



First Responder interested in obtaining services remotely: included are a health history questionnaire, an intake form, blank Release of information and other necessary HIPAA and other agency consent forms. Please print the packet, review the forms, complete the documents and scan them along with your ID, front and back of your insurance card(s) and submit these all to [newclientinfo@rsnwo.org](mailto:newclientinfo@rsnwo.org). in the subject line please reference First Responder intake packet.

Members of our support team will enter your information into our system and then reach out to you by phone to schedule an assessment. These are typically 2-hour sessions held at 10AM and 2 PM each weekday. This will be held on zoom, and all these details will be provided to you on this phone call. If these times are not conducive to your schedule please let us know and we can make other arrangements.

RNSWO will bill your commercial insurance for this assessment and ongoing individual counseling sessions. Other non-traditional insurance services would be out of pocket (Case Management/Substance Use Group services) which we outlined/explained prior to billing for such services. Should you want to access our Four County ADAMhs board assistance (based on residency/family size/income) a support staff could review this with you during your treatment time with us.

If you have recently experienced a mental health or substance use emergency or need immediate crisis intervention services, please be in contact with Crisis Care and Counseling Center at 1-800-468-4357. If you are in an immediate emergency, contact 911 or go to your nearest Emergency Room to ensure your safety.

Recovery Services remains committed to your overall wellbeing! If there is anything we can help you with during this time, please reach out to us.

Sincerely,

The RSNWO Team



Assistance with the funding for the assessment/treatment may be available, in part, by the local ADAMhs Board. Please provide the following items to the agency.

- Verification of all household income sources (at least 2 current check stubs, verification of child support, Social Security/Disability verification, including spouse's income)
- Residency verification (copy of a utility bill, credit card bill, probation department verification)
- Copy of any medical insurance card, including current Medicaid card.
- Photo Identification

If it is determined that you are eligible for assistance with the ADAMhs board, a Support Team Lead will be in contact to sign necessary paperwork.

If you have recently experienced a mental health or substance, use emergency or need immediate crisis intervention services, please be in contact with Crisis Care and Counseling Center at 1-800-468-4357. If you are in an immediate emergency, contact 911 or go to your nearest Emergency Room to ensure your safety.

Recovery Services remains committed to your overall wellbeing! If there is anything we can help you with during this time, please reach out to us.

Sincerely,

The RSNWO Team



## New Client Orientation

As part of your assessment and new client orientation, you will be asked to complete an intake form, health history questionnaire, provide copies of all insurance cards, provide your ID, verify your residency and income (for residents of Defiance, Fulton, Henry and Williams Counties) applying for financial assistance from the Four County ADAMHS board.

Part of this orientation with support staff will review your rights, expectations, and explanation of service provisions along with other necessary requirements. And these forms will be on our agency website [www.rsnwo.org](http://www.rsnwo.org) – new client documentation. RSNWO staff can provide you printed copies upon request.

Client Rights and Expectations and Client Grievance Policies

Notice of Privacy Practices (RSNWO and Four County ADAMHS Board)

Telemedicine/Electronic Service Provision/Risks/Local Resources

Health and Safety Resources, Office Safety Orientation

Rate Sheet

Information on Advanced Directives & Declaration of Mental Health

RSNWO staff can provide you with printed copies upon request

**Please follow the steps below to complete all required forms before your first appointment.  
Submitting complete paperwork helps us schedule you quickly.**

### **1. Client Intake Form (Pages 1–5)**

**Pages 1–4:** Provide your personal information, including contact details, demographics, living situation, employment, education, insurance, and emergency contacts.

**Page 5:**

- List everyone who lives in your household.
  - This is only needed if you plan to submit paystubs to apply for ADAMhs Board financial assistance.
- Sign and date at the bottom.
  - Your signature authorizes RSNWO to bill your insurance.
  - Any balance not covered by insurance is your responsibility.

### **2. Health Questionnaire**

- Complete pages **1–2** and the **top of page 3**.
- Leave the **bottom of page 3** blank for RSNWO staff.

### **3. Front Desk Intake Packet**

**Electronic Service Provision Consent (Telemedicine)**

- Indicate whether you agree to telemedicine services.
- RSNWO uses Zoom for telehealth.
- If you select “No,” you will need to attend appointments in person.

### **OBHIS Consent**

- Ohio collects non-identifying data to help determine funding and grant use.
- None of your personal information is released.
- Check “Yes” or “No.”

