

COMCARE Children's Services "Intake Packet"
Total of 10 pages including this one

Consent for Treatment document:

Check 2nd and 3rd box and enter child's name following each of the boxes. Sign, witness, and date.

Consent for Release of Information documents:

Check 3rd box "exchange information with".

Consents should be made out to the following: school, primary care physician, placement and past treatment facilities, and mental health providers. Feel free to copy releases if you need more. Mark the information you want exchanged with an "X", some releases are already marked and this is sufficient information for COMCARE. Regarding the area, "...information will be used for the purpose of", mark with an "X" as many boxes as needed.

Sign releases, witness, and date. Please remember to print the name of the original signer.

COMCARE of Sedgwick County
Consent for Treatment, Acknowledgement of Notice of Privacy Practices,
Acknowledgement of Client Rights & Responsibilities Information,
and Consent To Transport Minors

I consent for treatment/evaluation for myself at COMCARE of Sedgwick County.

I authorize and give consent for _____ to be treated in evaluation, therapy, medication management, case management and/or additional supported services at COMCARE of Sedgwick County.

I authorize and give consent for _____ to be transported by COMCARE employees as part of community based treatment services and in the event of medical and/or other emergencies

I acknowledge that a copy of Sedgwick County's Notice of Privacy Practices has been made available to me with the effective date of April 14, 2003.

I have been given a copy of COMCARE's **Client Rights and Responsibilities** document. I understand that if I have further questions about the information in the **Client Rights and Responsibilities** document I may call my care provider or the Program Manager where I receive services.

Consumer's Signature	Date
Parent/Legal Guardian Signature	Date
Relationship to Client, other than Self	
Witness Signature	Date

Name: _____, Patient ID#: _____
Consent for Treatment/Client Rights and Responsibilities/Transportation of Minors/Acknowledgement of Privacy Practices
22.008 Revised 12/03; 06/06

Received Clients' Right and Responsibilities: Yes No

COMCARE of Sedgwick County

FINANCIAL INFORMATION SHEET

CONFIDENTIAL

Waiver: Pending:

Center: _____

Client Name: _____ Birthdate: _____ SS#: _____

Address: _____ County: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Responsible party (if other than client): _____

Primary Insurance

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID #: _____ DOB: _____

Group #: _____ Effective Date: _____

Employer: _____

Healthwave Cert # _____

Secondary Insurance

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID #: _____ DOB: _____

Group #: _____ Effective Date: _____

Employer: _____

Third Insurance:

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID#: _____ DOB: _____

Group #: _____

Effective Date: - _____

Employer: _____

All patient fees, including co-pays, are due at the time of service. Clients will be billed the lesser of their sliding fee or copay. Our services are billed based on the type and amount of services you receive. Upon presenting proof of total

household income, such as check stubs, bank statements, or previous year's tax return, you may be eligible for our sliding fee rate. No one will be refused

treatment based on their ability to pay.

Total Household Income: _____

Number of Persons in Household: _____ % To Pay _____

\$ _____ per intake hour \$ _____ per injection

\$ _____ per Individual Therapy Hour \$ _____ per Ind Comm Support Hour

\$ _____ per Group Therapy Hour \$ _____ per Psychosocial Therapy Hour

\$ _____ per Case Management Hour \$ _____ per Attendant Care Hour

\$ _____ per Medication Review \$ _____ per Case Conference Hour

\$ _____ Co-Pay/Other

\$ _____ Co-Pay/Other

Extenuating Circumstances:

I hereby authorize COMCARE of Sedgwick County to file my claims with the Insurance companies listed on this financial and for payment from my insurance companies to be made directly to COMCARE of Sedgwick County. I also authorize COMCARE of Sedgwick County to release my initial assessment, any progress notes, results of psychological, psychiatric and/or substance abuse evaluations, medical history, and/or results of any laboratory tests in order to process my claims.

This consent and authorization is subject to a written revocation at any time except to the extent that action has already been taken. This consent will expire on _____ unless it is expressly revoked by the consumer.

