Catawba Valley Healthcare
CLIENT PROFILE

Client Name:								
	Last	First	M	Maiden/Suffix	Record No.	Date of Birth	Social Security #	Today's Date

Mailing Address:		City:	State & Zip:	Phone #:
Physical Address:		City:	State & Zip:	Email:

Sex: ☐ M ☐ F	Ethnicity:	Legal guardian (if applicable):	Name:	Phone #:

What is the main reason you came today? | Medicaid #:

Who referred you to CVH? | **Family Physician** ☐ No ☐ Yes, name of practice

I am interested in the following services: ☐ ***therapy/counseling*** ☐ ***medication management for mental health*** ☐ ***primary/medical care***

What are the current problems facing you? (Please check all that apply. If the individual is a child, please check those that apply to the child.)

___ cry easily	___ feel tense/nervous/panicky	___ physical problems	___ feel depressed/sad
___ feel afraid	___ sexual concerns	___ feel guilty	___ feel angry
___ unusual behavior	___ feel tired/no energy	___ mood swings/changes	___ trouble with temper
___ sleep problems	___ easily annoyed/irritated	___ problems with school	___ problems with work
___ financial problems	___ trouble concentrating	___ problems with housing	___ relationship problems
___ loss of interests	___ family problems	___ trouble with memory	___ thoughts of ending my life
___ feel threatened/not safe	___ problems with alcohol	___ problems with drugs	___ thoughts of hurting someone
___ appetite/weight change	___ often think of past trauma	___ difficulty keeping friends	___ hear voices/see things that others don't
___ thoughts of hurting myself (cutting, burning, etc.)		___ problems controlling impulses (gambling, computers, sexual, etc.)	

OTHER:	Have you ever been abused or neglected, including sexually molested?	☐ No	☐ Yes
	Have you ever witnessed or been involved in violent acts?	☐ No	☐ Yes
CRISIS ASSESSMENT:	Are you currently feeling like hurting yourself?	☐ No	☐ Yes
	Have you felt like hurting yourself within the last month?	☐ No	☐ Yes
	Are you currently feeling like hurting anyone?	☐ No	☐ Yes
	Have you felt like hurting anyone within the last month?	☐ No	☐ Yes

PSYCHIATRIC HISTORY:
HOSPITALIZATIONS:
Have you ever been in a hospital overnight for a **Psychiatric** condition (including involuntary commitments)? ☐ No ☐ Yes
If yes, when was your **most recent** Psychiatric Hospitalization?
OUTPATIENT TREATMENT:
Have you ever been treated as an outpatient for a **Psychiatric** condition (including involuntary outpatient commitments)? ☐ No ☐ Yes

SUBSTANCE USE/ABUSE HISTORY: ☐ None Please indicate the use of the following:

	Daily	Weekly	In the past	Age of 1st Use	Date of Last Use
Alcohol	☐	☐	☐		
Marijuana	☐	☐	☐		
Cocaine/Crack	☐	☐	☐		
Speed/LSD/Crystal Meth	☐	☐	☐		
IV Drugs	☐	☐	☐		
Herbal Medicines	☐	☐	☐		
Pain Medications	☐	☐	☐		
Sleep Medications	☐	☐	☐		
Other	☐	☐	☐		

Have you ever experienced alcohol/drug withdrawal symptoms? ☐ -Yes ☐ - No

LEGAL:	Have you ever been arrested or convicted of a felony or misdemeanor?	☐ No ☐ Yes
	Arrest in the Last 30 days?	☐ No ☐ Yes, how many _____
	Do you have or have you had any other significant legal problems?	☐ No ☐ Yes

SOCIAL HISTORY:

Marital Status	☐ Single, never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner
Employment	☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Retired ☐ Homemaker ☐ Not available for work ☐ Armed Forces/National Guard ☐ Seasonal/Migrant Worker **If employed, Employer Name:**_____
Education	☐ K-12; list grade: _____ ☐ High School Diploma ☐ GED ☐ Some College ☐ Bachelor's ☐ Master's ☐ Trade ☐ Special Ed
Military	☐ Yes, active ☐ Veteran ☐ Yes, Family Member ☐ No
Living Arrangements	☐ Private Residence ☐ Other Independent ☐ Homeless ☐ Residential Facility ☐ Foster Family/AFL
	☐ Nursing Home ☐ Rest Home ☐ Family Care Home ☐ Community MR ☐ Other _____