### **Client Declaration**

- Confirms you understand the information provided.
- All referenced documents are available at **rsnwo.org**.

### **Orientation Checklist**

- Reviewed with you during scheduling.
- Also available on our website.
- Bottom of page 4- Sign and date

### **4. Informed Consent**

- Print your name and today’s date
- Middle of page 2, select Adult
- Top of page 3- Do you have a living will?
- Bottom of page 3- Do you agree with above paragraph, select yes, if no, please call office
- Top of page 4- Do you consent to use of Eleos
- Bottom of page 5, Select yes or no
- Bottom of page 5-Sign and date

### 5.TPO Release of Information

- Enter today's date, your name, and your address.
- Print your full name and Date of Birth
- Purpose: initial: **Treatment, Payment, and Healthcare Operations.**
- Information we may share with insurance/healthcare providers includes: initial each line
  - **Assessment, Attendance, Behavioral Data, Diagnosis & Prognosis, Recommendations**
- Amount of information: initial: **Most recent admission.**
- Sign and date bottom right on the line that says Signature of Client age 12 and up.

### 6.Release of Information for emergency contact

- Enter today's date, your name, and your address.
- Print your full name and Date of Birth
- Purpose: initial: **Personal**
- Information we may share with emergency contact includes: initial each line as you wish, at least initialing: **Emergency Contact** , you may also include:
  - **Assessment, Attendance, Behavioral Data, Diagnosis & Prognosis, Recommendations**
- Amount of information: initial: **Most recent admission.**
- Sign and date bottom right on the line that says Signature of Client age 12 and up.

### 7. Submit Your Paperwork

- Email the following to [newclientinfo@rsnwo.org](mailto:newclientinfo@rsnwo.org) Attn: First Responder Intake
- Completed **Client Intake Form**
- Completed **Health Questionnaire**
- Completed **Front Desk Intake Packet**
- Completed **Informed Consent Packet**
- **Photo ID**
- **Insurance card** (front and back)
- A staff member will contact you after your paperwork is received.

## Client Intake Form

**Name (first, middle initial, last name) :** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Primary: Yes No Primary: Yes No  
 Can we leave a message? Yes No Can we leave a message? Yes No  
 Can we send Text Messages: Yes No

Text messaging may be used for Greenspace, billing statements, and other survey/assessment tools relating to your care

Email Address: \_\_\_\_\_ Agency allowed to use to register for Greenspace, billing statements, and other survey/assessment tools relating to your care

**Mailing Address:** Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Physical Address:** Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 (this needs verification for Four County Financial Assistance)

**County of Residence:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**If client is a minor they must have a custodial parent/guardian present for assessment**

**Parent/Legal Guardian Name:** \_\_\_\_\_

**Is there custody/guardianship paperwork in place? If so, this is required and must be presented before proceeding with visit.**

**Gender:** Male Female

**Gender Identity: (optional if different from gender identified above)** \_\_\_\_\_

**Race:**  Alaskan Native  Native American  Asian  Black/African American  Unknown  
 Pacific Islander  White  Other Single Race  Two or more races

**Primacy method of communication:**

Verbal  Sign Language  Written  Augmentative Device

**Primary Language:**

**Is an Interpreter needed?**  Yes  No

**Ethnicity:**  Cuban  Hispanic  Mexican  Puerto Rican  Other Hispanic Origin  Not Hispanic  Unknown

**Please check the individual's current living situation**

Own Home  Rent Home  With Parents  Correctional Facility  Friends Home  Homeless  Unknown  
 With Foster Parents  Nursing Facility  24-Hour Residential Care  Other: \_\_\_\_\_

**Marital Status:**  Divorced  Legally Separated  Married  Separated  Single  Widowed  Other

**Tobacco Use:**  User  Non-User

**Smoking Status**  Current Smoker  Former Smoker  Never Smoked  Unable to Collect



**Primary Language:**  English  Other list : \_\_\_\_\_  
**Is an Interpreter needed?**  Yes  No

**Military Status:**  Active Duty  Disabled Veteran  Discharged  None

**Military Service detail:**  Overseas  Reserve  Served in Afghanistan  Served in Iraq  N/A

**SSN:** \_\_\_\_\_

**If you were referred to our services, who referred you? You can list more than one – please be specific**

**Specific Referral Organization Name:** \_\_\_\_\_

**Address/phone number and or contact name at referral:** \_\_\_\_\_  
\_\_\_\_\_

**Please check the individual's employment status**  Employed-Full Time  Unemployed-Not seeking Work  Retired

Unemployed-seeking work  Employed-Part Time  Student  Disabled

Not in the Workforce list reason \_\_\_\_\_

Other: \_\_\_\_\_

If applicable: Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

**Highest completed education level (please mark one of the Following):**

Regular Education Classes list last grade completed \_\_\_\_\_

High School/GED  Vocational Education  Some College  associate's Degree  bachelor's degree

