ANNUAL (NEW AND EXISTING) PATIENT INFORMATION PACKET

DATE COMPLETED*	

PATIENT IDENTIFYING INFORMATION*

FIRST NAME		MIDDLE INITIAL		LAST NAME	
PREFERRED NAME		DOB		SSN	
PHONE 1				VM OK	☐ YES ☐ NO / TEXT OK ☐ YES ☐ NO
PHONE 2 (IF APPLICABLE)				VM OK	☐ YES ☐ NO / TEXT OK ☐ YES ☐ NO
GENDER AT BIRTH	☐ MALE ☐ FEMALE	GENDER IDENTITY	☐ MALE ☐ FEMALE	SEXUAL ORIENTATION	☐ HETEROSEXUAL (STRAIGHT) ☐ HOMOSEXUAL (GAY) ☐ BISEXUAL ☐ OTHER
RACE		ETHNICITY	☐ HISPANIC ☐ NOT HISPANIC	PRIMARY LANGUAGE	
MARITAL STATUS	☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	EMPLOYMENT STATUS	☐ FULL TIME ☐ PART TIME ☐ STUDENT ☐ UNEMPLOYED	RELIGIOUS AFFILIATION	
SCHOOL (IF ENROLLED)				CURRENT GRADE	

HOME ADDRESS*					
ADDRESS LINE 1					
ADDRESS LINE 2					
CITY		STATE		ZIP	

MAILING ADDRESS*				SAME AS HOME?	☐ YES ☐ NO
ADDRESS LINE 1					
ADDRESS LINE 2					
CITY		STATE		ZIP	

* INDICATES ANNUAL RENEWAL SECTION

FUNDING SOURCE INFORMATION*

PRIMARY PAYER INFORMATION*			PATIENT IS POLICY HOLDER	☐ YES ☐ NO
INSURANCE COMPANY				
POLICY NUMBER				
GROUP NUMBER (IF APPLICABLE)		POLICY HOLDER NAME (IF NOT PATIENT)		
POLICY HOLDER DOB		POLICY HOLDER SSN		

SECONDARY PAYER INFORMATION (IF APPLICABLE)*			PATIENT IS POLICY HOLDER	☐ YES ☐ NO
INSURANCE COMPANY				
POLICY NUMBER				
GROUP NUMBER (IF APPLICABLE)		POLICY HOLDER NAME (IF NOT PATIENT)		
POLICY HOLDER DOB		POLICY HOLDER SSN		

TERTIARY PAYER INFORMATION (IF APPLICABLE)*			PATIENT IS POLICY HOLDER	☐ YES ☐ NO
INSURANCE COMPANY				
POLICY NUMBER				
GROUP NUMBER (IF APPLICABLE)		POLICY HOLDER NAME (IF NOT PATIENT)		
POLICY HOLDER DOB		POLICY HOLDER SSN		

OTHER FUNDING SOURCE *			PATIENT IS POLICY HOLDER	☐ YES ☐ NO
FUNDING SOURCE NAME				
FUNDING SOURCE TYPE	☐ FCFC ☐ OOD ☐ DOD ☐ OTHER: ______________________________			
FUNDING SOURCE CONTACT		FUNDING SOURCE COUNTY (IF APPLICABLE)		
FUNDING SOURCE PHONE				

* INDICATES ANNUAL RENEWAL SECTION

GUARDIAN OR CUSTODIAN INFORMATION (FOR PATIENTS <18 OR UNDER GUARDIANSHIP)*

<table>
<tr><td>NAME</td><td colspan="5"></td></tr>
<tr><td>RELATIONSHIP TO PATIENT</td><td colspan="5"></td></tr>
<tr><td>GUARDIAN IS COUNTY</td><td>☐ YES
☐ NO</td><td>COUNTY
(IF APPLICABLE)</td><td colspan="3"></td></tr>
<tr><td>PRIMARY NUMBER</td><td colspan="5"></td></tr>
<tr><td>PHONE TYPE</td><td>☐ HOME
☐ WORK
☐ OTHER</td><td>OK TO LEAVE VOICEMAIL</td><td>☐ YES
☐ NO</td><td>OK TO TEXT</td><td>☐ YES
☐ NO</td></tr>
<tr><td>SECONDARY NUMBER</td><td colspan="5"></td></tr>
<tr><td>PHONE TYPE</td><td>☐ HOME
☐ WORK
☐ OTHER</td><td>OK TO LEAVE VOICEMAIL</td><td>☐ YES
☐ NO</td><td>OK TO TEXT</td><td>☐ YES
☐ NO</td></tr>
<tr><td>EMAIL</td><td></td><td>EMAIL TYPE</td><td>☐ HOME
☐ WORK
☐ OTHER</td><td>PORTAL</td><td>☐ YES
☐ NO</td></tr>
</table>

