MOUNTAIN HEALTH CARES

Patient Chart Number_____Registered by_____Date_____

PATIENT INFORMATION

Last Name: _____First Name: _____ MI: ____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Mailing Address: _____
Physical Address (if PO Box is provided): _____
City: _____ State: _____ Zip Code: _____
Sex: ___Male ___Female___ Birthdate: _____ Age: _____
Social Security#: _____ Email Address: _____
Maiden Name: _____ Place of Birth: _____ Mother's First Name: _____

Patient Initial:_____ By initialing, I approve MHCS to leave messages on my answering machine and/or voicemail.
Patient Initial:_____ By initialing, I am declining MHCS to add me to the mailing list for uses and disclosures of PHI (Protected Health Information) for marketing purposes.

Marital Status (check one): _____ Single _____ Married _____ Widowed
_____ Divorced ____ Legally Separated

Ethnicity: Hispanic or Latino: ___ Yes ___ No **Patient a Veteran:** ___ Yes ___ No

Race (circle all that applies): African American Asian Other Pacific Islander
Native American/Alaska Native Native Hawaiian White Unknown Decline to State

Communication Requirements: **Interpreter Needed:** ___ Yes ___ No
Hearing Impaired: ___ Yes ___ No
Legally Blind: ___ Yes ___ No

How did you hear about us: ____ Advertising _____ Outreach/Event _____Website
____ Internet Search ____ Referral from Friend or Patient
_____ Insurance Plan ____ Other_____

PROVIDER INFORMATION

Dentist Name: _____ Phone: _____
Specialist Name: _____ Phone: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Relationship to Patient: _____

INSURANCE INFORMATION
PRIMARY Insurance Company Name: _____
SECONDARY Insurance Company Name: _____
HEAD OF HOUSEHOULD (BILL TO)
Last Name: _____First Name: _____ MI: ___
Date of Birth: _____ Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Mountain Health is a federal qualified Health Center, 501(c) 3, non-profit agency. Our fees reflect our cost. In order to provide you with low cost medical care, payment is expected at time of service.

EMPLOYMENT STATUS
___Employed: (F/T **or** P/T) ____ Self Employed ____Unemployed ____Student: (F/T **or** P/T)
Patient's Employer_____ Work Phone: (____) _____
Source of Income: __ Employment __Unemployed ___Disability ___Retirement __Other
Type of Employment: ___Management ___Production ___Sales/Service
___Farming ___ Migrant
Monthly Gross Income: $_____ Family Size: _____

EDUCATION
Circle Patient's Highest Level of Education:
Elementary: None K 1 2 3 4 5 6 Junior High: 7 8
High School: 9 10 11 12 College: 13 14 15 16 Vocational School Other

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the above. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health care status or the above information.

I assign all medical and/or surgical benefits to which I am entitled, including Medicare benefits, to MOUNTAIN HEALTH & COMMUNITY SERVICES, INC. not to exceed the total of valid charges. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that certain services may be considered **non-covered or not medically necessary** by my insurance carrier(s) and that coverage may be denied. I understand that I am responsible for payment of these services. I authorize the release of any medical or other information to process claims to secure payment form insurance carrier and/or Medicare.

Signature Date

Mountain Health

CONSENT FOR TREATMENT

The undersigned patient and/or responsible relative or person hereby authorizes MOUNTAIN HEALTH AND COMMUNITY SERVICES and its assigned physician and ancillary personnel to administer and perform any and all medical examinations, treatment, diagnostic and surgical procedures, Behavioral Health Services or other services which may now or during the course of the patients care be deemed advisable or necessary.

I understand that ancillary personnel include Nurse Practitioners, Physician Assistants, Nurses, Medical Assistants and Billing Clerks.

It is further understood that if the patient or responsible party on behalf of the patient refuse any treatment suggested, I automatically release the clinic/office from responsibility for damages, which may occur, because of my refusal. Refusal of treatment will be documented and witnessed by not less than two (2) persons, including the treating Physician.

____

Print Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

Please provide us with names of individuals with whom we may discuss your care, provide paper work on your behalf, and who can pick up prescriptions for you. Thank you.

Name:______________________________Relationship:_________________Phone#:____________

☐ Check this box, if the person listed above can also discuss your Behavioral Health care.

☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________

☐ Check this box, if the person listed above can also discuss your Behavioral Health care.

☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________

☐ Check this box, if the person listed above can also discuss your Behavioral Health care.

☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________

☐ Check this box, if the person listed above can also discuss your Behavioral Health care.

☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

____

Signature of Witness Date

Mountain Health

CONSENT FOR HEALTH INFORMATION EXCHANGE

A Health Information Exchange (HIE) is a way of sharing your health information among participating doctors' offices, hospitals, labs, clinics and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and other health care professionals will not be able to search for your health information through the HIE to use while treating you. However, you may choose to allow participating providers to access your information through the HIE in the event of a medical emergency. Public health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE.