Master's Degree or higher  Unknown

**Education Type**

Not Enrolled  Currently enrolled in Pre-School  Currently enrolled in K-12<sup>th</sup> Grade

Currently Enrolled in Vocational Schooling/Job Training  Currently enrolled in college

Currently enrolled in other schooling  Has not been enrolled in any type for at least past 3 months

Unknown

**MH Education Type**

Adult or not enrolled in K-12<sup>th</sup> Grade  Does not have IEP  Has an IEP  Unknown

**Contacts/Guarantors Information**

**This allows for RSNWO to bill accurately and have other important persons added to your health record.**

**Adult Clients:** You may list self but do not need to re-enter your personal information. Please check all applicable boxes. Also, adults should list at a minimum the financial responsible party, a designated Power of Attorney (if applicable) and an emergency contact.

**Minor Children:** Clients under the age of 18 must have the following identified: Financial responsible party/statement recipient, emergency contact, insurance prescriber (if applicable), and guardian/legal guardian.

**Documenting persons and information on this document does NOT qualify as an Authorization of Release of Information. Additional documentation is required for information regarding services, attendance and treatment to be disclosed.**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_

If Guardian please provide: Date of Birth \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_\_\_

Check ALL That Apply:

- Legal Guardian       Emergency Contact       Power of Attorney  
 Financially Responsible/ Receives Statements       Self-Pay       Insurance Subscriber

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_

Check ALL That Apply:

- Legal Guardian       Emergency Contact       Power of Attorney  
 Financially Responsible/ Receives Statements       Self-Pay       Insurance Subscriber

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_

Check ALL That Apply:

- Legal Guardian       Emergency Contact       Power of Attorney  
 Financially Responsible/ Receives Statements       Self-Pay       Insurance Subscriber

**Insurance Information:** Client is responsible to provide ALL commercial/Medicare/Medicaid and any other known payer details at the time of the assessment and ongoing in treatment for timely accurate billing. As a Community Behavioral Health Provider RSNWO is not in network with most commercial insurance, many staff are not credentialed, and significant services are not covered nor billed to commercial payers. These will be reviewed with rates of each service and can be reviewed ongoing with recommendation of services so that a client has the information and awareness of the cost of the services provided and their responsibility for said services.

**Are you covered by Medicaid ?**  Yes  No      When yes, please provide a copy of your Medicaid/Managed Care Medicaid card

**Are you covered by Medicare?**  Yes  No      When yes, please provide a copy of your Medicare/Advantage plan cards with all supplement cards

**Are you covered by Commercial Health Insurance?**  Yes  No

Please list all the details below and provide a copy of your card(s) at the front desk.

**Primary Insurance**

Insurance Company Name: \_\_\_\_\_ Member ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Subscriber Relationship to Client \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Employer : \_\_\_\_\_

**Is this a Marketplace Product?**  Yes  No  Unknown

**Secondary Insurance**

Insurance Company Name: \_\_\_\_\_ Member ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Subscriber Relationship to Client \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Employer : \_\_\_\_\_

**Is this a Marketplace Product?**  Yes  No  Unknown



Residents for Four County ADAMhs Board can be eligible for financial assistance by providing details on their family size, annual income (verified by 2 current, consecutive checks stubs for all members employed), all health insurance plans and residency (providing a copy of a mailed bill or other address verification). Below is where we gather these items to determine where you would fall on the sliding fee scale. Residents of Defiance, Fulton, Henry, and Willams county are the only clients/families that need to complete this section. Clients that fall on a 0-10% sliding fee scale must apply for Medicaid before accessing Four County Assistance. RSNWO will facilitate the Medicaid application process, but it is the client responsibility (or financial responsible party) to comply fully with the application process to completion. Failure to do so requires payment in FULL at each session.

List all members of your household starting first with the client, list relationship and age.