<table>
<tr><td colspan="4">HOME ADDRESS*</td><td>SAME AS PATIENT?</td><td>☐ YES
☐ NO</td></tr>
<tr><td>ADDRESS LINE 1</td><td colspan="5"></td></tr>
<tr><td>ADDRESS LINE 2</td><td colspan="5"></td></tr>
<tr><td>CITY</td><td></td><td>STATE</td><td></td><td>ZIP</td><td></td></tr>
</table>

<table>
<tr><td colspan="4">MAILING ADDRESS*</td><td>SAME AS PATIENT?</td><td>☐ YES
☐ NO</td></tr>
<tr><td>ADDRESS LINE 1</td><td colspan="5"></td></tr>
<tr><td>ADDRESS LINE 2</td><td colspan="5"></td></tr>
<tr><td>CITY</td><td></td><td>STATE</td><td></td><td>ZIP</td><td></td></tr>
</table>

PLEASE INCLUDE A COPY OF GUARDIANSHIP PAPERWORK IF APPLICABLE (COURT ORDERS, ADOPTION DECREE, ICCA, ETC.)

* INDICATES ANNUAL RENEWAL SECTION

EMERGENCY CONTACT INFORMATION*

NAME	
RELATIONSHIP TO PATIENT	
PHONE NUMBER	

NAME	
RELATIONSHIP TO PATIENT	
PHONE NUMBER	

CURRENT PRIMARY CARE PROVIDER*

NAME	
ADDRESS	
PHONE NUMBER	

OTHER CURRENT MENTAL HEALTHCARE PROVIDER*

NAME	
ADDRESS	
PHONE NUMBER	

REFERRING PROVIDER

NAME	
ADDRESS	
PHONE NUMBER	

IF A DIAGONSTIC ASSESSMENT HAS BEEN COMPLETE, PLEASE INCLUDE

* INDICATES ANNUAL RENEWAL SECTION

MENTAL HEALTH HISTORY

PATIENT MENTAL HEALTH PROGRAM HISTORY			
COUNSELING (INDIVIDUAL OR FAMILY)	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
COUNSELING (GROUP)	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
CASE MANAGEMENT	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
MEDICATION MANAGEMENT	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
CPST	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
TBS	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
ACT	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
IHBT	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	
SUBSTANCE USE DISORDER TREATMENT	☐ CURRENT ☐ PREVIOUS ☐ NEVER	PROVIDER NAME DATES	

* INDICATES ANNUAL RENEWAL SECTION

CURRENT MEDICATIONS (IF ANY – INCLUDE MEDICATION NAME, DOSE, AND PRESCRIBER)*:

MEDICATION NAME	DOSAGE	INSTRUCTIONS	PRESCRIBING PROVIDER

ALLERGIES

ALLERGEN	REACTION

* INDICATES ANNUAL RENEWAL SECTION

SLIDING FEE DISCOUNT PROGRAM APPLICATION*

DATE COMPLETED*	

IT IS THE POLICY OF ANTHONY'S VILLA INC., TO PROVIDE PATIENT-CENTERED CARE REGARDLESS OF THE PATIENT'S ABILITY TO PAY. DISCOUNTS ARE OFFERED BASED UPON TOTAL HOUSEHOLD INCOME AND THE NUMBER OF PERSONS LIVING IN THE HOUSEHOLD. A SLIDING FEE SCHEDULE IS USED TO CALCULATE THE BASIC DISCOUNT AND IS UPDATED EACH YEAR USING FEDERAL POVERTY GUIDELINES.

A **FULLY** COMPLETED APPLICATION INCLUDING VERIFICATION OF INCOME MUST BE ON FILE AND APPROVED BY THE BUSINESS OFFICE BEFORE A DISCOUNT WILL BE APPLIED.

PERSONAL INFORMATION

LAST NAME		FIRST NAME	
DATE OF BIRTH		PHONE	
HOME ADDRESS		MAILING ADDRESS	
HOME CITY		MAILING CITY	
HOME STATE		MAILING STATE	
HOME ZIP		MAILING ZIP	

HOUSEHOLD SIZE INFORMATION

INDIVIDUALS RELATED BY BIRTH, MARRIAGE, OR ADOPTION AND RESIDING TOGETHER.

ANY MEMBER 18 YEARS OF AGE OR OLDER RESIDING IN THE HOUSEHOLD MUST PROVIDE PROOF OF INCOME.

