

Catawba Valley Healthcare

CLIENT PROFILE

Client Name:		Last		First		M.	Maiden/Suffix	Record No.	Date of Birth	Social Security #	Date	
Mailing Address:				City:			State & Zip:		Phone #:			
Physical Address:				City:			State & Zip:		Email:			
Medicaid #:				Race:			Ethnicity:		Primary Language:			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity:		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Female to Male <input type="checkbox"/> Male to Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Please List Other _____									
Do you speak fluent English? <input type="checkbox"/> Yes <input type="checkbox"/> No				Interpreter Needs: <input type="checkbox"/> Hmong <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____								
Do you have any other special needs?				<input type="checkbox"/> wheelchair/mobility <input type="checkbox"/> childcare <input type="checkbox"/> frail senior <input type="checkbox"/> visually impaired <input type="checkbox"/> physical disability								
What is the main reason you came today?							Who referred you to CVH?					
Legal guardian (if applicable): Name:							Phone #:					
I am interested in the following services: <input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication management for mental health <input type="checkbox"/> 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.)												
<input type="checkbox"/> cry easily	<input type="checkbox"/> feel tense/nervous/panicky	<input type="checkbox"/> physical problems	<input type="checkbox"/> feel depressed/sad	<input type="checkbox"/> thoughts or hurting myself (cutting, burning, etc)								
<input type="checkbox"/> feel afraid	<input type="checkbox"/> sexual concerns	<input type="checkbox"/> feel guilty	<input type="checkbox"/> feel angry	<input type="checkbox"/> problems controlling impulses (gambling, computers, sexual)								
<input type="checkbox"/> unusual behavior	<input type="checkbox"/> feel tired/no energy	<input type="checkbox"/> mood swings/changes	<input type="checkbox"/> trouble with temper									
<input type="checkbox"/> sleep problems	<input type="checkbox"/> easily annoyed/irritated	<input type="checkbox"/> problems with school	<input type="checkbox"/> problems with work									
<input type="checkbox"/> financial problems	<input type="checkbox"/> trouble concentrating	<input type="checkbox"/> problems with housing	<input type="checkbox"/> relationship problems									
<input type="checkbox"/> loss of interests	<input type="checkbox"/> family problems	<input type="checkbox"/> trouble with memory	<input type="checkbox"/> thoughts of ending my life									
<input type="checkbox"/> feel threatened/not safe	<input type="checkbox"/> problems with alcohol	<input type="checkbox"/> problems with drugs	<input type="checkbox"/> thoughts of hurting someone									
<input type="checkbox"/> appetite/weight change	<input type="checkbox"/> often think of past trauma	<input type="checkbox"/> difficulty keeping friends	<input type="checkbox"/> hear voices/see things that others don't									
OTHER:	Have you ever been abused or neglected, including sexually molested?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Have you ever witnessed or been involved in violent acts?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Are you currently pregnant?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Have you ever been suspected of having a head injury or brain injury?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
CRISIS ASSESSMENT:	Are you currently feeling like hurting yourself?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Have you felt like hurting yourself within the last month?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Are you currently feeling like hurting anyone?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Have you felt like hurting anyone within the last month?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
PSYCHIATRIC HOSPITALIZATIONS: Have you ever been in a hospital overnight for a Psychiatric condition (including involuntary commitments)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when was your most recent Psychiatric Hospitalization? _____												
PSYCHIATRIC OUTPATIENT TREATMENT: Have you ever been treated as an outpatient for a Psychiatric condition (including involuntary outpatient commitments)? <input type="checkbox"/> No <input type="checkbox"/> Yes												
SUBSTANCE USE/ABUSE HISTORY: <input type="checkbox"/> None Please indicate the use of the following:												
	Daily	Weekly	In the past	Age of 1 st Use	Date of Last Use	Have you ever experienced alcohol/drug withdrawal symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you taking any opioid replacement therapy such as methadone and buprenorphine as a part of your treatment plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you attending any community meetings in regards to your substance use? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, how frequently? _____						
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Speed/LSD/Crystal Meth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
IV Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Herbal Medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Pain Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Sleep Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
LEGAL:	Have you ever been arrested or convicted of a felony or misdemeanor?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Arrest in the Last 30 days?						<input type="checkbox"/> No	<input type="checkbox"/> Yes, how many _____				
	Do you have or have you had any other significant legal problems?						<input type="checkbox"/> No	<input type="checkbox"/> Yes				
SOCIAL HISTORY:												
Marital Status	<input type="checkbox"/> Single, never married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner											
Employment	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker <input type="checkbox"/> Not available for work <input type="checkbox"/> Armed Forces/National Guard <input type="checkbox"/> Seasonal/Migrant Worker											
Education	<input type="checkbox"/> K-12; list grade: ___ <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Trade <input type="checkbox"/> Special Ed											
Military	<input type="checkbox"/> Yes, active <input type="checkbox"/> Veteran <input type="checkbox"/> Yes, Family Member <input type="checkbox"/> No											
Living Arrangements	<input type="checkbox"/> Private Residence <input type="checkbox"/> Other Independent <input type="checkbox"/> Homeless <input type="checkbox"/> Residential Facility <input type="checkbox"/> Foster Family/AFL <input type="checkbox"/> Nursing Home <input type="checkbox"/> Rest Home <input type="checkbox"/> Family Care Home <input type="checkbox"/> Community MR <input type="checkbox"/> Other _____											
Sexual Orientation	<input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Please List Other _____											

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:
<input type="checkbox"/> Check if contact person lives with consumer <input type="checkbox"/> Check if declining or you do not have one identified	

	Name	Address
Emergency Contact (2)		

Phone Number(s):	e-mail address:
<input type="checkbox"/> Check if contact person lives with consumer	