Name \_\_\_\_\_ Relationship Self Age: \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Source of Income/Employer \_\_\_\_\_ Amount \_\_\_\_\_

Name: \_\_\_\_\_ Source of Income/Employer \_\_\_\_\_ Amount \_\_\_\_\_

Name: \_\_\_\_\_ Source of Income/Employer \_\_\_\_\_ Amount \_\_\_\_\_

Verified by check stubs, SSI paperwork, other verifications

**RSNWO Staff complete this section :**

Income: Annual for Household from all sources \_\_\_\_\_ Monthly Income \_\_\_\_\_ (RSNWO staff verifies)

Family Size for Four County Sliding Fee Scale: \_\_\_\_\_

Until full verifications are provided, the client is considered full self-pay and expected payment of charges in full are due at the time of service.

Client Sliding Fee Scale Rate \_\_\_\_\_% Four County ADAMhs Board Rate: \_\_\_\_\_ % Effective date \_\_\_\_\_

I acknowledge this is my sliding fee percent today. I may be required to complete Medicaid Application, provide more financial verifications to complete this. Until I complete this – I am fully responsible for every service at 100% full pay rate. I have been provided my current fee schedule applicable to these rates.

I authorize RSNWO to release any information acquired in the course of my treatment that will be necessary to process any insurance claims. I also authorize payment of any medical benefits directly to RSNWO. If payment of any such claims is made directly to me, I agree to sign over the check to RSNWO. I agree that if insurance does not cover the standard rate of my treatment or is not allowed even to be billed to insurance, I will pay my sliding fee portion.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Financial Responsible Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RSNWO Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical staff.

<b>Client Name</b> (First, MI, Last)	<b>Client No.</b>	<b>Age</b>
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Has the client had any of the following health problems?

	Now	Past	Never	What Treatment Received and Date(s)
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Pressure (high or low)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bone/Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cirrhosis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Disease/Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury/Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems/Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Health/Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactivity/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicide Attempts/Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Please note family history of any of the above conditions and client's relationship to that family member.**

<b>Client Name</b> (First, MI, Last)	<b>Client No.</b>
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Nutritional Screening (please check)												
<input type="checkbox"/> No Problem	<b>Eating</b>	<input type="checkbox"/> More	<input type="checkbox"/> Less	<b>Drinking</b>	<input type="checkbox"/> More	<input type="checkbox"/> Less	<b>Appetite</b>	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased			
	<input type="checkbox"/> Not Eating				<input type="checkbox"/> Takes Liquids Only							
<input type="checkbox"/> Nausea		<input type="checkbox"/> Vomiting		<input type="checkbox"/> Trouble Chewing or Swallowing								
<b>Special Diet</b>						<b>Other</b>						
Pain Screening												
<b>Does pain currently interfere with your activities?</b> If yes, how much does it interfere with these activities (please check)												
<input type="checkbox"/> No		<input type="checkbox"/> Yes		<input type="checkbox"/> Not at All		<input type="checkbox"/> Mildly		<input type="checkbox"/> Moderately		<input type="checkbox"/> Severely		<input type="checkbox"/> Extremely
<b>Please indicate the source of the pain.</b>												
Substance Use History/Current Use (please check appropriate columns)												
Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use	
Alcohol/Beer/Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Caffeine use?</b> If yes, form (coffee, tea, pop, etc.)						<b>How much a week</b> (cups, bottles)?						
<input type="checkbox"/> No <input type="checkbox"/> Yes												
<b>Tobacco use?</b> If yes, form (cigarettes, cigars, smokeless, etc.)						<b>How much a week</b> (packs, etc.)?						
<input type="checkbox"/> No <input type="checkbox"/> Yes												
<b>Print Name of Person Completing this Questionnaire</b>						<b>Signature of Person Completing this Questionnaire</b>				<b>Date</b>		

Comments, Recommendations, or Referrals by Medical Reviewer		<input type="checkbox"/> No Referral Needed
<b>Check Referral(s) Needed and Specify Action(s)</b>		
<input type="checkbox"/> Primary Care Physician: _____		
<input type="checkbox"/> Healthcare Agency: _____		
<input type="checkbox"/> Specialty Care: _____		
<input type="checkbox"/> Other (specify): _____		
<b>Recommendations shared with client?</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, client's response.		
<b>If no, how will recommendations be shared with client?</b>		
<b>Medical Reviewer Signature/Credentials</b> (Nurse, PA, NP, MD, DO)		<b>Date</b>

**Electronic Service Provision Consent: Telemedicine**

The use of Electronic Service Provision is commonly used at RSNWO for assessment, counseling and psychiatric service delivery. Other treatment services may be added as deemed necessary and appropriate. Electronic Service Provision seeks to improve an individual’s health by permitting two-way real time interactive communication between the client and the physical or therapist at a distant or separate site. Electronic Service Provision occurs through interactive telecommunications equipment that includes at a minimum audio and video equipment.