1. NAME/RELATIONSHIP AGE	5. NAME/RELATIONSHIP AGE
2. NAME/RELATIONSHIP AGE	6. NAME/RELATIONSHIP AGE
3. NAME/RELATIONSHIP AGE	7. NAME/RELATIONSHIP AGE
4. NAME/RELATIONSHIP AGE	8. NAME/RELATIONSHIP AGE

* INDICATES ANNUAL RENEWAL SECTION

SLIDING FEE DISCOUNT PROGRAM APPLICATION*

FINANCIAL INFORMATION

SELF	SPOUSE	EMPLOYER NAME & PHONE	START DATE	END DATE	HOW OFTEN PAID

INCOME SUMMARY

SOURCE	TOTAL HOUSEHOLD INCOME	ACCEPTED DOCUMENTS
WAGES		LAST FEDERAL INCOME TAX RETURN OR LAST TWO PAYCHECK STUBS PRIOR TO THE SIGNATURE DATE ON THIS APPLICATION.
INTEREST/DIVIDEND INCOME		BANK, CREDIT UNION, SAVINGS STATEMENT OR 1099.
SELF-EMPLOYMENT; RENTAL INCOME		STATEMENT OF INCOME AND EXPENSES FOR THE CURRENT YEAR.
PUBLIC ASSISTANCE, SOCIAL SECURITY/SUPPLEMENTAL SECURITY, FOOD STAMPS		AWARD LETTER(S) LISTING AMOUNT RECEIVED IN THE CURRENT YEAR. IF YOU RECEIVE MORE THAN ONE, PLEASE ADD THEM TOGETHER.
UNEMPLOYMENT INCOME		UNEMPLOYMENT COMPENSATION BENEFIT AWARD LETTER FOR THE CURRENT YEAR.
WORKER'S COMPENSATION		WORKER'S COMPENSATION BENEFIT AWARD LETTER FOR THE CURRENT YEAR.
CHILD SUPPORT/ALIMONY		DIVORCE DECREE STATING CHILD SUPPORT OR ALIMONY RECEIVED
RETIREMENT INCOME		LETTER SUPPLIED BY SYSTEM ADMINISTRATOR WITH MONTHLY BENEFIT AMOUNT FOR THE CURRENT YEAR.
VETERAN'S PAYMENTS		LETTER SUPPLIED BY VETERAN'S ADMINISTRATION WITH MONTHLY BENEFIT AMOUNT FOR THE CURRENT YEAR.
ASSISTANCE FROM OTHER FAMILY		A NOTARIZED STATEMENT FROM FAMILY OR FRIENDS EXPLAINING ANY FINANCIAL HELP THAT THEY GIVE YOU.
OTHER INCOME (SPECIFY)		
TOTAL		

SELF-DECLARATION OF INCOME

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE AS TO WHY YOU CANNOT PROVIDE PROOF OF ANY INCOME. I.E., WORKED ODD JOBS FOR CASH; STARTED NEW BUSINESS….

I UNDERSTAND THAT ALL THE INFORMATION GIVEN MAY BE CONFIRMED BY ANTHONY'S VILLA INC. I ALSO UNDERSTAND THAT PROVIDING FALSE INFORMATION IS CONSIDERED FRAUD AND WILL RESULT IN A DENIAL OF THE SLIDING FEE SCALE PROGRAM APPLICATION AND THAT I WILL BE RESPONSIBLE FOR THE PAYMENT OF CHARGES FOR THE SERVICES PROVIDED.

SIGNATURE ____ **DATE** ________________

* INDICATES ANNUAL RENEWAL SECTION

CONSENT FOR INSURANCE BILLING*

I HEREBY AUTHORIZE **ANTHONY'S VILLA** TO BILL MY INSURANCE COMPANY, AS IDENTIFIED ABOVE, FOR SERVICES RENDERED TO ME. I UNDERSTAND THAT THIS INCLUDES THE RELEASE OF MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIM.

ASSIGNMENT OF BENEFITS

I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND OTHER HEALTH PLANS TO **ANTHONY'S VILLA**. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE.

ACKNOWLEDGEMENT OF INSURANCE BILLING

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES, AND I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURES

SIGNATURE OF PATIENT	
DATE SIGNED	

IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME	
RELATIONSHIP TO PATIENT	
PERSONAL REPRESENTATIVE SIGNATURE	
DATE SIGNED	

PLEASE NOTE THAT BY SIGNING THIS FORM, YOU AGREE TO COOPERATE AND PROVIDE INFORMATION AS NEEDED TO PURSUE CLAIMS AND APPEAL DENIALS OF COVERAGE OR PAYMENT. FAILURE TO COMPLY MAY RESULT IN THE PATIENT BEING HELD RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH THE SERVICES RENDERED. BY SIGNING THIS FORM, YOU ARE ACKNOWLEDGING THAT YOU HAVE READ, OR HAVE HAD READ TO YOU, THE SPECIFIC CONSENT TO BILL INSURANCE AND THAT YOU UNDERSTAND ITS CONTENTS, INCLUDING YOUR RESPONSIBILITY TO COVER ANY CHARGES NOT PAID BY YOUR INSURANCE COMPANY.

