Mountain Counseling Associates, LLC

Chart#_____

Date:_____

CLIENT INFORMATION:

Client Name: _____
Last First MI Preferred Name (if different)

Date of Birth: ____/____/____ Age_____ SSN:_____

Gender: ☐ Female ☐ Male ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Parent / Guardian / Custodian(s) _____
Name(s) Relationship

Client Address: _____
Street / PO Box Apt. # City State Zip

Phone: _____
Check preferred contact # ☐ Home ☐ Work ☐ Cell

Additional Contact Information:
☐ Parent / Guardian / Representative _____
Name Relationship

Phone: _____
Check preferred contact # ☐ Home ☐ Work ☐ Cell

Have you seen another Mental Health Provider, Agency, or Psychiatrist within the past year? ☐Yes☐No

If so, who?_____ Date of Last Visit?_____ Currently Active?☐Yes☐No
If actively involved please discuss with your provider regarding further clinical information to obtain from/with that person or agency.

Emergency Contact / Consent: In case of emergency at this facility, you have my permission to contact my emergency contact, administer CPR, or call 911, as you see fit.

Emergency Contact Information: _____
Name Relationship

Phone: _____
Check preferred contact # ☐Home ☐Work ☐Cell

_____
Client / Parent / Guardian Signature ***Date***

Referral / Physician / Information:

☐Referred by:_____ May we contact your referral source? ☐Yes☐No Phone _____

Reasons for seeking services / desired services or outcomes:_____

Primary Physician: _____
Name Address Phone

Is this a Carolina Access Primary Care Physician? ☐Yes ☐No

Additional Information: Client is currently:
☐ Enrolled in School ☐ Employed ☐ Seeking Employment/Unemployed ☐ Unable to work ☐ Homemaker

Employer / Business: _____
Employer Occupation Length of Time

School: _____
School Name Grade Teacher

Mountain Counseling Associates, LLC

CLIENT NAME: _____ **Chart #** _____

Insurance Information:

☐ Client has no insurance, and is fully responsible for payment arrangements with individual therapists or doctors
☐ Client chooses not to use insurance, and is fully responsible for payment arrangements.
☐ Medicaid clients please list what county issued your insurance? _____

Primary Insurance: Must be completed even if card on file

Primary Insurance Company: _____
Insurance Provider — Plan Name (If relevant)

Plan Number — Group Number/ Name

Company Address

Primary Policy Holder:

Name — Date of Birth — SSN

Address — Phone – home — Phone – cell / other

Relationship to Client: ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

Responsible Party: Complete for all minors or others with guardians

Note: Responsible Party is responsible for all payments including copays and deductibles

Name — Date of Birth — SSN

Address — Phone – home — Phone – cell / other

Relationship to Client: ☐Self ☐Parent ☐Spouse ☐Other _____

Secondary Insurance:

Secondary Insurance Company: _____
Insurance Provider — Plan Name (If relevant)

Plan Number — Group Number/Name

Company Address

Secondary Policy Holder:

Name — Date of Birth — SSN

Address — Phone – home — Phone – cell / other

Relationship to Client ☐Self ☐Parent ☐Spouse ☐Other _____

Consent to Bill for Services & Consent to Release Information:

I authorize the release of any medical or other information necessary for the purpose of billing and /or getting reimbursement for services received by the Independent Providers affiliated with Mountain Counseling Associates, LLC.

CLIENT NAME-PRINTED — ***IF APPROPRIATE, PARENT / GUARDIAN / REPRESENTATIVE NAM E – PRINTED***

CLIENT / PARENT / GUARDIAN / REPRESENTATIVE SIGNATURE — ***DATE***

Mountain Counseling Associates, LLC

CLIENT NAME **Date of Birth:** **Chart#**

Consent for Services

By signing below, I certify and give informed consent for myself, or person for whom I have legal authority to consent, to receive counseling, medical services, or other clinical services performed by:

_____

NAME OF THERAPIST OR PHYSICIAN

CLIENT NAME – PRINTED ***LEGAL REPRESENTATIVE – PRINTED*** ***RELATIONSHIP TO CLIENT***

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE ***DATE***

SIGNATURE OF WITNESS ***TITLE*** ***DATE***

NOTE: If the client is unable to sign, or if the client is a minor signing on their own behalf, the provider signature certifies that efforts were made in good faith to inform client of all rights and responsibilities regarding consenting for services to be provided.