Should you be involved in Electronic Service Provision, the staff engaging in the electronic service will verify your identity by asking for the last four digits of your social security number or date of birth. This is to ensure that an imposter is not sitting in on the service and to ensure confidentiality is maintained.

Electronic Service Provision Benefits: This enables RSNWO to provide services to clients at the location of the client. Additional benefits include healthcare cost savings, improved access and timeliness of care and health needs being met.

Electronic Service Provision Risks: While RSNWO has taken steps to ensure that Electronic Service Provision is HIPAA compliant and confidentiality is maintained, there can be risks related to confidentiality should the software become hacked externally. Additionally, staff have been trained in use of equipment however glitches and issues with technology may impact on the quality of communication and interaction with the service providers. Please be aware that should a situation present where the individual needs to stop the telemedicine process due to the quality of service being compromised, the session may be adapted and interaction occur via telephone or with a provider at the site you are receiving services at.

Please be aware that this is not an exhaustive list of the risks and benefits of Electronic Service Provision/Telemedicine.

Client/Individual Agrees?

- Yes
- No

**OBHIS Consent**

The Ohio Department of Behavioral Health (ODBH) has developed a data collection system to comply with the requirements of the Substance Abuse Prevention and Treatment (SAPT) and Mental Health Block Grants. Providers certified or licensed by ODBH to provide

behavioral health services are required under ORC5119.61 and OAC 5122-28-04 to report information to OHBIS for clients treated for mental health or substance use disorder, when services are covered in whole or part by public funding through Medicaid, ADAMH Board, ODBH.

By signing below, I consent to myself, my child, or the individual that I am the legal guardian, for collection and submission of OBHIS data.

### **Orientation Checklist Support**

Support staff have completed (as applicable), reviewed, provided access to them on the agency website [www.rsnwo.org](http://www.rsnwo.org) and can make available upon request the following documents:

Financial obligations, fees, payment expectations, insurance, Medicaid information

Telemedicine Risks

Access to after-hour services

Physician Standing order

Health and Safety items: Seclusion and restraint, Tobacco policy, illegal and legal substances brought into program, prescription medications brought into the program, weapons brought into the program. Orient to office safety noting each office has evacuation routes and safety equipment locations.

Clients Rights, Responsibilities, and Expectation

Privacy Practices for RSNWO and Four County ADAMhs Board

Grievance Procedure

Education regarding advanced directives when indicated

Client/Individual Agrees?

- Yes                       No

### **Client Declaration**

I certify that I have been provided with the following information either through the provided website link ([www.rsnwo.org](http://www.rsnwo.org)) or paper copies if requested.

I acknowledge an understanding of this information and receipt of these documents or access to said documents.

Client Rights and Policy, Grievance Policy, Group Rules, Privacy Practices (RSNWO/Four County ADAMhs Board), Crisis Information, Client Fee information/Rates of services, Telemedicine Risks, Health Education information, Site health and safety information, Agency hours, locations, contact information, and Advance Directives

Client/Individual Agrees?

- Yes
- No

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT – RSNWO

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Treatment at Recovery Services of Northwest Ohio (RSNWO) is a joint effort involving yourself and/or your child and the treatment team (psychiatrists, therapists, case managers, nurses, clinical supervisors, etc.). To assist with case coordination and facilitate communication of treatment concerns, the treatment team and clinical staff members participate in clinical supervision and peer consultation. This may result in your case being discussed in clinical treatment team meetings, supervision and other case consultations.

In general, the benefits of clinical treatment may include, but is not limited to increased insight, improvement in self-esteem, improvement in interpersonal relationships, relief of symptoms including anxiety and depression, and improvement in your ability to function day to day. Specific therapeutic goals which address areas of concern and needs will be addressed in your Individualized Service Plan. Due to the sensitive nature of an individual's treatment, it is possible that treatment may provide a temporary increase in your or your child's negative symptoms or stress level and there is no guarantee that symptoms will be reduced and/or eliminated.

Diagnostic assessment, which may include formal psychological testing, is an important aspect of your or your child's treatment to aid in increasing our knowledge of your or your child's personality and/or intellectual functioning. This may aid in your or your child's progress in therapy.

