ANA·ZAO
COMMUNITY PARTNERS

Intake Face Sheet

Client Name: _____ _____ _____ **DOB:** _____
First *Middle* *Last* *Mo/Day/Year*

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Contact: _____ _____ _____ _____
Cell *Home* *Work* *Email*

SSN: _____ **In Case of Emergency, contact:** _____
###-##-#### *Name/Relationship to Client*

_____
Phone

Contact Permission: Check the boxes that apply, below.

	You may email me information about services.
	You may text me information about services.
	You may leave messages about services at my **cell** number.
	You may leave messages about services at my **home** number.
	You may ask for return calls to Anazao at my **work** number.

Race: *Check all that apply*

	White		Native American/Alaskan
	Black/African American		Asian
	Hispanic/Latino		Hawaiian/Pacific Islander

Ethnicity: *Check one*

	Hispanic
	Not Hispanic

Consents and Client Rights:

Initial below indicating you have read and understand the following statement.

_____ I consent to behavioral health treatment by Anazao Community Partners (ACP). I have been advised of the risks and benefits of treatment. I have been advised of my rights as a client or parent/guardian of a client. I understand that ACP uses an Electronic Health Record (EHR) as part of the PartnerSolutions Health Informatics Consortium (PSHIC). I understand that private information may be shared with other partners in this consortium through the EHR. I understand that in order to determine my eligibility for public funds to pay for services, private information will be disclosed to the Mental Health and Recovery Board (MHRB) of Wayne and Holmes Counties and to the Ohio Department of Mental Health and Addiction Services (OMHAS) through the PSHIC, the NextGen EHR, the SmartCare, Medicaid Information Technology System (MITS) or Managed Care claims systems. I understand that any records that are specifically related to substance use are protected by federal law (42 CFR Part 2) and cannot be disclosed without my written consent and that federal rules restrict the use of this information to criminally investigate or prosecute me. I understands that each client at ACP has a number of rights and that these include, but are not limited to: being treated with respect, dignity, autonomy and privacy; being served in a humane setting; being informed of condition, services and alternatives; the right to refuse any service; being served with a current and collaborative treatment plan; the right to confidentiality of and personal access to treatment records; freedom from discrimination and the right to file a grievance. I understand that Mark Woods, Executive Director, serves as the agency's Client Rights Officer and that he can be reached at 330-264-9597. I understand that I can review this information in full detail at www.anazao.co.

Signature of Client: *(if 12 or older)* _____ Date: _____

Guardian: *(if Client under 18)* _____ Date: _____

Witness: _____ Date: _____

For questions about this form, or assistance completing the form, please call our office at 1-800-721-9472.