It is understood that any consumer payment, which results in a credit balance after insurance payment is received will be refunded to me after all charges are paid in full.

Consumer or Responsible Party Signature	Date Signed by Client
Witness Signature	Date

Revoked: Yes; Date:

COMCARE of Sedgwick County
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	Social Security #:
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I hereby authorize COMCARE of Sedgwick County to:

- Disclose information to
 Request information from
 exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed): **Mental Health Association**

Address: **555 N Woodlawn Suite 3105**

City: **Wichita**

State: **KS**

Zip Code: **67208**

Phone (optional): **316-681-1821**

Fax (optional): **316-686-2032**

Check specific information being authorized to be released or obtained:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Admission Intake
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Psychiatric Evaluation Report
<input type="checkbox"/> Substance Abuse Evaluation Report
<input checked="" type="checkbox"/> Presence in Program
<input type="checkbox"/> Completed External Forms (identify specific form): _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medical History, Lab results
<input type="checkbox"/> Diagnosis
<input checked="" type="checkbox"/> Treatment Plan
<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> Progress Notes
<input checked="" type="checkbox"/> Verbal or written progress reports/consultation |
|---|--|

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

I understand that this information will be used for the purpose of:

- Evaluation
 Treatment
 Case Coordination
 Follow-up care
 Other (specify): _____

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified PHI expires, but not later than one year from date listed below. **** If this item is left blank, the authorization shall remain effective for 365 days after the date listed below.**

I, the undersigned, have read the above and authorized the request or disclosure of Protected Health Information (PHI) as described.

I understand that treatment is not conditioned upon the execution of this authorization.

I understand that COMCARE of Sedgwick County cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.

I understand COMCARE of Sedgwick County may charge fees to provide copies of records and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act for this purpose.

I understand that I may revoke this authorization at any time by providing verbal or written notice to my treatment provider except to the extent that action has been taken in reliance on the authorization or as otherwise stated in Sedgwick County's "Notice of Privacy Practices".

Signature of Client/Legal Guardian	Signature of Witness for External Entities
Printed Name of Legal Guardian and Relationship	Date

For Internal COMCARE releases, the electronic staff signature serves as the Witness signature

(42 C.F.R. Part 2: Prohibition of Redisclosure: The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient).

COMCARE OF SEDGWICK COUNTY

Attn: Medical Records
1929 W. 21st St., Wichita, KS 67203

Patient Name: _____,

Patient ID: _____

Revoked: Yes; Date:

COMCARE of Sedgwick County
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	Social Security #:
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I hereby authorize COMCARE of Sedgwick County to:

- Disclose information to
 Request information from
 exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed): **Behavioral Link**

Address: 334 N Topeka

City: **Wichita**

State: **KS**

Zip Code: **67202**

Phone (optional): **316-682-8092**

Fax (optional): **316-682-8308**

Check specific information being authorized to be released or obtained:

- | | |
|--|--|
| <input type="checkbox"/> Admission Intake
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Psychiatric Evaluation Report
<input type="checkbox"/> Substance Abuse Evaluation Report
<input checked="" type="checkbox"/> Presence in Program
<input type="checkbox"/> Completed External Forms (identify specific form): _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medical History, Lab results
<input type="checkbox"/> Diagnosis
<input checked="" type="checkbox"/> Treatment Plan
<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> Progress Notes
<input checked="" type="checkbox"/> Verbal or written progress reports/consultation |
|--|--|

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I understand that this information will be used for the purpose of:

- Evaluation
 Treatment
 Case Coordination
 Follow-up care
 Other (specify): _____

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1929 W. 21st St., Wichita, KS 67203

Patient Name: _____,

Patient ID: _____

Revoked: Yes; Date:

COMCARE of Sedgwick County
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	Social Security #:
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I hereby authorize COMCARE of Sedgwick County to:

- Disclose information to
 Request information from
 exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed): _____(physician)_____

Address:

City: _____ State: _____ Zip Code: _____

Phone (optional): _____ Fax (optional): _____

Check specific information being authorized to be released or obtained:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Admission Intake
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Psychiatric Evaluation Report
<input type="checkbox"/> Substance Abuse Evaluation Report
<input checked="" type="checkbox"/> Presence in Program
<input type="checkbox"/> Completed External Forms (identify specific form): _____
<input checked="" type="checkbox"/> Other: <u>Medication Review Notes</u> | <input checked="" type="checkbox"/> Medical History, Lab results
<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> Progress Notes
<input checked="" type="checkbox"/> Verbal or written progress reports/consultation |
|---|--|

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I understand that this information will be used for the purpose of:

- Evaluation
 Treatment
 Case Coordination
 Follow-up care
 Other (specify): _____

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1929 W. 21st St., Wichita, KS 67203

Patient Name: _____,

Patient ID: _____

Revoked: Yes; Date:

COMCARE of Sedgwick County
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	Social Security #:
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I hereby authorize COMCARE of Sedgwick County to:

- Disclose information to
 Request information from
 exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed): (resource parents)

Address:

City: State: Zip Code:

Phone (optional): Fax (optional):

Check specific information being authorized to be released or obtained:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Admission Intake
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Psychiatric Evaluation Report
<input type="checkbox"/> Substance Abuse Evaluation Report
<input checked="" type="checkbox"/> Presence in Program
<input type="checkbox"/> Completed External Forms (identify specific form): _____
<input type="checkbox"/> Other: _____ | <input checked="" type="checkbox"/> Medical History, Lab results
<input checked="" type="checkbox"/> Diagnosis
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COMCARE OF SEDGWICK COUNTY

Attn: Medical Records
1929 W. 21st St., Wichita, KS 67203

Patient Name: _____

Patient ID: _____

COMCARE of Sedgwick County Children's Services – Initial Assessment Information

Today's Date		Child's Name: Last			First	Middle	Other names known:	
Social Security No.	Age	Date of Birth		Home Phone		Other Phone		
Address:				City		State		Zip Code
Parent/Guardian Name: Last			First			Middle	Relationship to Child	
Address:				City		State		Zip
Race/Ethnicity:				Education:				
<input type="checkbox"/> Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian				<input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Other _____				
				Current Grade: _____ School: _____ High School Graduate: <input type="checkbox"/> Yes <input type="checkbox"/> No GED: <input type="checkbox"/> Yes <input type="checkbox"/> No Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what Class/Subject? _____				
Are you able to Speak, Read, and/or Write in the following Language(s)? (Check all that apply)								
<input type="checkbox"/> American Sign Language <input type="checkbox"/> Filipino <input type="checkbox"/> Italian <input type="checkbox"/> Speak Limited English <input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Japanese <input type="checkbox"/> Understand Limited English <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Spanish <input type="checkbox"/> Do Not Speak/Understand English <input type="checkbox"/> Danish <input type="checkbox"/> Hebrew <input type="checkbox"/> English <input type="checkbox"/> Other _____								
Who Referred You to Comcare? _____								
Custody Status:								
<input type="checkbox"/> Child in Need of Care <input type="checkbox"/> Juvenile Offender <input type="checkbox"/> Both JO and CINC <input type="checkbox"/> Does Not Apply								
Have you had any involvement with:								
<input type="checkbox"/> DCCCA Day Reporting <input type="checkbox"/> DCCCA Family Preservation <input type="checkbox"/> United Methodist Youthville (UMY) <input type="checkbox"/> Kansas Children's Service League								
Family History: Provide the following information about parents and siblings.								
Relationship	Name	Age				Location (city & State)		
Is there any Mental Illness or Substance Abuse in family? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If Yes, please identify: _____								
Emergency Contact Person (someone other than parent/guardian):								
Name: _____								
Address: _____ City: _____ State: _____ Zip: _____								
Home Phone: _____ Other Phone: _____								
Relationship to Child: _____								

