Greater Vision Counseling & Consulting Agency, PLLC

Tailored Care Management

Annual - Client Intake Information Sheet

Date: _____ **Referral Source:** _____ **MR#:** _____

Client Name: _____ **If Female, Maiden Name:** _____

DOB: _____ **Age:** _____ **Social Security #:** _____

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

Email Address (if applicable):

_____

Phone #: _____ **Primary Language:** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Spouse's Name: _____ Phone #: _____

Race: ☐ American Indian ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Multiracial

Gender: ☐ Male ☐ Female ☐ Other: _____

Ethnicity: ☐ Cuban ☐ Puerto Rican ☐ Hispanic or Latino ☐ Not Hispanic/Latino ☐ Mexican ☐ Other _____

Education Level: ☐ High School Diploma ☐ GED ☐ Some College ☐ Type of Degree_____ Grade Level: ____

Employment: ☐ Employed FT ☐ Employed PT ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed

Military Status: ☐ Active Duty ☐ Retired

Legal Guardian:

_____

Phone # _____ **Relation:** _____

Emergency Contact:

_____

Phone #: _____ **Relation:** _____

Type of Insurance: _____ **ID #:** _____ **Group #:** _____

Secondary Insurance: _____ **ID #:** _____ **Group #:** _____

Policy Holder's Name: _____

Client's Employers Name/School Name: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Other Physicians/Psychiatric: _____ **Phone #:** _____

Number in Household: _____ **Household Income:** _____ **Living Arrangements:** _____

Annual - Client Clinical Intake

Office use only

Client Name: _____ **DOB:** _____ **Insurance:** _____ **MR#** _____

Presenting Problem by Age/Disability: ☐ AMH ☐ CMH ☐ ADD ☐ CDD ☐ ASA ☐ CSA

Brief Description of Presenting Problem:

_____

_____

_____

Competency: ☐ Competent ☐ Incompetent ☐ Minor **Need Severity:** ☐ EMERGENT ☐ URGENT ☐ ROUTINE

Have you ever been convicted of a crime: ☐ Yes ☐ No If yes, explain: _____

What medical conditions do you have? ☐ **None**

☐ Diabetes ☐ High Blood Pressure/Hypertension ☐ High Cholesterol ☐ Heart Disease ☐ History of Stroke ☐ History of Heart Attack ☐ Hepatitis ☐ Liver Disease ☐ Thyroid Disease ☐ Migraines ☐ Asthma ☐ Chronic Pain _____ ☐ Arthritis ☐ Osteoporosis ☐ Sleep Apnea ☐ Allergies ☐ COPD or Emphysema ☐HIV or AIDS ☐ Other medical conditions not listed:

_____

_____

What mental health conditions do you have? ☐ **None**

☐ Depression ☐ Anxiety ☐ PTSD ☐ Bipolar I ☐ Bipolar II ☐ Obsessive Compulsive Disorder ☐ ADD/ADHD ☐ Schizoaffective Disorder ☐ Autism Spectrum Disorder ☐ Eating Disorder ☐ Substance ☐ Use Disorder (sober or currently using) ☐ Alcoholism (sober or currently using) ☐ Cancer ☐ Other mental health conditions not listed:

_____

Are you currently taking medications? ☐ Yes ☐ No If yes, please list or specify below:

_____

_____

_____

_____

_____

_____

_____

Allergies: ☐ Yes ☐ No If yes, please list with reaction:

_____

Have you been hospitalized in the past? ☐ Yes ☐ No If yes, explain: _____

Are you Pregnant ☐ Yes ☐ No ☐ N/A

Are you a risk to yourself or others? ☐ Yes ☐ No If Yes, explain: _____

Are you in need of Detox? ☐ Yes ☐ No If yes, explain:

_____

Are you Aggressive or Self-Injurious? ☐ Yes ☐ No If yes, explain: _____

Are your living arrangements stable? ☐ Yes ☐ No If no, explain: _____

Do you feel safe in your living situation? ☐ Yes ☐ No If no, explain: _____

Name of Person Completing Form: _____ ***Date:***

_____

Greater Vision Counseling & Consulting Agency, PLLC – TCM

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#**

_____

Consent for Assessment and Treatment

I, _____ (consumer/parent/legally responsible person), give my consent for **Greater Vision Counseling & Consulting Agency PLLC, Tailored Care Management Program** to provide assessment, treatment and/or other services for the above-named consumer. I reserve the right to withdraw my consent at any time. I also reserve the right to refuse, at any time, any services offered to me. I also give my consent for agency staff to provide and/or obtain emergency medical care from a hospital or physician.

If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all modalities are refused, the voluntarily admitted consumer may be discharged.

A minor may seek and receive periodic services from a physician without parental consent for the prevention, diagnosis and treatment of (1) venereal disease and other diseases reportable under G.S. 130A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance.

ACKNOWLEDGEMENT OF RECEIPT

By checking below, I certify that I have reviewed and/or received a copy of the following documents:

- ☐ Consumer Rights/Bill of Rights
- ☐ Notice of Privacy Practices
- ☐ Financial Agreement
- ☐ Service Plan

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Greater Vision Counseling & Consulting Agency, PLLC - TCM

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Authorization for Use and Disclosure of Protected Health Information

I hereby request and authorize **Greater Vision Counseling & Consulting, PLLC** – TCM to release/obtain and/or exchange information with:

Agency/Individual: _____

Address: _____

Telephone Number: _____

Nature of records to be released: (***Client/Guardian must check beside each applicable document***)

- ☐ Admission Assessments/Screening
- ☐ Treatment Recommendations
- ☐ Needs Assessment
- ☐ Progress/Psychotherapy Notes
- ☐ Medications/Lab Results
- ☐ AIDS/HIV
- ☐ Other: _____
- ☐ Treatment Plans/Service Plan
- ☐ Psychiatric Evaluations/Psychological Evaluations
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Substance Abuse/Legal History
- ☐ School Attendance/Education Information

I understand the purpose of the disclosure/redisclosure will be used for: (***Client/Guardian must initial beside each applicable document***)

- ☐ Insurance/Medicaid/Medicare determination of benefits
- ☐ To assist in the development of individual treatment/service plan
- ☐ Provide data to assist with evaluations/assessment.
- ☐ To assist in securing benefits from entitlement programs.
- ☐ Coordination of services between agencies

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from discoing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions G.S. 130A-143 shall be strictly confidential.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year **(365 days)** from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Greater Vision Counseling & Consulting - TCM** will begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information indicated by initials will be disclosed.

I understand Substance Abuse records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Paragraph 2, and cannot be disclosed with written authorization unless otherwise provided for in the regulations.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Greater Vision Counseling & Consulting Agency, PLLC - TCM

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☐ AIDS/HIV ☐ School Attendance/Education Information
☐ Other: _____

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☐ Provide data to assist with evaluations/assessment.

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_____ _____ _____
Client or Legal Guardian Signature *Relationship* *Date*

_____ _____
Witness Signature *Date*

Greater Vision Counseling & Consulting Agency, PLLC - TCM

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If YES, please name the members allowed:

_____

_____

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*