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

CURRENT LEGAL FULL NAME:____

Last First M. Initial Maiden Name

ADDRESS ____SOC. SEC. #: _________________

CITY _______________________ STATE ________ ZIP _________ COUNTY _____________

PH: HM/MSG ___________________CELL PH #_________________

AGE _______ BIRTH DATE ___________________ SEX _______

HIGHEST LEVEL OF EDUCATION _____________________

MARITAL STATUS: 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 ABOUT US ____________________

CURRENT PRIMARY CARE PHYSICIAN ________________________

REFERRED BY_____________ _________________

RECEIVED SERVICES HERE BEFORE ? ___ YES ___ NO

IF YES, UNDER WHAT NAME? (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 ---