_____
Client Signature **Date**

Catawba Valley Healthcare

ADMISSION HEALTH HISTORY

Client Name:							
	Last	First	M.I.	Maiden/Suffix	Record No.	Today's Date	Medicaid ID Number:

Birth Date:		Your Age:	

Height:_____ **Weight Now**:_____

Last Flu Vaccine _____ (date) | Any other Vaccines and date _____

Previous Treatment:
Psychiatric Treatment? ☐ No ☐ Yes Substance Use Treatment? ☐ No ☐ Yes

Recent Dental Exam?	☐ No ☐ Yes Date _____
Recent Hearing Test?	☐ No ☐ Yes Date _____
Recent Eye Exam?	☐ No ☐ Yes Date _____
Recent Foot Exam?	☐ No ☐ Yes Date _____
Recent Colonoscopy?	☐ No ☐ Yes Date _____

Smoke Tobacco? ☐ No ☐ Yes
Smokeless tobacco? ☐ No ☐ Yes
Vape? ☐ No ☐ Yes
Have you smoked or used smokeless tobacco in the past? ☐ No ☐ Yes

Guns in the Home?	☐ No ☐ Yes
Guns Locked in Safe Storage?	☐ No ☐ Yes
Narcotics Locked in Safe Storage?	☐ No ☐ Yes

Any Falls in the Last Year? ☐ No ☐ Yes | with injury ☐ No ☐ Yes

FEMALE:
Last Mammogram _____ Last Pap Smear _____
Date of Last Period?_____ Menopause? ☐
☐ Hysterectomy ☐ Tubal Ligation ☐ Never Pregnant
Pregnancies: Please indicated number in each category

How many _____	Stillbirths _____	Premature births _____
Spontaneous Abortion _____	Single Births _____	Multiple births _____
Miscarriage _____	Normal Deliveries _____	Caesarean Section _____

Male: Last PSA blood test? _____

MEDICAL HISTORY: Have you ever had or been treated for (please check):

☐ Alcoholism	☐ Esophageal (Acid) Reflux	☐ Pancreatitis
☐ Alzheimer's	☐ Fibromyalgia	☐ Peripheral Vascular Disease
☐ Anemia	☐ Gastric Ulcer	☐ Psychiatric Disorders
☐ Asthma	☐ Liver Disorder	☐ Kidney Disorders
☐ Bleeding Disorder	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Cancer _____	☐ HIV	☐ Seizures
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Skin Disorders
☐ COPD	☐ Hypertension (high blood pressure)	☐ Stroke
☐ Chronic Sinusitis	☐ Irritable bowel syndrome	☐ Substance Use
☐ Coronary Artery Disease	☐ Heart Attack	☐ Thyroid Disorders
☐ Diabetes	☐ Migraines	☐ Urinary Tract Infection
☐ Ears, Nose, Throat Disorder	☐ Osteoarthritis	
☐ Eye Disorders	☐ Osteoporosis	

SURGERIES: (please list)

Client Name:							
	Last	First	M.I.	Maiden/Suffix	Record No.	Today's Date	Medicaid ID Number:

MEDICAL HOSPITALIZATIONS: (please list)
Psychiatric:
Medical:

FAMILY HISTORY:

Name	Age	If Living, Health	Age at Death	If Deceased, Cause
Father:				
Mother:				
Bio/Half Brother:				
Bio/Half Sister:				

FAMILY MEDICAL HISTORY: (please check):