☐ Check this box to Opt-In ☐ Check this box to Opt-Out except in a Medical Emergency
☐ Check this box to Opt-Out Completely (EVEN in a Medical Emergency)

_____

Print Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

_____

Signature of Witness Date

Mountain Health

HIPAA CONSENT

I_____ acknowledge that I have reviewed and understand the following Mountain Health & Community Services, Inc. (Mountain Health) regarding my rights and responsibilities:

1. I understand my Patient Rights and Responsibilities which are posted in the waiting. I also understand that I may request a copy of the Patient Rights and Responsibilities from the receptionist.
2. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
   - Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
   - Obtain payment from third party payers.
   - Conduct normal healthcare operations such as quality assessments and physician certifications.
   - I acknowledge that I have received a copy of Mountain Health & Community Services, Inc. (Mountain Health), Privacy Practices containing a more complete description of the uses and disclosures of my health information, and I consent to the use of my Protected Health Information (PHI) for treatment, payment, and healthcare operations of the practice.
   - I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.
   - I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.
3. I understand that all co-pays are due at the time of services. In the event, I cannot pay my co-pay at the time of service. ***I will be billed my co-pay and an additional $10.00 processing fee.***
4. I understand and acknowledge that I have ability to receive or decline Advance Directives offered by the front desk receptionist at my initial visit and at any time I have access to change my Advance Directives by speaking with the receptionist at the front desk.

_____ _____ _____

Patient Name Signature Date

If you would like a copy of Patient Rights and Responsibilities, HIPAA Privacy Notice and/or Advance Directives, please request copies from the receptionist.

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature regarding Mountain Health's Patient Rights and Responsibilities, HIPAA Privacy Notice and/or Advance Directives Acknowledgement and, $10.00 co-pay processing fee, but was unable to do so as documents below:

_____ _____

Date Staff Member Signature

Reason:_____

PATIENT HEALTH QUESTIONNAIRE-9
(P H Q - 9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Mountain Health

BEHAVIORAL HEALTH INFORMED TREATMENT CONSENT AND DISCLOSURE FORM

Welcome to Mountain Health Behavioral Health Services. It is both a pleasure to have you here and to begin our journey together. Please read each policy stated in this treatment and disclosure form and initial certifying that you have both read and fully understand the contents. Please feel free to ask a staff member to clarify any part of this agreement that you do not understand.

Treatment Philosophy

Therapy is goal-directed and problem focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. A treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to a treatment plan is necessary for you to experience the most successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here: _____**

Emergency Access

A covering physician or provider is available after hours to handle **emergencies**. By calling the main office number during after hours, you will be instructed on how to contact the on-call provider. **Initial here: _____**

Financial Terms: Insurance Coverage and Co-payments

We will bill your insurance for sessions; however you are responsible for all co-payment amounts and deductibles as set by your benefit plan. All co-payments are due at the time of service. As per MHCS policy, you will be billed a $10.00 late co-pay charge if you do not pay your co-payment at the time of visit. Missed appointments and late cancellation charges are not covered by your insurance plan and are ultimately your responsibility.

At any time during treatment, you will inform MHCS of any insurance changes.

Initial here: _____

Late Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. Please contact our office within 24 hours to cancel/reschedule you appointment.

Therapy Patients: If you "no show" or cancel your appointment with less than 24 hours notices two times within treatment, you will be referred back to your primary care physician or insurance company for reassignment to another practitioner.

Initial here: _____

Limits of Confidentiality Statement

Privacy: This is a basic constitutional right of a person to decide how much personal information can be shared with others.

Confidentiality: Similar to the right to privacy, but narrower, refers to the obligation not to disclose any information about a client, research subject, supervised employee, etc., obtained during the course of a professional relationship without the person's permission.

All information between practitioner and patient is held strictly confidential. There are exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental issue becomes an issue in a lawsuit.
3. The client's identification can be adequately disguised or removed such as in situations where we may consult with fellow professionals for the purpose of consultation, as long as the client's identity is not revealed.
4. The patient presents as a physical danger to self (Johnson v. County of Los Angeles, 1983) or others (Tarasoff v. Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).
6. The FBI requests information (Patriot Act -18 U.S.C. §2709)

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.
All written and spoken material from any and all sessions is confidential unless an authorization for release of information form is filled out, signed and returned to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of treatment, details of the group discussions are not to be discussed outside of the counseling sessions. **Initial here: _____**

Release of Information
I authorize release of information to my Primary Care Physician, as well as other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. I agree that, should we need to consult with other professionals regarding my treatment, I give my permission to do so, provided that MHCS does not disclose my name or facts about me which could lead others to know my identity. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration, and other purposes related to my health plan. **Initial here:** _____

Consent for Treatment
I authorize and request my practitioner to carry out psychological exams, treatment, and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that, while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. **Initial here**: _____

Please provide us with names of individuals with whom we may discuss your care, provide paper work on your behalf, and who can pick up prescriptions and/or medical information on your behalf. Thank you.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

I certify that I have read, fully understand, and agree to follow all policies disclosed in this treatment and disclosure form.

_____	_____	_____
Patient Signature	Patient Name	Date

General Consent for Child of Dependent Treatment
I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize MHCS to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____	_____
Patient Name	Date
_____	_____
Signature of Parent/Legal Guardian/ Representative	Relationship to patient

AUDIT QUESTIONNAIRE: SCREEN FOR ALCOHOL MISUSE:

Name:_____ Date:_____

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?
    a. Never
    b. Monthly or less
    c. 2-4 times a month
    d. 2-3 times a week
    e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
    a. 1 or 2
    b. 3 or 4
    c. 5 or 6
    d. 7 to 9
    e. 10 or more

3. How often do you have six or more drinks on one occasion?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
    a. No
    b. Yes, but not in the past year
    c. Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
    a. No
    b. Yes, but in the past year
    c. Yes, during the past year

Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

GAD-7

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by the following problems? (Use a check to indicate your answer)	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if someone awful might happen	0	1	2	3

(For office coding: Total score T_____ = _____ + _____+ _____)