Upon the completion of the diagnostic assessment, recommendations may be provided to you regarding treatment that may be helpful in decreasing identified symptoms and improving your health and functioning. You may refuse or reject certain treatment recommendations while agreeing to or exploring other treatment recommendations without penalty from RSNWO.

As part of Substance Use Disorder and Mental Health Disorder Services, you and/or your child may be asked to submit to random drug screens. This drug screen may include observation by the agency medical department or clinical team. In addition, if a drug screen is refused, this will be considered a positive drug screen and may be reported to other involved providers in your treatment, including your referral source.

Your consent may reveal information that may be used by third parties to make decisions that could have a significant effect on your or your child's life. Third parties may include, but is not limited to the Courts, The Department of Job and Family Services, Bureau of Disability, Workman's Compensation, Insurance Companies, etc. Please understand that you may or may not limit third party access to information; however the third party may penalize you as a result of these limits. RSNWO and its employees are mandated reporters

and the following disclosures do NOT require consent or authorization by you: To avert imminent harm to client or others, as per duty to protect statute; disclosure of child and/or elder abuse and/or neglect; court order; the Office of Civil Rights to determine compliance with the privacy rule; defending of legal action brought by a client.

By signing the Informed Consent for Treatment form I hereby consent to the following:

I authorize the staff of Recovery Services of Northwest Ohio to use any or all procedures and treatments customarily employed in behavioral health facilities in the treatment of psychiatric, mental health and emotional disorders, substance use disorder treatment in order to provide care and treatment. Customary care may include, but is not limited to psychological methods such as counseling, psychotherapy, psychiatry, random and observed drug screens, evaluations and aftercare.

I acknowledge that I have received an explanation of risks and benefits of each proposed treatment, alternative treatments and no treatment. I have been given an opportunity to ask clarifying questions and have had my questions answered in a satisfactory manner.

I acknowledge it has been shared with me that RSNWO utilizes an Electronic Health Record where all client files are stored. This EHR is secured and compliant with HIPPA standards to ensure my confidentiality is maintained.

**Client is:**

- Adult
- Minor

**Signing Party is:**

- Parent
- Guardian

As a parent, I consent for my child to receive Mental Health Services and Substance Use Disorder Services. I understand that this may include random observed drug screens.

- Yes
- No

I have received a copy of and explanation of the Client Rights and Grievance Procedures of RSNWO according to the Ohio Department of Mental Health and Addiction Services (OMHAS) and Commission on Accreditation of Rehabilitation Facilities (CARF). I have been given an opportunity to ask clarifying questions and have had my questions answered in a satisfactory manner.

I understand that if I or my child is treated by a non-independently licensed clinician (SWA, LSW, LPC, CDCA, LCDC II, LCDC III, etc.), they will be supervised by an independently

licensed clinician or psychologist. This may include clinicians I or my child is treated by in group settings.

Do you have a psychiatric advanced directive or a living will? If yes, please provide a copy for our files.

- Yes
- No

I have been provided a copy of an Advanced Directive in my Intake Packet provided during the RSNWO Financial Intake. I have been provided with an opportunity to ask questions and gain clarification regarding this document. I have had my questions answered in a satisfactory manner.

I acknowledge that I completed a Financial Intake with a member of the RSNWO staff. At that time, a financial agreement with RSNWO was established where cost of services and fees associated with services were discussed with me. I acknowledge I was given an opportunity to ask questions and have my questions answered in a satisfactory manner. I acknowledge that I signed a Fee Agreement with RSNWO and agree to abide by that Fee Agreement.

I recognize that this Informed Consent for Treatment is active and may be acted upon throughout my treatment services with RSNWO and will not end until I have been discharged from this treatment cycle by all providers with RSNWO.

I recognize that should I invite or the service provider request other individuals, for example family members, significant others, friends, etc. to participate in my treatment session, I am the identified client and the other individual present is not a client, but a third party to my treatment session. You will be asked to sign a release of information for the third party and define the information to be released before staff allow the third party to participate in the session, unless there are circumstances that constitute an emergency. By involving the third party in the treatment session, this does not provide them will access to your client record, unless a release of information is signed providing this right. Please be aware, RSNWO does not have a clinical obligation to the third party as they are not a client to the agency, nor a responsibility to maintain the third parties confidentiality.

Client/Individual Agrees?

- Yes
- No

## INFORMED CONSENT FOR USE OF ELEOS HEALTH SOFTWARE

Eleos is a software program that will allow your clinician to be more present in your sessions by drafting documentation for your notes while you and your clinician focus on your treatment goals and the session at hand. The software helps your clinician gain valuable insights and data that may be overlooked during typical sessions. The voice analysis feature of the software learns words and phrases specific to you and your clinician, which leads to an increase in personalized, adequate, and effective care.