****

Statement of Receipt and Understanding Of Client Rights and Responsibilities:

By signing below, you indicate you have been given notification the Client Rights and Responsibilities and Privacy Notice. A copy has been made available to take home with you for future reference, or to read as posted. You are indicating you have read them and understand them.

CLIENT NAME – PRINTED ***LEGAL REPRESENTATIVE – PRINTED*** ***RELATIONSHIP TO CLIENT***

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE ***DATE***

SIGNATURE OF WITNESS ***TITLE*** ***DATE***

Mountain Counseling Associates, LLC

CLIENT HEALTH HISTORY

Chart #_____

Client Name:_____ Date of Birth:_____ Today's Date: _____

Person Completing Form:_____ Relationship to client:_____

Primary Care Physician and Phone Number:

_____

Other Physicians/Specialists seen in last year:

_____

Please List All Prescription, Over the Counter, Vitamin/Herbal Medication Currently Taking

☐ List attached Include Name, Dosage, and Directions:

_____

Pharmacy Name/Address/Phone: _____

Medication/Drug allergies and Adverse Reaction: _____

Previous Hospitalizations/Surgeries/Injuries:

Dates and Reason: _____

CLIENT MEDICAL HISTORY: (Circle One)

Addictions	Yes	No
Allergies	Yes	No
Arthritis/Gout	Yes	No
Asthma/Respiratory Prob.	Yes	No
Blood /Vascular Problems	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Eating disorder/weight prob.	Yes	No
Heart Trouble	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Immune System Problems	Yes	No
Liver Disorders	Yes	No
Psychiatric/Emotional Prob.	Yes	No
Premature Birth	Yes	No
Seizures/Epilepsy	Yes	No
Sexually Transmitted Dis.	Yes	No
Sleep Disorder	Yes	No
Stomach/Intestine Problems	Yes	No
Stroke	Yes	No
Urinary/Bladder/Kidney Prob.	Yes	No

SOCIAL HISTORY: (Circle One)

Marital Status

Single Married Separated Divorced Widowed Partnered

Use of Alcohol

Never Current Previous Amount _____

Use of Tobacco - including smokeless

Never Current Previous Amount _____

Use of Drugs

Never Current Previous Amount _____

Occupation:_____

Excessive Exposure at Home/Work to:

Fumes Dust Noise Smoke Solvents Airborne Particles Lead

Pregnant? Yes No Due _____

FAMILY HISTORY:

Depression / Anxiety	Yes	No	Relation? _____
Other Mental Health	Yes	No	Relation? _____
Birth defects/Disabilities	Yes	No	Relation? _____
Cancer	Yes	No	Relation? _____
Diabetes	Yes	No	Relation? _____
Heart Disease	Yes	No	Relation? _____
Stroke/ Vascular Dis.	Yes	No	Relation? _____

If yes, explain_____

Other Health Information to note:_____

Mountain Counseling Associates, LLC

P.O. Box 2272, Hendersonville, NC 28793 Phone: 828-692-7300 Fax: 828-692-7710

RELEASE OF INFORMATION or COORDINATION OF CARE

Client Name (Print):_____ **DOB:** _____

Medicaid /Health Choice# (if applicable) _____

I authorize _____ to ☐release ☐receive information to/from
Mountain Counseling Associates, LLC Provider Name

Provider/Individual/ Organization: _____
Name/Specific Organization

_____ _____ _____
Address **Phone** **Fax**

Information that may be released/received:

( ) Mental Health/Physical Information: ☐Presence and Progress in Treatment ☐Assessments ☐Diagnosis ☐ Demographic
Initials check all that apply ☐TX/Recovery Plans ☐Psychiatric Summary ☐Medication Records

( ) Drug/Alcohol Treatment Information: ☐Presence and Progress in Treatment ☐Assessments ☐Diagnoses
Initials check all that apply ☐TX/Recovery Plans ☐Psychiatric Summary ☐Medication Records

( ) HIV/AIDS Information *
Initials *I understand that HIV/AIDS information will not be released without written consent. HIV/AIDS information is protected under federal regulation § 130A-143 Confidentiality of records. All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential.