☐ Alcoholism	☐ Diabetes	☐ Mental Illness
☐ Allergies	☐ Eczema	☐ Migraines
☐ Alzheimer's Dementia	☐ Esophageal (Acid) Reflux	☐ Osteoarthritis
☐ Anemia	☐ Gastric Ulcer	☐ Respiratory Disorders
☐ Anxiety Disorder	☐ Heart Attack	☐ Seizures
☐ Asthma	☐ Heart Disease	☐ Sickle Cell Anemia
☐ Autistic Disorder	☐ Hepatitis	☐ Skin Disorders
☐ Autoimmune Disease	☐ HIV	☐ Stroke
☐ Cancer _____	☐ Hypertension (high blood pressure)	☐ Thyroid Disorders
☐ Congestive Heart Failure	☐ Kidney Disease	☐ Thrombophlebitis
☐ Deep Vein Thrombosis	☐ Kidney Stones	☐ Tuberculosis

Other Conditions not listed:

ADVANCED DIRECTIVE: If you desire information regarding an Advanced Directive, please inform your assigned staff member and check here: ☐

SOCIAL HISTORY:
RELATIONSHIP STATUS:

☐ Married	☐ Divorced	☐ Widowed
☐ Single	☐ In a Relationship	☐ Separated

EMPLOYMENT HISTORY:

☐ Full Time	☐ Not Employed	☐ On Disability
☐ Part Time	☐ Retired	☐ Applying for Disability

LIVING SITUATION:

☐ Homeless ☐ Streets ☐ Shelter ☐ Tent	☐ Nursing Home	☐ Renting
Transitional Housing	☐ Family Care Home	☐ Owns/Buying
☐ Group Home	☐ Lives w/ family	
☐ Assisted Living Facility	☐ Lives w/ friends/significant other	

EDUCATION: Please choose highest level completed

☐ Never attended school	Some College	Doctorate
☐ Less than 12th grade Last grade completed_____	Associate's Degree	Trade School
High School Diploma	Bachelor's Degree	Technical School
GED	Master's Degree	Currently in School

Difficulty Reading? ☐ No ☐ Yes
Do you have or have you ever had a Developmental Disability or Developmental Delay? ☐ - Yes ☐ - No
(If yes, describe)

Client Name:							
	Last	First	M.I.	Maiden/Suffix	Record No.	Today's Date	Medicaid ID Number:

Do you have any Allergies? (please list) Please also list the adverse reactions.
Medication:
Food:
Environmental:

Current Medications	☐ - None			
	Medication	Dosage/Frequency	Prescribed By	How Helpful Is It?

Client Signature: Date:

Catawba Valley Healthcare
Emergency Medical Information

Consumer Name:	**Record Number:**
Medicaid ID Number:	**Date of Birth:**
Email address:	**Date:**

	Name	Address
Emergency Contact (1)		
Phone Number(s):		**e-mail address:**
☐ Check if contact person lives with consumer		☐ Check if declining or you do not have one identified

	Name	Address
Emergency Contact (2)		
Phone Number(s):		**e-mail address:**
☐ Check if contact person lives with consumer		

	Name	Address
Guardian		
Phone Number(s):		**e-mail address:**
☐ Check if contact person lives with consumer		

	Name	Address
Psychiatrist		**Hickory**
Fax Number:		

	Name	Address
Family Physician		
Fax Number:		☐ Check if declining or does not have a Family Physician identified

Hospital of Choice	
Pharmacy of Choice ***Note: CVH will send prescriptions only to one pharmacy at a time, in accordance with State law.**	**Name of Pharmacy:** **Location:** **Phone Number:**
Allergies	

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		Date:

SCREENING TOOLS

PHQ 9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	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

WHO-5 Well-being Index Please respond to each item by marking one box per row, regarding how you felt in the last **two weeks**.	All of the Time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
1. I have felt cheerful in good spirits	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. I have felt calm and relaxed	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3. I have felt active and vigorous	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I woke up feeling fresh and rested	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5. My daily life has been filled with things that interest me	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