The use of this valuable information by the clinician has proven to lead to better session quality, faster relief to your concerns, and on average reduces the episode of care duration by 50%. Additionally, Eleos software has shown to improve clinician satisfaction and retention, therefore reducing overall turnover rates of clinicians. The software will run silently along with your session and you should notice few if any changes to your experience, with the exception of your clinician being more present in the session and not being distracted by taking notes.

I understand that the information gathered by Eleos Health may be used for supervision, documentation, analytical, quality, and training purposes. The information is secured through end-to-end encryption and securely stored in a cloud-based, password-protected environment provided by Eleos Health. Eleos Health is a HIPAA, SOC2 and HITRUST compliant software program that your clinician may use during your individual, family/couples, or group counseling sessions.

Client/Individual Agrees?

- Yes                       No

# ORIENTATION CHECKLIST CLINICAL – RSNWO

Clinician and Client Complete

Standards of professional conduct related to services

Informed Consent to Treat

Client Expectations

Transition and Discharge

Response to identification of potential risk to person served

Program Rules and expectation including restrictions, events, behaviors and likely consequences, means by which the person may regain rights/privileges

Identification of the purpose and process of the assessment

Description of how person centered plan will be developed

Person's participation in the goal development and achievement

Potential course of treatment/services

How motivational incentive may be used

Expectation for legally required appointments, sanctions or court notifications

Expectation for family involvement

Identification of the person responsible for service coordination.

Client/Individual Agrees?

- Yes                       No

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

# TPO-Release of information

## Recovery Services of Northwest Ohio

511 Perry Street, Defiance, Ohio 43512

Phone (419)782-9920 Fax (419)784-2523

### Authorization For Release Of Information

**Expires:** 1 year from \_\_\_\_\_  
(Date of authorized Client or Guardian's Signature on this form)

**Note:** All matters relating to alcohol or drug abuse records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters can not be given out without the consent of the client. Section 2.31 of the P. L. 93-282, Part 2, requires the following information:

Recovery Services of Northwest Ohio is hereby granted my permission to exchange information with:  
My treatment providers, health plans, third party payers and people helping to operate this program

I understand that if my information is disclosed to a covered entity or a business associate, my information may be redisclosed in accordance with HIPPA. I understand that information shared for treatment, payment or health care operations, to covered entities and business associates, can not be redisclosed for civil, criminal, administrative, and legislative proceedings against me unless I have given separate written consent. I understand that records or information disclosed under this consent may be redisclosed by the recipient and that the information redisclosed may no longer be protected under 42 CFR Part 2. If I do not consent to the disclosure of my records or information, it may not be readily available to those who need the information to give me appropriate care, coordinate care, or provide reimbursement for services rendered.

\_\_\_\_\_  
(Full name of the client) \_\_\_\_\_ (Date of Birth)

**Purpose or need for disclosure:** Please check applicable item(s):

\_\_\_\_\_ Continuity of care      \_\_\_\_\_ Resolution of legal matters      \_\_\_\_\_ Personal  
\_\_\_\_\_ Treatment, Payment and Healthcare operations

**Specific information to be disclosed:** Please have client initial applicable item(s)

_____ Assessment	_____ Behavioral data	_____ Diagnosis & Prognosis	_____ Recommendations
_____ Referrals	_____ Attendance	_____ Progress Notes	_____ Progress
_____ Lab Results	_____ Psychiatric Evaluation	_____ Drug Screen Results	_____ Financial & Billing
_____ Emergency Contact	_____ Messages	_____ Case Manager Services	
_____ Other (specify) _____			

**Amount of information to be disclosed:**

Information covering the most recent admission \_\_\_\_\_, Information covering all previous admissions \_\_\_\_\_  
Information covering Other (specify) \_\_\_\_\_.

The following rules apply as it relates to the timeline and revocation of the release of information. This release of information naturally expires 1 year from the date of the authorized signature or this release of information expires 6 months post discharge from care if it is not revoked prior to discharge or does not expire naturally within the 1-year time frame from the authorized signature.

I understand that this consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. My refusal to sign this authorization will **NOT** affect my ability to obtain treatment, payment, or enrollment in a health plan.