☐**Other**: _____

REASON: ☐Provide continuity of care ☐Compliance with program ☐Specify _____
☐Personal Use ☐Legal Purposes ☐Social Security/Disability ☐Insurance/Managed Care ☐Coordination of Care

Dates of Service (if left blank all dates of service) FROM _____ **TO**_____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.
I have the right to:
1) Review and understand the Notice of Privacy Practices;
2) This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3) Inspect and receive a copy of the material to be released;
4) Request restrictions on how my health information is used and disclosed; and
5) Receive a copy of this authorization and the Notice of Privacy Practices
This form has been fully explained and I certify that I understand its contents. I understand that the provider may not condition treatment on obtaining this consent/authorization from me. I understand this release will remain in effect for 1 year from date signed or I revoke in writing.

_____ _____
Client's Signature/Name of Individual giving Oral Consent when physically unable to sign **Date**
"I understand the nature of the release and freely give oral consent"

_____ _____
Signature of Authorized Person in lieu of Participant **Date**
☐Power of Attorney ☐Guardianship Order ☐Parent of Minor

_____ _____
Witness Signature **Date** **Oral Consent/Witness Signature** **Date**
☐ **Copy Accepted** ☐ **Copy Refused**

Mountain Counseling Associates, LLC

Patient/Client Rights and Responsibilities

Patient/Client Responsibilities:

These are the expectations that you, as a health care consumer, have a right to expect in any health care visit with a Mountain Counseling Associates provider.

1. Treatment without discrimination based on race, ethnicity, religion, sex, gender identity, sexual orientation, national origin, age, disability or veteran status.
2. Care that is considerate and respectful.
3. Participation in decisions regarding treatment.
4. The name and function of personnel providing services and the identity of other personnel and institutions assisting in treatment.
5. Appropriate and competent assessment and treatment.
6. Complete and current information concerning your diagnosis, treatment and expected outcome in terms you can be reasonably expected to understand.
7. Receipt of information regarding condition/treatment options.
8. The ability to refuse treatment and to be informed of any potential consequences.
9. Confidentiality to the extent consistent with care.
10. Privacy of all records pertaining to your treatment, except as required by law or when life is in danger.
11. Access the information contained in your records within the limits of the law.
12. Continuity of care and to be informed of the possibility of continuing requirements following the end of treatment.
13. Participation in research only if consent is given and is fully informed of the purpose.
14. An itemized statement of all charges, upon request.
15. A smoke-free environment.
16. A safe environment free from, physical, sexual, and verbal abuse as well as neglect and exploitation by staff, and visitors.
17. Ways to report concerns about patient care and safety. If concerns are not resolved by the Mountain Counseling Associates provider, client can contact the Joint Commission at 800-944-6610 or complaint@jointcommission.org.

Patient/Client Responsibilities:

These are your responsibilities, which you as a health care consumer; have to the providers at Mountain Counseling Associates.

1. Provide accurate information on symptoms, past illnesses, hospitalizations, medications, and psychological treatment.
2. Pay for your portion of services at the time they are provided.
3. Meet any financial obligations for care, treatment or services rendered at Mountain Counseling Associates.
4. Tell us if you don't understand instructions and/or information.
5. Become informed of the scope of basic services offered, the costs, and importance of medical insurance, and to actively seek clarification of any aspect of participation in Mountain Counseling Associates programs and services, including cost, that is not understood.
6. Provide adequate time to comply with requests for medications, prescriptions, and requests for information from outside sources.
7. Keep appointments, or change them as soon as possible.
8. Follow treatment plans.
9. Clearly state refusal of treatment.
10. Consider the rights of other patient/clients and staff.
11. Respect other's property.
12. Refrain from smoking while in facility or on facility premises, except in specifically designated areas.

IN CASE OF EMERGENCY PLEASE CALL 828-251-4439 FOR THE PROVIDER ON CALL