DAST 10

The following questions concern information about your possible involvement with drugs ***not including alcoholic beverages*** during the past 12 months. "Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months……	Yes	No
1. Have you used drugs other than those required for medical reasons?	☐ 1	☐ 0
2. Do you abuse more than one drug at a time?	☐ 1	☐ 0
3. Are you unable to stop abusing drugs when you want to? (If never use drugs, answer 1)		
4. Have you ever had blackouts or flashbacks as a result of drug use?	☐ 1	☐ 0
5. Do you ever feel bad or guilty about your drug use?	☐ 1	☐ 0
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ 1	☐ 0
7. Have you neglected your family because of your use of drugs?	☐ 1	☐ 0
8. Have you engaged in illegal activities in order to obtain drugs?	☐ 1	☐ 0
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ 1	☐ 0
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions,bleeding)?	☐ 1	☐ 0

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		Date:

Social Determinants of Health Assessment

There are local programs to help you with needs that can affect your health.
Are there things you need help with?

	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	☐	☐
1.a. Is having enough food a current need or concern?*	☐	☐
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	☐	☐
2.a. Is food not lasting a current need or concern?	☐	☐
3. Do you have housing?*	☐	☐
4. Are you worried about losing your housing?	☐	☐
5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	☐	☐
5.a. Are having utilities a current need or concern?	☐	☐
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	☐	☐
6.a. Is this a current need or concern?	☐	☐
7. Do you feel physically and emotionally safe where you currently live?	☐	☐
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐	☐
8.a. Is this a current concern?*	☐	☐
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	☐	☐
9.a. Is this a current need or concern?	☐	☐
1o. In the past 12 months, have you had trouble affording health insurance (such as deductibles, co-payments, etc.)	☐	☐
10.a. Is health insurance a current need or concern?	☐	☐
11. In the past 12 months, have you had trouble paying for or accessing medications?	☐	☐
11.a. Is this a current need or concern?	☐	☐
12. In the past 12 months, have you had concerns over obtaining or maintaining employment?	☐	☐
12.a. Is employment a current need or concern?	☐	☐

For completion by therapist/staff: ☐ Check and initial _____, confirming that if three (in bold) or more of items **1.a, 2.a, 3 (if no), 5.a, 6.a, 7 (if no), 8.a, 9.a, 10.a, 11.a, 12.a.** are checked that a plan will be developed to address the deficits. *Essential; needs to be addressed immediately. 091919

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
Consumer Orientation & Handbook Acknowlegement Form

Orientation to CVH:
I can access a copy of the CVH Consumer Orientation Handbook by going to www.cvhnc.org or by asking a CVH staff for a printed copy. If I require clarification about, Access to Services, Medication Management Procedures and Expectations, Payment and fee for services, Health and Safety at CVH, Employee Ethics and Professional Behavior, Complaint Process, providing feedback to CVH, how to access the appeals process, or any other issue related to CVH and its services, I may communicate with any staff member or reach CVH by calling (828) 695-5900 and ask for the QM Department.

Consumer Rights*:*
By signing below I am acknowledging that I can access a copy of an overview of consumer rights which is posted at all CVH facilities, in the CVH Consumer Orientation Handbook, by going to www.cvhnc.org or by asking CVH staff for a printed copy. I understand that I have the right to ask further questions should I need additional clarification or have future concerns related to consumer rights.

Privacy Practices*:*
By signing below I am acknowledging that I can access a copy of an overview of privacy practices which is posted at all CVH facilities, in the CVH Consumer Orientation Handbook, by going to www.cvhnc.org or by asking CVH staff for a printed copy. I understand that I have the right to ask further questions should I need additional clarification or have future concerns related to privacy practices.
I understand the following and/or know how to access this information:

1) How CVH will use my health information for the purposes of my treatment, payment for my treatment, and CVH's health care operations.
2) How CVH may use and share my health information for purposes other than treatment, payment, and health care operations.
3) How CVH will share my health information as required and/or permitted by law.

No Show/Cancellation Agreement:
My signature below indicates that I understand that CVH has a no-show cancellation agreement. If I do not have Medicaid I can be charged a fee of $25 for not cancelling an appointment with at least a 24 hour notice. I acknowledge that I will be responsible to pay any no show fees that I incur. I know that I can access additional information about the No Show/Cancellation agreement through my Orientation Handbook.

