



Service Enrollment Form

Date: _____

Personal Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Alternate Name: _____ Date of Birth (DOB): _____ SSN: _____

I am under 18 years of age: Yes No I have a legal guardian: Yes No

Do you have an Advanced Directive? Yes No If yes: Medical Psychological

If no: Would you like more information? Yes No

Address: _____ City/State: _____

Zip Code: _____ Phone Number: _____ Email: _____

Best Way to Contact: Phone Text Email

By checking this box, I give permission for RHS to contact me through text and/or email.

Gender: Male Female Other: _____

Ethnicity: Cuban Mexican Puerto Rican Not of Hispanic or Latino Origin Jewish

Race: Alaskan Native/American Indian Asian Black/African American Native Hawaiian Caucasian
 Other: _____ Refused/Unknown

Are you under court supervision? Yes No Explain: _____

Marital Status: Single Divorced Widowed Married

Student: Yes No Name of School: _____

Current Grade/Highest Level of Education: _____

Employed: Yes No Name of Employer: _____

Medical Information:

Primary Care Provider: _____ Pharmacy & Location: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

May we contact this person in case of emergency? Yes No

Authorized Individuals for Protective Health Information Sharing:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Name: _____ Phone: _____

Parent or Guardian Information (For minors or those under Guardianship):

Parent/Guardian Name: _____ Mother Father Guardian

Phone Number: _____ Address: _____

Additional Parent/Guardian Information:

Parent/Guardian Name: _____ Mother Father Guardian

Phone Number: _____ Address: _____

For Individuals Under 18:

Parents' Relationship Status: Married Separated Divorced Never Married

Are both parents living? Yes No If no which parent is deceased; _____

Child Resides With: Both Parents Mother Father Other: _____

Supporting Documentation: Please provide a copy of supporting documentation regarding guardianship, custody arrangements, or no contact orders.

I was referred by: _____

Insurance Information:

Primary Insurance: Insurance Provider: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Phone Number: _____

Policy Holder Address: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Holder's Relationship to Patient: Self Spouse Parent Other

Secondary Insurance (if applicable): Insurance Provider: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Phone Number: _____

Policy Holder Address: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Holder's Relationship to Patient: Self Spouse Parent Other

If there is **Tertiary Insurance**, please provide that information as well.

Signature & Authorization:

Signature: _____ Date: _____

Printed Name of Signer: _____

Relationship to Applicant: Self Parent Guardian

Consent for Treatment

Individual Rights & Responsibilities:

RHS presumes legal competence unless a court rules otherwise and requires documentation. Enrollment does not affect legal rights. RHS complies with mandated reporting laws and Idaho's duty-to-warn requirements. Individuals have rights to respectful care, timely services, treatment participation, health records access, and grievance filing. Responsibilities include providing updated information, respecting others, keeping appointments, engaging in treatment, and meeting financial obligations.

Grievance Procedure:

If you have concerns, first address them with your assigned professional or their supervisor. Unresolved issues can be submitted in writing to RHS within 30 days for Executive Team review, with a decision made within 15 business days. Services will continue during investigations, though staffing changes may occur. For insurance issues, contact your provider, with RHS offering support if needed. Participants can submit anonymous grievances to RHS or any insurance program. HIPAA violations can be reported to the Office for Civil Rights within 180 days.

Privacy Notice/HIPPA:

RHS safeguards your health information in compliance with HIPAA, using it only for treatment, payment, and healthcare operations. We do not disclose your data without consent unless required by law. You have the right to access, correct, and control communication about your information. For inquiries or to exercise your rights, contact RHS Human Resources.

Benefits & Risks of Services:

RHS enhances well-being through behavioral and physical health services, promoting stability, independence, and overall health. While risks include side effects, emotional challenges, and treatment discomfort, active participation leads to long-term success.

Telehealth:

RHS provides secure, HIPAA-compliant telehealth services to enhance accessibility and health outcomes while prioritizing privacy. Eligible members must have appropriate technology, provide consent, and meet clinical criteria. Those enrolled in RHS Medicated Assisted Treatment (MAT) program are not eligible for telehealth. Licensed providers must comply with regulations, and all sessions must use secure platforms in private settings.

Financial Agreement:

Rehabilitative Health Services (RHS) is an approved provider with most insurance carriers and will submit claims on behalf of patients, though individuals remain financially responsible for unpaid balances. Accurate insurance information is required, and some plans may need prior authorization to avoid full financial liability. Parents or guardians are responsible for minor patients' payments, and refunds for credit balances will be issued to the designated guarantor. Patients assign insurance benefits to RHS, authorizing claim processing and, for Medicare/Medicaid, the release of medical information to CMS. A sliding scale fee discount and cash pay program are available for eligible patients experiencing financial hardship. For plan-specific details, contact your insurance provider.

I have been informed of:

- ✓ My individual rights and responsibilities while working with RHS
- ✓ The steps to file grievance
- ✓ The Privacy/HIPPA notice of RHS
- ✓ The benefits & Risks of services I may choose
- ✓ The telehealth policy of RHS to which I agree to participate in these services as outlined by the services I may choose.
- ✓ The Financial Agreement of RHS.

I understand that I may request further information about the above policies if I so wish by requesting a copy at the front desk.

Client Name Printed: _____ Signature: _____

Date: _____ Relationship to Applicant: Self Parent Guardian

Requested Services

Service descriptions & provider bios are available at rhscare.com

I've marked the services below that I'm interested in at this time. I understand I can request additional services or discontinue services at any time.

Medical

- Primary Care (Patient Centered Medical Home) Provide I request:
- MAT (Medicated Assisted Treatment- Opioids) ○ David Adams FNP-CC

Behavioral

- | | |
|--|--|
| <h4><u>Clinical</u></h4> <ul style="list-style-type: none">○ Mental Health Medication Management○ Therapy Individual Group Family | <h4><u>Community</u></h4> <ul style="list-style-type: none">○ CBRS○ Case Management○ Peer Support○ Family Support○ Youth Support |
|--|--|

- #### Psychological Testing
- Psychological Testing
 - Neurofeedback

- #### Substance Use
- Therapy Individual Group
 - Drug & Alcohol Assessment
 - Case Management
 - Recovery Coaching

Early Serious Mental Illness Program (STAR/ESMI)

- This program is for ages 15-30. Enrollment is contingent upon assessment of qualifications.

Intensive Youth Services

- This program is for ages 12-17. Enrollment is contingent upon assessment of qualifications.

Client Name: _____

Signature: _____

Date: _____

Relationship to Applicant: Self Parent Guardian