* INDICATES ANNUAL RENEWAL SECTION

CONSENT FOR MENTAL HEALTH SERVICES*

I HEREBY VOLUNTARILY CONSENT TO ENGAGE IN OUTPATIENT MENTAL HEALTH SERVICES WITH **ANTHONY'S VILLA INC**. THESE SERVICES MAY INCLUDE DIAGNOSTIC EVALUATIONS, PSYCHOTHERAPY, MEDICATION MANAGEMENT, AND GROUP THERAPY, AS DEEMED NECESSARY BY MY PROVIDER(S). I UNDERSTAND THAT I HAVE THE RIGHT TO PARTICIPATE IN DECISIONS REGARDING MY TREATMENT PLAN.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED OR WAS OFFERED A COPY OF ANTHONY'S VILLA'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MENTAL HEALTH INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I SHOULD READ THIS NOTICE CAREFULLY.

EMERGENCY MENTAL HEALTH SERVICES

I UNDERSTAND THAT THE STAFF AT ANTHONY'S VILLA WILL MAKE EVERY EFFORT TO REACH MY EMERGENCY CONTACTS BEFORE MAKING DECISIONS ON MY BEHALF IN A CRISIS SITUATION, BUT IF THEY CANNOT BE REACHED, I AUTHORIZE AND CONSENT TO ALL NECESSARY EMERGENCY MENTAL HEALTH INTERVENTIONS.

RISKS AND BENEFITS

I UNDERSTAND THAT MENTAL HEALTH SERVICES MAY HAVE BOTH BENEFITS AND RISKS. TREATMENT MAY LEAD TO UNCOMFORTABLE EMOTIONS, THOUGHTS, AND MEMORIES. ON THE OTHER HAND, IT CAN ALSO LEAD TO SIGNIFICANT REDUCTIONS IN FEELINGS OF DISTRESS, IMPROVED RELATIONSHIPS, AND RESOLUTION OF SPECIFIC PROBLEMS. I UNDERSTAND I CAN DISCUSS POTENTIAL BENEFITS AND RISKS WITH MY PROVIDER(S).

SIGNATURES

PATIENT SIGNATURE	
DATE	

IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

NAME	
RELATIONSHIP	
SIGNATURE	
DATE	

* INDICATES ANNUAL RENEWAL SECTION

HIPAA RELEASE OF INFORMATION *

PATIENT NAME					
PATIENT DATE OF BIRTH					
PATIENT HOME ADDRESS					
CITY		STATE		ZIP	

PURPOSE OF RELEASE

THIS AUTHORIZATION PERMITS **ANTHONY'S VILLA INC.** TO USE AND DISCLOSE THE ABOVE-NAMED INDIVIDUAL'S HEALTH INFORMATION FOR THE FOLLOWING PURPOSE(S):

	TREATMENT
	PAYMENT
	HEALTHCARE OPERATIONS
	OTHER (SPECIFY):

DESCRIPTION OF INFORMATION TO BE DISCLOSED

THE FOLLOWING CATEGORIES OF HEALTH INFORMATION MAY BE DISCLOSED UNDER THIS AUTHORIZATION:

	MEDICAL HISTORY
	MENTAL HEALTH HISTORY
	TREATMENT RECORDS
	BILLING RECORDS
	OTHER(SPECIFY):

INDIVIDUALS OR ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE INFORMATION

NAME	ANTHONY'S VILLA INC.
ADDRESS	PO BOX 337 SANDUSKY, OH 44871-0337
PHONE	(567)290-2658

INDIVIDUALS OR ORGANIZATIONS AUTHORIZED TO RECEIVE AND USE INFORMATION

NAME	
ADDRESS	
PHONE	

EXPIRATION

THIS AUTHORIZATION EXPIRES ON (MUST BE WITHIN 1 YEAR):	

YOUR RIGHTS

YOU DO NOT HAVE TO SIGN THIS AUTHORIZATION. REFUSAL TO SIGN THIS WILL NOT AFFECT YOUR ABILITY TO OBTAIN TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME, BUT YOU MUST DO SO IN WRITING AND SUBMIT IT TO THE ABOVE ADDRESS.

SIGNATURE

I HAVE READ AND UNDERSTOOD THIS FORM, AND I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT OR REPRESENTATIVE	
DATE	

* INDICATES ANNUAL RENEWAL SECTION