Recording
No video, photography or recording of any visit is allowed.

I understand that it is my obligation as a CVH Consumer to consult my *Consumer Orientation Handbook* and if needed, to request additional information from staff relating to any issues pertaining to my services, treatment or any other information listed in the handbook.

_____	_____	_____
Consumer/Legally Responsible Person's Signature	Relationship to Consumer	Date
_____		_____
Witness Signature		Date

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
Medication Agreement

This agreement covers the prescribing of all medications including but not limited to controlled substances by Catawba Valley Healthcare. Controlled substances are to be used with caution because of their potential for misuse. Our medical staff will work with you to understand the benefits and risks of federally controlled medications such as benzodiazepines and opiates.

To better serve you we will follow these general guidelines:

1. Please tell us of any other medical providers that are prescribing you medications and give us a list of all the medications you are currently taking.

2. You will be asked to sign a release so we can share treatment information with all your medical providers.

3. You may be required to have drug or lab tests for us to better meet your treatment needs. This may include, but not limited to initial and random drug screens. You or your insurance will be billed for this cost.

4. Missed medical appointments will result in you being required to see a prescriber in person before medications will be refilled.

5. Medications will be sent electronically to your pharmacy. Information in Eprescribe may contain information about which drugs are covered by your drug benefit plan, notice from the pharmacy if your prescription has been picked up, not picked up, or partially filled and information about your current and past prescriptions.

To better serve those receiving controlled substances the following general guidelines also apply:

6. Use only one drug store for any controlled medication we prescribe. Tell us if you change your pharmacy.

7. If you are prescribed Controlled Substances by another provider, we will coordinate with that provider prior to prescribing additional controlled substances. Prescription of controlled substances from other providers will be avoided for consumers receiving opiates and other controlled substances from other providers outside of CVH. We will regularly check the NC Controlled Substance Reporting System

8. Lost or stolen controlled medication replacement may be considered with a police report.

9. Controlled medication refills will not be called in to your drug store, you must be seen in person for a refill.

10. No prescriptions for a controlled substance will be written for any person participating in Drug Court.

11. CVH will comply with NC regulations regarding e-prescribing of certain controlled substances.

12. You may be required to come to CVH for a pill count of prescribed medications, failure to do so may result in discontinuation of the medication.

13. No controlled substances refilled early more than once per two years.

Thank you for your cooperation and understanding. Please ask us if you do not understand these guidelines or have questions about your treatment options. Please understand that violation of the above agreement may result in discontinuation of medications or medication management services. When/if someone is re-entering services after having been discharged for violating the agreement they will not be prescribed controlled substances. We wish you success.

I have read, understand and agree to follow the above Medication Agreement.

_____	_____	_____
Consumer/Legally Responsible Person's Signature	Relationship to Consumer	Date

_____	_____
Witness Signature	Date

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
Consent to Treatment

Informed Consent to Treatment

Welcome to Catawba Valley Healthcare (CVH) and thank-you for selecting us as your service provider for behavioral health or integrated care services. Before services are initiated, we must have your voluntary, informed, and legal consent to provide treatment. It is our responsibility to provide you with information about the services we provide and services/treatment you may receive at CVH. This is your legal right as a consumer and we want to assure you understand and agree to the following:

1. My assigned provider will explain my behavioral health and/or medical condition and provide information about available treatment/services;
2. My assigned provider will explain any risks associated with my treatment/services, such as the possibility of experiencing emotional or physical discomfort;
3. My assigned provider will explain the expected benefits of treatment and likely consequences if I do not receive or participate in services/treatment;
4. My assigned provider will provide information about alternative treatments that may be available to treat my behavioral health and/or medical condition;
5. I understand that I may ask questions and expect answers regarding my behavioral health and/or medical condition and/or the services and treatment I am receiving;
6. I have had explained to me and fully understand that my consent for treatment is totally voluntary and that I may choose to refuse or withdraw my consent and discontinue treatment at any time (as allowed by law);
7. Additional information about rights, informed consent, risks, and benefits is included in the CVH Consumer Handbook.