	Name	Address
Guardian		

Phone Number(s):	e-mail address:
<input type="checkbox"/> Check if contact person lives with consumer	

	Name	Address
Psychiatrist		Hickory

Fax Number:		
	Name	Address
Family Physician		

Fax Number:	<input type="checkbox"/> Check if declining or does not have a Family Physician identified
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Hospital of Choice	
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Pharmacy of Choice	Name of Pharmacy: Location: Phone Number:
<small>*Note: CVH will send prescriptions only to one pharmacy at a time, in accordance with State law.</small>	

Allergies	
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Catawba Valley Healthcare
ADMISSION HEALTH HISTORY

Client Name:	Colon	Sherry			35379		
	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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Recent Hearing Test?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Recent Eye Exam?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Recent Foot Exam?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Recent Colonoscopy?	<input type="checkbox"/> No <input type="checkbox"/> 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):

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

SURGERIES: (please list)

Client Name:	Colon	Sherry			35379		
	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):

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

<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<input type="checkbox"/> Single	<input type="checkbox"/> In a Relationship	<input type="checkbox"/> Separated

EMPLOYMENT HISTORY:

<input type="checkbox"/> Full Time	<input type="checkbox"/> Not Employed	<input type="checkbox"/> On Disability
<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Applying for Disability

LIVING SITUATION:

<input type="checkbox"/> Homeless <input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Tent	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Renting
Transitional Housing	<input type="checkbox"/> Family Care Home	<input type="checkbox"/> Owns/Buying
<input type="checkbox"/> Group Home	<input type="checkbox"/> Lives w/ family	
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Lives w/ friends/significant other	

EDUCATION: Please choose highest level completed

<input type="checkbox"/> Never attended school	Some College	Doctorate
<input type="checkbox"/> Less than 12 th 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)

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

Catawba Valley Healthcare Consumer Orientation & Annual Reminders

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. I am responsible for cancelling an appointment with at least a 24 hour notice. Repeated no-shows or cancellations are not acceptable and could result in termination of services. 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. I further understand that I may request a copy of this signed agreement.

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 within 48 hours, failure to do so may result in discontinuation or tapering 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. I further understand that I may request a copy of this signed authorization.

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 (including gain or loss of insurance). 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 ensuring 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. I understand this consent will be valid until all services rendered are billed and payment is received. **I further understand that I may request a copy of this signed authorization.**

My current guarantor information as of today is below.

Medicaid
 Medicare
 Partners Behavioral Health Management (IPRS)
 Private Insurance: _____
 Other: _____

Deductible _____ Co-pay or Co-insurance _____

(Complete for IPRS Consumer only)

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> 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		<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly
Other sources of income	Type:	Amount:	
Other sources of income	Type:	Amount:	
Income verified by	<input type="checkbox"/> Paystubs <input type="checkbox"/> Entitlement Records <input type="checkbox"/> Verbal Report <input type="checkbox"/> No income form <input type="checkbox"/> Other		
If you have a change in number of household or income, you must report this to CVH.			

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
205 Morgan St SE
Valdese, NC 28690
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 further understand that I may request a copy of this signed authorization.

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

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 authorization will expire on the following date, event or condition _____
I understand if I fail to specify an event or condition this authorization will be valid for one year

_____ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable (infectious) and non communicable diseases disclosure will include that information.

_____ I understand that if my record contains information relating to alcohol use, abuse or dependence, drug use, abuse or dependence, this disclosure will include that information.

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
205 Morgan St SE
Valdese, NC 28690
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 further understand that I may request a copy of this signed authorization.

I hereby authorize Catawba Valley Healthcare to:

- release information
 exchange information
 release and exchange information

Name of person or specific entity _____
Emergency Contact: _____
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 authorization will expire on the following date, event or condition _____
I understand if I fail to specify an event or condition this authorization will be valid for one year

_____ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable (infectious) and non communicable diseases disclosure will include that information.

_____ I understand that if my record contains information relating to alcohol use, abuse or dependence, drug use, abuse or dependence, this disclosure will include that information.

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
205 Morgan St SE
Valdese, NC 28690
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 further understand that I may request a copy of this signed authorization

I hereby authorize Catawba Valley Healthcare to:

- release information exchange information release and exchange information

Name of person or specific entity _____ Emergency Contact: _____

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 authorization will expire on the following date, event or condition _____
I understand if I fail to specify an event or condition this authorization will be valid for one year.

_____ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable (infectious) and non communicable diseases disclosure will include that information.

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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
205 Morgan St SE
Valdese, NC 28690
Phone: 828-624-1900
Fax: 828-398-4147

Catawba County Office
327 1st Ave NW
Hickory, NC 28601
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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 further understand that I may request a copy of this signed authorization.

I hereby authorize Catawba Valley Healthcare to:

- release information
 exchange information
 release and exchange information with/to

<input type="checkbox"/> Partners Behavioral Health Management	<input type="checkbox"/> Amerihealth Caritas	<input type="checkbox"/> United HealthCare of NC
<input type="checkbox"/> Vaya Health	<input type="checkbox"/> Carolina Complete Health	<input type="checkbox"/> Wellcare of NC
<input type="checkbox"/> Cardinal Innovations	<input type="checkbox"/> BCBS NC Healthy Blue	<input type="checkbox"/> 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 authorization will expire on the following date, event or condition _____
I understand if I fail to specify an event or condition this authorization will be valid for one year.

 I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable (infectious) and non communicable diseases disclosure will include that information.

I understand that if my record contains information relating to alcohol use, abuse or dependence, drug use, abuse or dependence, this disclosure will include that information.

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

- If I gain insurance, I will notify CVH immediately. I understand that failure to do so is fraudulent.
- If my number in household or income changes, I will notify CVH.
- 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