Behavioral Health Clinic and Community Mental Health Center proudly serving Clay, Cloud, Geary, Jewell, Marshall, Mitchell, Pottawatomie, Republic, Riley, and Washington Counties since 1956.

Pawnee
Mental Health

Accompaniment of Minor Children (under age 18) by an Authorized Adult

Please list below any adults (18 or older) who are authorized to stay with your minor child during his/her treatment sessions.

Name	Relationship to the Child

As the Parent/Guardian of _____ I understand that (please initial):

_____ My involvement in treatment services, such as therapy and medical services plays an integral part in my child's treatment success.

Therefore:

_____ I agree as the legal guardian, I will be present for treatment planning sessions with my minor child (usually the first session after the Diagnostic Evaluation and every 60-90 days thereafter).

_____ I agree that a legal guardian or one of the adults authorized above will stay in the designated waiting room the entire time my child is receiving office-based services such as therapy and medical services.

_____ I agree that my child's therapy or medical appointment may be rescheduled if he/she is not accompanied by an authorized adult.

I agree to the above terms and conditions, and I understand that these conditions may be amended by my child's provider based upon our individual needs.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date