Authorization for Emergency Treatment

In case of an emergency, I authorize CVH or contract agency staff to seek medical care from a hospital or physician if I am unable to do so for minor child, adjudicated incompetent adult or myself for whom I am responsible. CVH may need to contact individuals of my choosing should an emergency occur. I have identified these persons that I want to be contacted in the case of an emergency on the CVH Emergency Medical Contact form.

Consent for Reminder Phone Calls

CVH uses an automated phone call system to remind consumers about scheduled appointments. By signing below, I consent to receive reminder calls, unless I have indicated otherwise in the Comments line below.

Consent for Follow-up Contact

There may be times that CVH needs to contact me to discuss information relevant to the treatment and services I receive from CVH. This may include information about appointments, services, and requests to know how I am benefiting from services. By signing below, I consent to such contact, unless I have indicated otherwise in the Comments line below.

Telepsychiatry

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the provider and the patient are not in the same physical location. Telepsychiatry may be scheduled based on a provider's availability or consumer choice provided their insurance allows the service. You may also request face to face visits. Providers may determine telepsychiatry is not the most appropriate delivery of care, due to complexity or inability to access telehealth capability. Based off that determination consumer would be seen face to face.

I have read and fully understand the information on this page, to include the opportunity for me to ask and have my questions about treatment and services answered. My signature (or signature of legal guardian) indicates that I am providing informed consent for CVH to provide treatment services.

_____	_____	_____
Consumer/Legally Responsible Person's Signature	Relationship to Consumer	Date
_____		_____
Witness Signature		Date

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
Consumer Payment Agreement

Release of Information, Assignments of Benefits and Consumer Responsibility
I hereby authorize Catawba Valley Healthcare to release the necessary information from my records to my guarantor (Medicaid, Medicare, Medicare/Medicaid, Managed Care Organization, Private Insurance, Advantage Plans, PrePaid Health Plans etc.) for billing and management services. I also authorize CVH to work denials on my behalf.

Information released to any of the above may include the dates of service, type of service, diagnosis, name or service provider, financial charges, HIV/AIDS related treatment, any available drug and alcohol information and medical records. I authorize payment by my insurance company/funding source to be paid directly to CVH for services rendered. I have been informed there are statutes and rules protecting the confidentiality of information; once my Protected Health Information (PHI) is disclosed to an authorized individual/agency, there is potential for that PHI to be re-disclosed by the recipient and thus, no longer protected under the Privacy Rule.

It is my responsibility to inform CVH of any changes that may affect billing or charges to my account. If I fail to provide this information, I understand I will be fully responsible for charges. I understand I am financially responsible to CVH for charges applied to any deductible, co-payments or co-insurance fee and for all charges not covered by my insurance. Insurance co-pays, co-insurance and unmet deductibles are due at time of service. I agree to pay the established fee(s). I may be denied an appointment if I refuse to pay for services.

Your insurance will be automatically filed as a courtesy to you. Please be sure to provide a copy of your insurance card to staff. If you are referred for services outside of CVH (i.e. labs), please note you are responsible for insuring we have proper insurance information at the time of the referral. Also, you are responsible for any fees associated with these outside services.

By signing below, I acknowledge this informed consent has been explained to me. I may request an update list of fees related to my services at any time. Also, **I may be charged $25** for a scheduled appointment if I do not cancel 24 hours in advance. I understand this consent will be valid until all services rendered are billed and payment is received.

