CENTRAL KANSAS MENTAL HEALTH CENTER
(Dickinson, Ellsworth, Lincoln, Ottawa & Saline Counties)
Client Information Form

CLIENT'S CURRENT
LEGAL FULL NAME:_____
Last First M. Initial Maiden Name

ADDRESS _____SOC. SEC. #: _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

PHONE: HOME/MSG _____CLIENT'S HIGHEST LEVEL OF EDUCATION _____

CELL PH #_____AGE _____ BIRTH DATE _____ SEX _____

MARITAL STATUS: (Circle) MARRIED SINGLE DIVORCED SEPARATED WIDOW COMMON LAW

RACE/ETHNICITY: WHITE___ AMERICAN INDIAN___ ASIAN___ ALASKAN___
BLACK OR AFRICAN AMERICAN, NOT OF HISPANIC ORIGIN _____
PACIFIC ISLANDER___ HISPANIC OR LATIN____ CUBAN___ OTHER___

EMPLOYED: ___ YES ___ NO OCCUPATION: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

VETERAN: ___ YES ___ NO HOW DID YOU LEARN OF US _____

CURRENT PRIMARY CARE PHYSICIAN _____

WHO REFERRED YOU HERE ? _____

HAVE YOU PREVIOUSLY USED OUR SERVICES ? ___ YES ___ NO

WHAT WAS YOUR NAME AT THAT TIME? (If different) _____

LIST OTHER FAMILY MEMBERS RECEIVING SERVICES HERE: _____

_____

DOES PERSON RECEIVING SERVICE HAVE A LEGAL GUARDIAN ___ YES ___ NO

PLEASE LIST PARENT OR GUARDIAN INITIATING TREATMENT TODAY:

NAME: _____RELATIONSHIP:_____PHONE_____

ADDRESS: _____CITY/STATE/ZIP_____

SSN: _____ PLACE OF EMPLOYMENT _____

BUSINESS PHONE _____ CELL PHONE_____

PLEASE LIST OTHER BIOLOGICAL OR ADOPTIVE PARENT, OR OTHER LEGAL GUARDIAN:

(DO NOT LIST STEP PARENTS, UNLESS THEY HAVE LEGALLY ADOPTED THE MINOR)

NAME: _____RELATIONSHIP:_____PHONE_____

ADDRESS: _____CITY/STATE/ZIP_____

SSN: _____ PLACE OF EMPLOYMENT _____

BUSINESS PHONE _____ CELL PHONE_____

PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE/RESIDENTIAL TREATMENT:

ADDRESS: DATES:

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

PLEASE CIRCLE PRIMARY SOURCE OF FAMILY INCOME: WAGES, SOCIAL SECURITY, WELFARE, RETIREMENT, DISABILITY, UNEMPLOYMENT, OTHER

INSURANCE POLICY HOLDER'S NAME _____

DOB: _____ PHONE: _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

INSURANCE COMPANY _____ I.D. # _____

PLACE OF EMPLOYMENT _____ GROUP # _____

MEDICAID # _____ MEDICARE # _____

---------- COPIES OF ALL CARDS MUST BE PRESENTED ----------

DISCOUNTED RATES MAY BE AVAILABLE TO RESIDENTS OF OUR 5 COUNTIES. IF YOU WISH TO APPLY FOR A DISCOUNT, PLEASE COMPLETE THE FOLLOWING:

HOUSEHOLD GROSS (before deductions) INCOME _____

NUMBER OF IMMEDIATE FAMILY MEMBERS LIVING ON INCOME _____(IN HOME)

DISCOUNTED HOURLY FEE _____ (for individual therapy sessions)

YOUR SIGNATURE ON THIS ADMISSION FORM WILL:

1. VERIFY THE ACCURACY OF THE INFORMATION YOU HAVE PROVIDED.
2. AUTHORIZE C.K.M.H.C. TO EXCHANGE THE INFORMATION NECESSARY TO BILL YOUR INSURANCE COMPANY AND TO HAVE THE BENEFITS PAID DIRECTLY TO C.K.M.H.C.
3. ACKNOWLEDGE YOUR RESPONSIBILITY FOR COSTS NOT PAID BY INSURANCE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH C.K.M.H.C.
4. ACKNOWLEDGE YOUR RESPONSIBILITY REGARDLESS OF ANY STIPULATIONS ORDERED BY THE COURT.
5. CONSENT TO THE TREATMENT OF THIS CLIENT.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

I RECEIVED AND UNDERSTAND THE CLIENT'S RIGHTS AND RESPONSIBILITIES HANDOUT _____.

--- PLEASE CHECK IN AND OUT AT THE FRONT DESK FOR EACH APPOINTMENT ---