ViaQuest Psychiatric & Behavioral Solutions

WILSON HEALTH

Behavioral Health Care
Mental Health Referral

TYPES OF BEHAVIORAL HEALTH SERVICE REQUESTED:

☐ Psychiatry (Medication Management) ☐ Therapeutic Behavioral Support (TBS) (Medicaid Only)

DEAF SERVICES (IF APPLICABLE):

☐ Deaf ☐ DeafBlind ☐ Deaf Low Vision

Client Name: _____

Name/Title Of Person Making Referral: _____ Referral Date: _____

Organization/Phone/Fax/Email: _____

Check Any Current Mental Health Symptoms:			
☐ Hallucinations	☐ Delusions	☐ Thought disorder	☐ Psychotic behavior
☐ Anxiety	☐ Nervousness	☐ Obsessive / compulsive	☐ Phobias / fears
☐ Mood swings	☐ Irritability	☐ Sleep disturbance	☐ Depressed mood
☐ Anger	☐ Hyperactivity	☐ Attention deficit	☐ Eating problems
☐ Oppositional	☐ Defiant	☐ Antisocial	☐ Delinquent behavior
☐ Over sexualized behavior	☐ Dementia w/ behaviors	☐ Somatic complaints with no known medical cause	

Presenting Problem: (list below why client should be seen)

Desired Outcome: (list below what results are expected from services)

Please Provide:

- Face Sheet
- Medication List (If Wanting Psych/Med Management Services)

INFORMED CONSENT FOR SERVICES & TREATMENT

(ViaQuest Community Solutions, ViaQuest Day & Employment Services, ViaQuest HealthCare Services, ViaQuest Psychiatric & Behavioral Solutions, ViaQuest Residential Services)

WILSON HEALTH

I understand that I have the right to make informed decisions about my treatment and services received. The type and extent of services that I will receive will be determined for the best course of treatment and services for me. I understand that a range of professionals, some of whom may be internally trained, will provide services. All professional staff will be supervised according to regulations and/or licensure requirements. If applicable, I understand that certain treatments (e.g. psychotherapy and/or medication) recommended may provide significant benefits but may also pose risks which will be discussed with me.

I agree to the following (please check the applicable sections):

Billing and Payment (REQUIRED)

☑ I understand that payment of all fees is due at the time of service. I authorize ViaQuest to bill my insurance and release pertinent information to my insurance carrier. I am responsible for understanding my benefit plan and for paying all copays, deductibles, and any fees as applicable not paid by insurance for any reason.

☑ I understand that that any self-pay or other arrangements will need to be handled via ViaQuest Billing Department. I authorize ViaQuest to review my financial information and verify that I have provided correct and complete documentation regarding income and household occupants to qualify for a sliding fee rate or billing structure, as applicable.

Handbook (REQUIRED)

☑ I acknowledge receiving or being offered a copy of the Handbook. The Handbook provides details specifically about my Rights, the Company Notice of Privacy Practices, and the Compliant & Conflict Resolution process. I understand the Notice of Privacy Practices explains how ViaQuest is permitted to use and disclose my Protected Health Information and that the Handbook outlines applicable policies and expectations of receiving treatment/services from ViaQuest.

Communication Preferences

For scheduling purposes (non-confidential communications), I authorize ViaQuest to contact me via:

☐ **Unencrypted e-mail** ☐ **Home/Cell Phone/Videophone** ☐ **Work Phone** ☐ **Text Messaging**

For confidential communications, I authorize ViaQuest to contact me via:

☐ **Home Phone/Cell Phone/Videophone** ☐ **Work Phone** ☐ **U.S. mail at my designated address** ☐ **Encrypted e-mail only** ☐ **Fax**

Release of Photos/Video

☐ I authorize ViaQuest to film, photograph, or record me; I understand and agree for filming, photograph(s) or recording maybe used for identification, treatment, education & training, and promotion/marketing. I understand and agree that this material may be used within ViaQuest social media, print marketing or website, newspapers, television, magazines, radio, professional journals or discussion groups.

Telehealth (Psychiatric & Behavioral Solutions ONLY)

☑ I understand that services may be provided by real-time, secure/confidential telehealth services where permitted. I understand that confidentiality is ensured as long as the telehealth equipment utilized is arranged by ViaQuest. In the event of equipment malfunction/failure or the Internet connection becomes lost or disrupted during the course of the telehealth session, I understand that the facility/location contracting with ViaQuest is obligated to have a telephone accessible in order for the telehealth visit to continue until the Internet connection is re-established. In addition, the facility/location is obligated to have a person available who is familiar with the operation of the telehealth equipment in the event of a problem with the operations. In accordance with privacy and security requirements, prior to the start of a telehealth session, I will verify my identity by stating my name and providing my personal identification number which is the last four (4) digits of my Social Security number. I acknowledge that receiving telehealth comes with limitations including, but not limited to:

- Changing the clinical aspects of receiving treatment/services,
- Security considerations (e.g. technical difficulties during the telehealth session, no physical presence during clinical treatment/services, etc.) when receiving treatment/services via telehealth; and
- Loss of confidentiality even when following all privacy and security (HIPAA) regulations, policies and procedures.

I have read and understand the above. I understand that I may stop services at any time, and I consent to the services and treatment offered to me by ViaQuest. I understand I should keep the Handbook and refer to it if I have questions.

Printed Name of Individual Served: _____ Birthdate of Individual Served: _____

Signature of Individual Served: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Witness: _____ Date: _____

OFFICE STAFF USE ONLY IF ACKNOWLEDGEMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgment of Receipt:

□ Handbook and Notice of Privacy Practices given to the individual served but they refused to sign the acknowledgement.
□ Handbook and Notice of Privacy Practices was mailed to the home address of the individual served as stated in records.
□ Handbook and Notice of Privacy Practices was mailed to an alternate address at the request of the individual served.
□ Handbook and Notice of Privacy Practices was faxed or e-mailed to the individual served at their request.
Other reason(s) why written acknowledgement not obtained: _____