Guinn . . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Part I: Adult Patient Initial Visit and Screening Information

Patient Information Section

Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/____	XXX-XX-__ __ __ __

Gender	Citizenship	Race (□ Mixed - check all that apply)		Ethnicity
□ Male □ Female	□ U.S. Citizen □ Permanent Residence □ Refugee □ Other	□ American Indian □ Alaskan Native □ Asian □ Asian - Indian	□ Black/African American □ Native Hawaiian □ Pacific Islander □ White	□ non-Hispanic/Latino □ Hispanic/Latino

Current Address - Street/PO Box	Preferred Phone #	Alternate Phone #

City	State	Zip Code	Email Address
	TX		

Marital Status		Parenting Status	Number in Household	Medication Allergies
□ N/A(Child) □ Single □ Married □ Separated	□ Divorced □ Widowed □ Cohabitating	□ N/A (Not a parent) □ Parent in One-Parent Family □ Parent in Two Parent Family □ Non-custodial Parent (Children not living in home or children are adults)	____ Dependents (under 18) ____	□ No □ Yes (If yes, list)

Last grade completed in School?		Disability Status	Employment Status
□ No schooling □ Nursery to 4th □ 5th or 6th □ 7th or 8th □ 9th □ 10th □ 11th	□ 12th: no diploma □ High Sch Grad □ GED □ 1-2 year college/trade □ 3-4 year college □ Bachelors □ Masters	□ N/A or None □ Disabled - Mental □ Disabled - Physical □ Disabled - Mental & Physical □ Disabled - Veteran □ Disabled - Short Term Illness □ Disabled - Developmental	□ N/A □ Full Time □ Part Time □ Searching □ Not employed - student □ Not seeking employment □ Disabled

Primary Language	Military	Military Branch		VA Discharge Status	
□ English □ Spanish □ Other _____	□ Yes □ No	□ N/A □ Army □ Navy	□ Air Force □ Marines	□ N/A □ Honorable □ General □ Medical	□ Bad conduct □ Dishonorable □ Other

Appointment Reminders & Permission to Contact

Permission to Contact Me (Check all that apply):

I grant permission to GHT staff to contact me as follows:

□ *By phone & leave a message on voicemail if no answer*
□ *By leaving a message with anyone who answers*
□ *By email*
□ *By text message*

Appointment Reminders

GHT has an automated text message appointment reminder system that can send a reminder text to your cell phone the day before your upcoming appointment.

□ *No thanks, I do not want a text message appointment reminder.*
□ *Yes, I would like to receive a text message appointment reminder.*
The cell phone number is: [____ ____ - _____].
The cell phone carrier is: (Verizon, Sprint, ATT, etc) [_____]
Note: We do not charge for this service, however any usual charges you incur for receiving a text message would apply.

Insurance Section or Other Funding Source

Insurance or other Payment Source:

☐ Medicaid ☐ Regular Commercial Insurance ☐ Employee Assistance Program
☐ Self pay ☐ Contract ☐ Other ☐ Learning Lab

Insurance or Medicaid HMO company name:		Medicaid # (if applicable):	

If Medicaid; Specify Type: ☐ Traditional ☐ STAR Health (Foster Care) ☐ STAR Plus ☐ CHIP

Group/Policy # (if applicable):		Member ID #:	
If EAP, number of visits authorized:		Authorization #:	
Name of Primary Insured (if Different than Patient):			
Name of Primary Insured's Employer (if applicable):			
Copayment Required?	☐ Yes ☐ No	If required, CoPay amount per Visit:	$
Prior Authorization Required?	☐ Yes ☐ No	If "Yes", Authorization Number?	

Billing Authorization Statements

- I request that payment of authorized insurance benefits, including Medicare and/or Medicaid be made to the organization listed below for any services provided to me by that organization.
- I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.
- I understand that I am financially responsible to the organization for any charges not covered by my health plan benefits. It is my responsibility to notify the organization of any changes in my health care coverage.
- In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

Acknowledgement of Patient Notices

Initials _____ Section A: I acknowledge receipt of the Notice of Privacy Practices of GHT, LLC.

Initials _____ Section B: I acknowledge providing voluntary general consent to behavioral health treatment and procedures.

Initials _____ Section C: I acknowledge participation in treatment planning.

Initials _____ *Section D:* I acknowledge being informed regarding advance directives for mental health in the event that I become incapacitated (applies to adults only).

☐ I do not want to complete an advance directive at this time

☐ I want to complete an advance directive

_____ ____/____/_____
CLIENT SIGNATURE (or parent/guardian for minor) DATE

CLIENT SOCIAL SECURITY # (or parent/guardian for minor): XXX-XX-__ __ __ __

_____ ____/____/_____
STAFF SIGNATURE DATE

[Staff: Copy of Insurance Card Attached? ☐ Yes ☐ No]