St. Lawrence County Mental Health Clinic

80 State Highway 310, Suite 1
Canton, NY 13617
Phone: 315-386-2167 Fax: 315-386-2435

Referral Form: ADULT

Referral Date:		Client ID # (for internal use):	
Name:	Date of Birth:	Age:	Gender:
Address:			
Primary Phone #:		Is it ok to leave a message? Yes No	
Alternate Phone #:		Is it ok to leave a message? Yes No	
Social Security #:	Email Address:	Veteran Status:	
Emergency Contact Person:	Relationship:	Phone: Ok to leave a message? Yes No	
Past Mental Health Treatment: Yes No	If yes, Where and When?		
Employment:			
Who referred you to this clinic? Self Other:			
Please describe your current symptoms and the problems you would like to address:			
Current Suicidal Thoughts: Yes No	Recent Suicidal Thoughts: Yes No		
Any previous suicidal attempts: Yes No If yes, when did they occur and how many:			
Primary Care Doctor:			
Current Medications Prescribed (Psychiatric Medications & General Health Medications):			
Medication:	Prescribed By:		
Difficulty Sleeping: Yes No	Appetite Changes: Yes No		
Weight Changes: Loss Gain	Anxiety: Yes No		
Alcohol/drug usage:	Legal/Court Involvement:		

FOR OFFICE USE ONLY

Assigned Counselor:
Date/Time of Scheduled Appointment:

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Demographic/Fee Evaluation Form

Please Complete Page 1 and Sign Page 2

Name: Click here to enter text.		**DOB:** Click here to enter text.
Address: Street: Click here to enter text.		Apt: Click here to enter text.
City: Click here to enter text.	Zip code: Click here to enter text.	County of Residence: Click here to enter text.
Gender: Click here to enter text.		**Social Security #:** Click here to enter text.
Phone Number: Click here to enter text.		**May messages be left at this number? ☐ Yes ☐ No**
Emergency Contact (Name/Relationship/Phone #) Click here to enter text.		
What is your preferred language? Click here to enter text.		
Do you need: A translator/interpreter? ☐ Yes ☐ No		**An assistive communicative device? ☐ Yes ☐ No**

Insurance Information

Do you have (check all that apply)? ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Other		
Medicaid Number: Click here to enter text.	**Managed Care:** ☐ Yes ☐ No	**Company:** Click here to enter text.
Medicare Number: Click here to enter text.	**Managed Care:** ☐ Yes ☐ No	**Company:** Click here to enter text.

Private Insurance Company: Click here to enter text.	**ID #** Click here to enter text.	**Copay:** Click here to enter text.
Group Number: Click here to enter text.	**Subscriber/Policy Holder:** Click here to enter text.	
Policy Holder's Address: Click here to enter text.	**Phone:** Click here to enter text.	
Employer Name: Click here to enter text.	**Policy Holder's DOB:** Click here to enter text.	
Policy Holder's Relationship to Client: Click here to enter text.		
Other: Click here to enter text.		

For office purposes only:	
Patient IMA#	Finance Reviews: ☐ yes Staff Initials:
Is this a: ☐ first fee eval? ☐ Updated fee eval?	

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Financial Agreement

I am responsible for paying for the clinical services provided by St. Lawrence County Community Services (SLCCS). At the time of service, if I am not covered by any insurance policy accepted by the SLCCS I am required to pay for these services. Payment and copays/coinsurance are expected at the time of service unless other arrangements have been made. I also grant permission for SLCCS to contact the St. Lawrence County Department of Social Services, my insurance provider and/or emergency contact person for matters related to my insurance/coverage/payment agreement. As a parent or guardian bringing a child to receive clinic services, I am responsible for paying the patient responsibility or copay/coinsurance for the clinical services provided by St. Lawrence County Community Services (SLCCS) for that child.

I authorize SLCCS to bill and release appropriate information to my insurance company and/or Medicare and/or Medicaid. I authorize payment directly to SLCCS, as well as permitting a copy of this authorization to be used as an original. I authorize SLCCS to act as my agent in helping obtain payment from my insurance company and/or Medicare and/or Medicaid.

I have received a copy of the Billing Policy and Procedures which I have read and have had an opportunity to ask any questions.

I agree to pay $ Click here to enter text. **Copay/Coinsurance/Patient Responsibility for each clinic visit.**

Patient or Parent/Guardian Signature	**Date:** Click here to enter text.

Required Extended Fiscal Review		
Income Type		
SSD: $ Click here to enter text.	SSI: $ Click here to enter text.	Wages: $ Click here to enter text.
VA Benefits: $ Click here to enter text.	Public Assistance: $ Click here to enter text.	Other: $ Click here to enter text.
Employer Name: Click here to enter text.		Number in Household: Click here to enter text.
Gross Pay $ Click here to enter text.	per Click here to enter text.	

Copay/Coinsurance: ☐ Yes ☐ No	Sliding Scale: ☐ Yes ☐ No	Amount: Click here to enter text.
Copay/Coinsurance Amount: Click here to enter text.		

If applicable, sliding scale fee amount for clinical services is determined based on an individual's total income and the number of people residing in the household. The chart used to make the determination is available upon request.