As required by section 2.32(a). Prohibition on Disclosure: "This information has been disclosed to you from records protected by federal confidentiality rules. 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 C.F.R., Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

\_\_\_\_\_  
(Signature of Client age 12 and up) \_\_\_\_\_ (Date)

\_\_\_\_\_  
(Signature of Parent or legal guardian of Client) \_\_\_\_\_ (Date)

\_\_\_\_\_  
(Signature of Staff Witness/Referral Source) \_\_\_\_\_ (Date)

Emergency Contact     Medical Provider     Referral Source     Other

<b>For Office Use Only</b>	
<b>Staff Person Releasing Information:</b> <i>Agency Authorized Staff Only</i>	<b>Date:</b>

I recognize that I have the right to revoke a Release of Information and am doing so at this time. My signature below signifies that I have acted upon my right. I recognize that any action and communication that has already occurred prior to the revoking of the Release of Information was acted upon with the understanding that the Release of Information was active at that time. Upon signing below, the Release of Information is no longer active and cannot be acted upon by RSNWO staff members. Should you change your mind and consent for future communication between RSNWO and the listed party, a new Release of Information will need to be signed at that time.

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Witness/Referral Source

\_\_\_\_\_  
Date

**EMERGENCY CONTACT**

**Release of Information**

**Recovery Services of Northwest Ohio**

511 Perry Street, Defiance, Ohio 43512

Phone (419)782-9920 Fax (419)784-2523

**Authorization For Release Of Information**

**Expires:** 1 year from \_\_\_\_\_  
(Date of authorized Client or Guardian's Signature on this form)

**Note:** All matters relating to alcohol or drug abuse records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters can not be given out without the consent of the client. Section 2.31 of the P. L. 93-282, Part 2, requires the following information:

Recovery Services of Northwest Ohio is hereby granted my permission to exchange information with:

(Name of Individual or of the Organization to which the Information is to be made)

(Complete Address): \_\_\_\_\_ Phone# \_\_\_\_\_  
\_\_\_\_\_ Fax# \_\_\_\_\_

\_\_\_\_\_ (Full name of the client) \_\_\_\_\_ (Date of Birth)

**Purpose or need for disclosure:** Please check applicable item(s):

\_\_\_\_\_ Continuity of care \_\_\_\_\_ Resolution of legal matters \_\_\_\_\_ Personal

**Specific information to be disclosed:** Please have client initial applicable item(s)

_____ Assessment	_____ Behavioral data	_____ Diagnosis & Prognosis	_____ Recommendations
_____ Referrals	_____ Attendance	_____ Progress Notes	_____ Progress
_____ Lab Results	_____ Psychiatric Evaluation	_____ Drug Screen Results	_____ Financial & Billing
_____ Emergency Contact	_____ Messages	_____ Case Manager Services	
_____ Other (specify) _____			

**Amount of information to be disclosed:**

Information covering the most recent admission \_\_\_\_\_, Information covering all previous admissions \_\_\_\_\_  
Information covering Other (specify) \_\_\_\_\_.

The following rules apply as it relates to the timeline and revocation of the release of information. This release of information naturally expires 1 year from the date of the authorized signature or this release of information expires 6 months post discharge from care if it is not revoked prior to discharge or does not expire naturally within the 1 year time frame from the authorized signature.

I understand that this consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. My refusal to sign this authorization will **NOT** affect my ability to obtain treatment, payment, or enrollment in a health plan.

As required by section 2.32(a). Prohibition on Disclosure: "This information has been disclosed to you from records protected by federal confidentiality rules. 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 C.F.R.. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

\_\_\_\_\_  
(Signature of Client age 12 and up) (Date)

\_\_\_\_\_  
(Signature of Parent or legal guardian of Client) (Date)

\_\_\_\_\_  
(Signature of Staff Witness/Referral Source) (Date)

Emergency Contact  Medical Provider  Referral Source  Other

<b>For Office Use Only</b>	
Staff Person Releasing Information: <i>Agency Authorized Staff Only</i>	Date:

I recognize that I have the right to revoke a Release of Information and am doing so at this time. My signature below signifies that I have acted upon my right. I recognize that any action and communication that has already occurred prior to the revoking of the Release of Information was acted upon with the understanding that the Release of Information was active at that time. Upon signing below, the Release of Information is no longer active and cannot be acted upon by RSNWO staff members. Should you change your mind and consent for future communication between RSNWO and the listed party, a new Release of Information will need to be signed at that time.

\_\_\_\_\_  
Signature of Client/Parent/Guardian Date Signature of Staff Witness/Referral Source Date