My current guarantor information as of today is:

☐Medicaid ☐Medicare ☐ Partners Behavioral Health Management (IPRS)

☐Private Insurance: _____ ☐Other: _____

Deductible _____ Co-pay or Co-insurance _____

(Complete for IPRS Consumer only)

Marital Status: ☐Married ☐Single ☐Widowed	**Consumer**	**Spouse/Other**
Number of dependants that live in home (including self)		
Current income (hourly rate)		
Number of hours worked on average per week		
Frequency of income	☐Weekly ☐Biweekly	☐Weekly ☐Biweekly

Other sources of income	Type:	Amount:
Other sources of income	Type:	Amount:
Income verified by	☐ Paystubs ☐ Entitlement Records ☐ Verbal Report ☐ No income form ☐ Other	

_____ _____ _____
Consumer/Legally Responsible Person's Signature Relationship to Consumer Date

_____ _____
Witness Signature Date

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Authorization to Use and Disclose Protected Health Information
Catawba Valley Healthcare

☐ Burke County Office
301 East Meeting Street, Suite 104
Morganton, NC 28655
Phone: 828-624-1900
Fax: 828-398-4147

☐ Catawba County Office
327 1st Ave NW
Hickory, NC 28601
Phone: 828-695-5900
Fax: 828-695-4256

NOTICE – PLEASE READ: Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization. I understand that my treatment and payment for my services may not be conditioned upon my signing this authorization. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State confidentiality laws. Catawba Valley Healthcare will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

I hereby authorize Catawba Valley Healthcare to:

☐ **release information** ☐ **exchange information** ☒ **release and exchange information**

Name of person or specific entity Primary Physician: _____

Address _____

Phone number/Fax Number _____

INFORMATION TO BE USED/DISCLOSED

Consumer or Legally Responsible Person must ***INITIAL* the following items needed:**

_____ Clinical Assessments/Evaluations	_____ ER records	_____ Cardiac Diagnostics
_____Treatment Plan/PCP	_____ Referral Information	_____ Psychological Evaluation Reports
_____ Medication Records/Prescriber Orders	_____ Consultation Reports	_____ Developmental Disability Records
_____ Progress Notes (Therapy, Prescriber and Nursing)	_____ ECG	_____ Financial Information
_____ Service Notes	_____ EKG	_____ School Records/Consultation
_____ Laboratory Records	_____ Imaging Reports	_____ Employment Records/Reports
_____ Discharge Information	_____ Ultrasound Reports	_____ Court Reports/Records

_____ Other (CLEARLY SPECIFY) _____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☒ Continuity of Care ☐ Emergency Contact/Crisis Support

☐ Other (Specify)_____

This consent will expire on or when: 1 year from the date signed below **(Not to exceed one year from the date signed)**

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****

Signature of Consumer or Legally Responsible Person	**Relationship to Consumer**	**Date**
Witness	**Title**	**Date**

NOTICE OF REVOCATION

I hereby revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Consumer/ Legally Responsible Person Signature: _____ **Date Revoked:** _____

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Authorization to Use and Disclose Protected Health Information
Catawba Valley Healthcare

☐ Burke County Office
301 East Meeting Street, Suite 104
Morganton, NC 28655
Phone: 828-624-1900
Fax: 828-398-4147

☐ Catawba County Office
327 1st Ave NW
Hickory, NC 28601
Phone: 828-695-5900
Fax: 828-695-4256

NOTICE – PLEASE READ: Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization. I understand that my treatment and payment for my services may not be conditioned upon my signing this authorization. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State confidentiality laws. Catawba Valley Healthcare will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

I hereby authorize Catawba Valley Healthcare to:

☐ **release information** ☐ **exchange information** ☒ **release and exchange information**

Name of person or specific entity Referral Source: _____

Address _____

Phone number/Fax Number _____

INFORMATION TO BE USED/DISCLOSED

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_____ Clinical Assessments/Evaluations	_____ ER records	_____ Cardiac Diagnostics
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I hereby authorize Catawba Valley Healthcare to:

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Name of person or specific entity Emergency Contact: _____

Address _____

Phone number/Fax Number _____

INFORMATION TO BE USED/DISCLOSED

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_____ Laboratory Records	_____ Imaging Reports	_____ Employment Records/Reports
_____ Discharge Information	_____ Ultrasound Reports	_____ Court Reports/Records

_____ Other (CLEARLY SPECIFY) _____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☐ Continuity of Care ☒Emergency Contact/Crisis Support

☐ Other (Specify)_____

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I hereby authorize Catawba Valley Healthcare to:

☐ **release information** ☐ **exchange information** ☒ **release and exchange information with/to**

☐ **Partners Behavioral Health Management**	☐ **Amerihealth Caritas**	☐ **United HealthCare of NC**
☐ **Vaya Health**	☐ **Carolina Complete Health**	☐ **Wellcare of NC**
☐ **Cardinal Innovations**	☐ **BCBS NC Healthy Blue**	☐ **Other** _____

INFORMATION TO BE USED/DISCLOSED

Demographic information, PCP, Treatment Plans, PCP revisions, Treatment Plans revisions, diagnosis revisions, admission assessment, any other assessments and referral forms, substance abuse addendum, infectious disease questionnaire, target pop, NC-SNAP (if applicable), NC TOPPS, psychological evaluations, service orders, authorization forms, termination summaries, and any other relevant information needed for authorization, payment, auditing or management of services.

_____ Other (CLEARLY SPECIFY) _____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☐ Continuity of Care ☐ Emergency Contact/Crisis Support

☒ Other (Specify) authorization, payment, managing, coordinating, facilitating and monitoring services

This consent will expire on or when: 1 year from the date signed below **(Not to exceed one year from the date signed)**

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Signature of Consumer or Legally Responsible Person | **Relationship to Consumer** | **Date**

Witness | **Title** | **Date**

NOTICE OF REVOCATION

I hereby revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Consumer/ Legally Responsible Person Signature: _____ **Date Revoked:** _____

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
Income Attestation / Client Hardship Application

Section I – Income

☐ **No Income Statement**

I _____, do attest that I have no income currently and no insurance. I also attest that I have no employment and receive no disability, SSI, or government funding. This information is given in good faith and should information be made available that shows otherwise, I understand that I am responsible for any and all fees that are applicable based on any discovered income. I also understand that my financial status should be re-evaluated every **180 days to assess any change in status.

OR

☐ **I have income and I attest that:**

- The family income / wages that I have reported is true and accurate
- The number in household that I have reported is true and accurate
- That I currently have no insurance

Section 2 – My Responsibilities

- <u>If I gain insurance, I will notify CVH immediately.</u> I understand that failure to do so is fraudulent.

- By signing below, I acknowledge that when I fail to report insurance coverage, I am responsible for the cost of services which have passed my insurance's timely filing period. Failure to pay these cost incurred may result in termination of services.

_____	_____	_____
Consumer/Legally Responsible Person's Signature	Relationship to Consumer	Date
_____		_____
Witness Signature		Date

Consumer Name:	Date of Birth:	Record #:
Medicaid #:		

Catawba Valley Healthcare
SERVICE ORDER

The following designated treatments are medically necessary for the above-named client.
Screening, Case consultation and Evaluation are to be delivered under standing orders in accordance with Agency Policy.

Date of Assessment:

Need	Service	Date of Order	Was there a Verbal Order?	Date of Verbal Order* (if applicable)	Signature
☐	Outpatient Treatment - Individual/Group		Yes ☐ No ☐		
☐	Community Support Team		Yes ☐ No ☐		
☐	Targeted Case Management		Yes ☐ No ☐		
☐	Assertive Community Treatment Team		Yes ☐ No ☐		
☐	Psychosocial Rehabilitation Services		Yes ☐ No ☐		
☐	Supported Employment		Yes ☐ No ☐		
☐	ADVP		Yes ☐ No ☐		
☐	Day Activity		Yes ☐ No ☐		
☐	Group Living Low		Yes ☐ No ☐		
☐	Supervised Living Low		Yes ☐ No ☐		
☐	Supervised Living Moderate		Yes ☐ No ☐		
☐	Mobile Crisis Management		Yes ☐ No ☐		
☐	Peer Support - Individual/Group		Yes ☐ No ☐		
☐	OTHER:		Yes ☐ No ☐		
☐	OTHER:		Yes ☐ No ☐		

*Whenever a verbal order is made, there must be a treatment note indicating the date, reason for the verbal order, who received the order and the name and credentials of the prescriber making the order. Verbal orders must be countersigned within 72 hours.