Signature Health Intake Form

Personal Information:

Client Name:
Client Date of Birth:
Name of Client's Legal Representative:
Relationship to Client:

Acknowledgment of Receipt of Client Handbook, Client Rights, Grievances, and Notice of Privacy Practices:

I acknowledge that I have received, either in paper copy or electronically, the Signature Health Client Handbook, which contains a description of Signature Health programs, program rules and expectations, Signature Health's Client Rights, Confidentiality, and Grievances Policy, and Signature Health's Notice of Privacy Practices. If I have received the Client Rights, Confidentiality and Grievances Policy and the Notice of Privacy Practices electronically, I understand that I can request a paper copy of the Client Rights, Confidentiality and Grievances Policy and the Notice of Privacy Practices.
https://www.signaturehealthinc.org/patient-forms/

Acknowledgment of Orientation:

I have received orientation to Signature Health, Inc. and understand that I may ask questions at any time. A staff member is available to answer any questions I may have regarding Signature Health, Inc. and the Client Handbook. I have been oriented and am familiar with the premises including emergency exits, fire suppression, and the availability/location of first aid kits. If I am participating in telehealth services, I understand that I have the right to be oriented to the premises and the facility's safety equipment should I later choose to receive services onsite.

No Call/No Show or Late Cancellation Policy Notice:

The first No Show/Late Cancel will result in a either a phone call or a letter sent to the patient requesting contact with the agency, encouraging them to continue services, and asking if they intend to do so. The second No Show/Late Cancel will result in a letter sent to the patient requesting contact with the agency with their intention to continue services. In addition, all future appointments will be removed from the scheduler. If the patient wishes to continue services, staff and patient will jointly develop a plan to reduce barriers in maintaining appointments. Future appointments will be scheduled one at a time until the patient and their care coordinator determine barriers to maintaining consecutive appointments have been reduced. The third No Show/Late Cancel will result in the patient only being seen for acute services and being required to use our walk in services. Patients who are administratively placed on "walk in services only" for any reason are not eligible for re-instatement for six (6) months unless authorized by the Office Director. Patients who are administratively

discharged for any reason are not eligible for re-admission for one (1) year unless authorized by the Office Director.

Fee Schedule:

The following are the fees associated with the most common services that are provided to clients of Signature Health: Intake Assessment - $213.00/Visit; Group Therapy - $55.00/Group; Counseling (45 min) - $137.00/Session; Counseling (60 min) - $163.00/Session; Urine Screen Collection - $60.00/Screen; Psychiatric Eval-Level 4 - $329.00/Evaluation; Psychiatric Eval-Level 5 - $422.00/Evaluation; Medical Follow Up-Level 3 - $140.00/Visit; Medical Follow Up-Level 4 - $208.00/Visit; Partial Hospitalization Program/Intensive Outpatient Program - $200.00/Session. The full fee schedule is available upon request and fees are subject to change without notice. Each patient or their parent/guardian is responsible to pay his or her fees, file insurance claims and obtain any pre-authorizations necessary. As a courtesy, Signature Health, Inc. will bill on your behalf and accept payments (full or partial) from Medicare and Medicaid. If Signature Health is an in-network member of your private insurance plan, it will also bill your insurance on your behalf and accept payments. However, each patient or his/her parent/guardian is responsible for obtaining any pre-authorizations necessary. If applicable, co-pays and deductible amounts are due prior to receiving services. Failure to pay your fees in full prior to receiving services may result in your appointment being rescheduled. If you cannot afford to pay our full fee, you may apply for our sliding scale. A completed sliding scale application is required and proof of income may be required depending on which programs you are receiving services from. Signature Health offers a 50% off discount to patients who pay in full at the time of appointment. If a patient is eligible for the sliding scale as well, then the patient will be offered either the sliding fee or the prompt-pay discount, whichever is greater. By signing this document, you acknowledge that you understand the above information and agree to pay for your services.

Notice of MACSIS Enrollment:

This is a notification of enrollment into the Multi-Agency Community Services Information System (MACSIS). To receive alcohol, drug addiction, and/or mental health services paid for by public funds, you must provide information so that the appropriate county ADAMHS/ADAS/CMH Board can enroll you in the county behavioral healthcare plan, determine if you are eligible for publicly funded services, and pay the provider for your services through the MACSIS computer system, which connects the Board to the Ohio Department of Mental Health and Addiction Services and Ohio Department of Jobs and Family Services. All information will be kept confidential, consistent with state and federal law. Name identifying information will only be used to pay for services provided to you. Demographic information will be kept without your name attached and reported to the state departments and the Ohio Health Care Data Center. This information will not be available to other services or used for any other purposes. Billing information will be kept for up to seven (7) years after you have received services and only demographic information will be kept after that time. I acknowledge that I have received and understand this information

FTCA Deemed Status

Signature Health receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain Health or Health-related claims, including malpractice claims, for itself and its covered individuals. Additionally, our facilities have Federal Tort Claims deemed status. I acknowledge that I have been informed of Signature Health's deemed status.

Signature:
Printed Name:
Date: