ClientFirst of NC, LLC

FACESHEET

Date_____/_____/______ Client Record/LME #: ________________

Name ____ ______________________

(Last) (First) (Middle) (Maiden Name)

DOB: ____/____/____ **SSN:** _______-_____-_______ Gender: ☐Male ☐Female

Address: ____

(Street)

____

(City) (State) (Zip+4) (County of Residence)

Home Number:______________________ **Cell Number:**_______________________ **Work Number:**____________________

Email for appointment notification:____

Race: ☐Black/African American ☐White/Anglo/Caucasian ☐American Indian/Native American ☐Other: ______________________

Ethnicity: ☐Hispanic-Mexican American ☐Hispanic-Puerto Rican ☐Hispanic-Cuban ☐Hispanic-Other ☐Not Hispanic Origin

Marital Status: ☐Annulled ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner ☐Minor

Highest Education Level Completed:______________________

Employment: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Not in the work force ☐Student

Are you Interested in Seeking employment? ☐- Would you like to know how working would affect your benefits? Would you like to learn more about employment services offered by ClientFirst Behavioral?

Emergency Contact :____Telephone: __________________ Additional #: _______________

Contact Address:____

(Street)

____

(City) (State) (Zip+4)

Relationship to Client: ☐Spouse ☐Mother ☐Daughter ☐Father ☐Son ☐Grandmother ☐Granddaughter ☐Grandfather ☐Grandson ☐No Relation ☐Other

Responsible Party (if under 18 yrs):____Relationship: ________________________

Home Number: ____Cell Number:____

Do you have a Legal Guardian? ☐Yes ☐ No

Legal Guardian Name: ___________________________Relationship: ___________________ Telephone: ______________________

Primary Insurance: ☐Medicaid ☐Medicare ☐BCBS ☐Other (Specify): ______________________ Policy #:_________________________

Secondary Insurance: ☐Medicaid ☐Medicare ☐BCBS ☐Other (Specify): _______________________ Policy #:________________________

☐ Self Pay/No Insurance/IPRS

Number in Household: __________ **Number of Children**________ **Gross Monthly Family Income $** ________

Policy Holders Name:________________________ **DOB:**______________ **Relationship to Insured:**______________

Primary Care Physician Office:____ **Physician Name**:_________________________________

____ Phone #:_________________________

(Street) (City) (State) (Zip)

Preferred Pharmacy:_________________________**Location:**_________________________ **Telephone #:**__________________________

Clients Initials:_____________

ClientFirst of NC, LLC
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Smoker? ☐Yes ☐ No How Long? ______________________________ Daily Usage ______________________________

Alcohol Use? ☐Yes ☐ No Age Started? ___________________________ Daily Usage ______________________________

Illicit (Illegal) Drugs? ☐Yes ☐ No Age Started? ______________________ Daily Usage ______________________________

Do you have Medication Allergies: ☐Yes ☐ No Allergic reactions:______________________________

What symptoms are you experiencing? ______________________________

How long have you had these symptoms? ______________________________

Active/Current Medications:______________________________

Historical/ Previous Medications: ______________________________

Medical History:______________________________

Family history of Mental Illness? ______________________________

Have you seen a Therapist before? ☐Yes ☐ No How long ago? ______________________ Therapist's Name: ________________

Have you seen a Psychiatrist before? ☐Yes ☐ No How long ago? ________________________ Psychiatrist's Name_________________

Height:______________________ **Weight:**____________________

How did you hear about ClientFirst? ______________________________

****For security reasons, What is your Mother's Maiden name?** ______________________________

Signature:______________________________ **Date:**______________________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

ClientFirst Behavioral Health

Outpatient Safety Plan

Client's Printed Name: ____________________ DOB:____________ Record#: ______

If you experience a mental health emergency after business hours, that cannot wait until ClientFirst re-opens, call the Mobile Crisis Support Team at 866-241-7245. You can also call 911 or report to the closest emergency room for assistance.

Regular business hours for ClientFirst, not including holidays, are as follows:

Monday through Thursday from 8:00 a.m. – 6:00 p.m.
Fridays: 8:00 a.m. – 5:00 p.m.
(A one hour lunch will occur each day based on the doctor's schedule)

The holiday schedule is listed below. Changes in this schedule are posted well in advance:

January 1st CLOSED
Memorial Day CLOSED
July 4th CLOSED
Labor Day CLOSED
Thanksgiving Day and the day after Thanksgiving: CLOSED
Christmas Eve and Christmas Day: CLOSED
Exact Dates and/or Additional closures will be posted prior to the date(s) of closure

________________________________	____________________
Client Signature	**Date**

2719 Graves Drive
Suite 5
Goldsboro, NC 27534
(919) 330-4367 (919) 330-4375 FAX

ClientFirst Behavioral Health

Consent/Acknowledgment for Treatment/Client Contract

Client Name:	DOB:
Guardian Name:	Relationship:
Record Number:	Medicaid/Ins #:

I understand that I am consenting to a psychiatric and/or psychotherapeutic evaluation and treatment for myself, my child, or another individual (named above) under my guardianship. I understand this therapeutic relationship can be terminated at any time, by either party.

While consenting to treatment I also understand that I, as client or the guardian of the client, am responsible for all fees related to treatment, evaluation and professional services provided regardless of whether my health insurance carrier covers or reimburses the services. I agree to render payment for co-pays and insurance deductibles on the day the services are provided. I consent for ClientFirst to correspond with my insurance company using the information I have provided to them. This consent covers, but is not limited to: verification, billing and collections, electronic transmissions and telephone conversations.

Cancellation/No Show policies are necessary due to the high demand of available appointments. I understand that if an appointment is not cancelled at least 24 hours in advance, or I "no-show", I will be charged a fifty dollar ($50) fee; this is PATIENT responsibility and is not, nor covered by my insurance company. This fee MUST be paid in full prior to making any further appointments with our prescribing provider.

ClientFirst understands that there are times when you must miss an appointment due to emergencies or obligations for work/family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

I consent for information about me to be shared between providers within the ClientFirst office and Eastpointe. This consent shall be valid during any current or future services provided by ClientFirst.

I understand that ClientFirst utilizes the Prescription Drug Monitoring Program, which is used to help prevent inappropriate uses of controlled substances, like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances such as painkillers, muscle relaxants, stimulants, sleep aids, and steroids. It does not contain records about other prescription drugs like antibiotics, antidepressants, or any other category of prescription medication. Your information remains a confidential part of your client record, and only personnel licensed to prescribe medications can access this database. Providers may; deny prescribing controlled substances, require testing prior to prescribing, limit quantity's or restrict certain medications. Prescribing of controlled substances is solely at the discretion of the licensed provider.

To obtain controlled substances through the use of legal prescriptions which have been obtained by the knowing and willful misrepresentation of information to or from one or more practitioners is illegal. Any person who violates this section shall be guilty of a Class 1 misdemeanor, and up to a Class I felony.

ClientFirst has regular business hours; M-TH 8am-6pm, F- 8am-5pm. ClientFirst observes New Year's Day, Memorial Day, 4th of July, Labor Day, 2 days at Thanksgiving and 2 days at Christmas. Exact dates or additional closures will be posted. During nonbusiness hours, holidays or other closures, ClientFirst requests you to call Mobile Crisis Support Team at **866-241-7245**. You can also call **911** and/or go to your nearest emergency room. This emergency contact information can also be obtained by calling our office phone and listening to the office greeting.

Client Initials: _______________

Consent for Treatment/Client Contract

Client Name:	DOB:
Guardian Name:	Relationship:
Record Number:	Medicaid/Ins #:

My signature below acknowledges my understanding and informed consent of the above statements. I understand that if I did not opt to receive copies of the above policies, I may request them at a future date. I may also, at any time review the posted copy of Client Rights and Crisis and Important number provided in the waiting room.

My informed consent covers the following topics:

- My consent for treatment, including emergency medical treatment
- My consent for my care to be discussed by ClientFirst professional staff if they feel I might benefit from other services provided by this agency
- My consent to discuss payment, authorizations or service related topics with EastPointe, for purpose related to treatment
- Medication Consent, to review Prescription Drug Monitoring program performed by the prescribing provider
- Acknowledgment that the prescribing provider may require testing or studies prior to prescribing controlled substances or any other medications at their professional discretion
- Acknowledgment that the prescribing provider may; limit, refuse or restrict certain medications based on their professional guidelines
- Receipt of Client Rights
- Receipt of HIPAA and Privacy Practices
- Consent to file insurance claims to, Federal, State, Private, Independent or Commercial carriers
- Acknowledgment of Cancellation/No Show Policy for medication management appointments
- Acknowledgment that ClientFirst Behavioral Health will not recognize me as an active patient if I have not attended a face to face appointment within 6 months
- I have been provided with required notification on how to access crisis services during nonbusiness hours
- Emergency, Governor's Advocacy and American's Disability Act numbers are posted in the area waiting room and a copy will be provided to me upon request

_______________________________________ _____________________________

Client/Parent/Legal Guardian *Date*

_______________________________________ ______________________________

Staff Witness *Date*

CLIENTFIRST OF NC, LLC Policy And Procedure on Client Rights	
Effective: February 12, 2009	Approved By: Beverly Brown, Executive Director
Retired (Policy Only):	Revised: September 26, 2011 Revised: December 19,2013 Revised: May 3, 2016

POLICY: To ensure that staff are educated and respectful of client's rights when delivering services, and to ensure that clients understand their rights and the grievance procedure if they believe their rights have been violated. Employees of ClientFirst will advocate for the rights of clients served, and clients will receive a copy of their rights during the initiation of services.

PROCEDURE: All clients of ClientFirst of NC, LLC, have the right to:Be treated fairly regardless of their ethnicity, values, beliefs or lifestyle, and to receive services from trained, caring staff. Clients will be protected to the extent possible by Program Staff, from harm, abuse, neglect, discrimination and financial or other exploitation, retaliation or humiliation.

- Restrictive interventions will not be used. This includes physical restraints or physical contact of any type. All instances of alleged improper treatment of clients will be reported to the County Department of Social Services, Adult Protective Unit.
- Be free from unwanted invasion of privacy.
- No client will be suspended or expelled from services at ClientFirst except that: If a client makes physical contact with a staff member or makes a serious threat of bodily harm, that client will be discharged from services. The MCO will be notified of any such occurrence and staff will cooperate in the transfer of services to another agency of the client's choice which can provide appropriate services for the client.
- Be provided with information which supports the right to make informed decisions and personal choices and to be respected for their informed choice to select a provider or on a regular basis when making decisions regarding services. This will include advocating for clients rights when making other decisions that fall within the perimeter of services provided by this agency. Information will be communicated to the individual served in a way that is understandable to them, prior to receiving services or at the initiation of services. Client Rights will be reviewed again with each client as needed for review or clarification. For individuals in the program for more than one year, Client Rights should be reviewed annually. A copy of the Client's Rights policy is available during business hours.
- Clients are informed that they may refuse services, treatment, medications, etc., and to be involved in all aspects of their goals, interventions and needed services, and composition of the service delivery team.
- The guarantee that personal information gathered by Program staff is protected as private and confidential. Financial
- Information, including billing services is protected, to the fullest extent possible. Only staff with a need to know have access to this information.

- Pertinent information will be provided to potential clients in sufficient time to facilitate decisions about whether they wish to receive services from ClientFirst, and will be notified that there are other agencies who provide the same or similar services. Clients will be informed of the MCO/DHHS/Medicaid policy on receiving certain programs concurrently with another program.
- Confidential information includes, but is not limited to photographs, videotapes, audiotapes, client records, reimbursement records, verbal information relative to clients served, client information stored in automated files, and clinical staff member client files.
- Information is not shared with providers outside of the Program unless the client has provided informed written consent in writing. Disclosure without consent may occur during certain situations to provide to, and receive from, the area MCO; emergency medical situations, and criminal matters, as [properly requested by court authorities.
- With release of information forms signed by clients, lab tests will be requested from the providing medical physicians to provide early detection of any health problems that are possibly being caused by psychotropic medications. Currently, Mako Labs is located inside ClientFirst, and all patients have access to this service when they are in the office.
- Clients have a right to review their record by requesting so in writing. The review will be in the presence of a staff member designated by the Executive Director.
- Clients are provided with informed consent prior to signing for release of any personal information, including information provided the Department of Social Services, guardian ad litem, or the court.
- Each client, as part of the intake process, shall be given a copy of Client Rights informing them of their rights. Clients will be required to sign the document acknowledging that he/she has received a copy of his/her rights as part of the initiation of services, and again annually if enrolled in an agency program. Employees will receive and sign for a copy of the Client Rights policy upon hire, and will participate in training as determined by their supervisor. Clients may request a copy of, or clarification of their Client Rights at any time. Staff have access to the ACTT policy and all other policies at all times on the F Drive/Policies and Procedures.

Name_______________ DOB: _________ Record#____________ MDC/CNDS: ___________________

ClientFirst of NC, LLC Policy and Procedure for Privacy Practices	
Effective Date: November 22, 2010	Approved By: Beverly Brown, Program Director
Retired Date (policy only):	Revised Date: July 25, 2011 March 25, 2014

We are required by law to protect the privacy of health care information about you. We call this Protected Health Information (PHI). This may be information related to health care services that we provide to you or payment for health care services provided to you. It may also be information about your past, present, or future health care condition. We are required to follow the procedures in this notice. ClientFirst will not disclose PHI about you outside our organization without written consent unless otherwise permitted/ required by state and federal confidentiality/privacy laws. If you sign an authorization allowing us to disclose PHI about you, you may later revoke or cancel the authorization. If you would like to revoke your authorization, you may do so by completing the revocation section on the authorization form. Your revocation will be honored except for information that may have already been disclosed. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services regarding your treatment and, coordinating and managing your health care with others. We may use and disclose your PHI to arrange for payment (such as preparing billing and managing accounts). Cooperating with outside organizations that evaluate, certify, or license health care providers, staff, or facilities in a particular field or specialty, or assisting various people who review our activities. Resolving complaints, grievances, and appeals within our organization and/or contract agencies. We may also use or disclose PHI about you to a disaster relief organization, such as the Red Cross, if we need to notify someone about your location or condition. We are required by law to report to the Department of Social Services if we have knowledge of, or suspect, abuse or neglect.
We may disclose PHI about you with an appropriate order from a judge. We may disclose health information about you to a law enforcement official for specific law enforcement purposes, such as limited information to a police officer if you were being transported to a hospital for involuntary commitment. We may disclose PHI about you for certain government functions, such as national security or protective services for the President. We may use PHI to contact you, by either mail, phone, fax, e-mail and/or voice mail to provide appointment reminders or seek payment for treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request to see and receive a copy of PHI about you by requesting in writing 30 days in advance. Instead of providing a full copy of the information to you, we may give you a summary or explanation of the information about you, if you agree in advance to the cost of the summary or explanation. If you believe that your privacy rights have been violated by us, or you want to complain to us about our privacy policies and procedure, you may file a complaint with us. All complaints will be investigated to help resolve any issues you may have. We will not take any action against you or change our treatment of you in any way if you file a complaint

To file a complaint with Eastpointe, you may contact them at 888-977-2160, and ask for their Privacy Officer.

You may also send a written complaint to the Office for Civil Rights, US Department of Health and Human Services:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Employment Income Verification Form

Please write in the amount of income of benefits received from any and all of the below resources:

_______________Amount of SSI monthly supplement

_______________Amount of SSDI monthly supplement

_______________Amount of monthly TANF payment

_______________Amount of weekly/monthly employment income

_______________Amount of monthly Veterans Benefits

______________Amount of Court Ordered Child Support Payments

_______________Other Welfare Assistance, if applicable

APPLICANT CERTIFICATION: I am not employed and do not receive any income from employment. I also understand and agree that if I should become employed I will report this change to the Program Representative. I do not receive any benefits other than those listed above.

Applicant Signature ____ Date ______________

APPLICANT CERTIFICATION: I am employed and I earn ___________________________ per month. I do not receive any benefits other than the benefits listed above.

Applicant Signature ____ Date ______________

Legal Guardian Signature ____ Date ______________

VERIFICATION OF ANNUAL FAMILY INCOME FOR IPRS FUNDING

You must report any and all household income to receive IPRS funding for your treatment at ClientFirst. Income includes total annual cash receipts before taxes from all sources. Include, family members, or significant others who are interdependent financially. Please complete this form and sign below verifying that you have reported all sources of income as described herein.

Do you, or any interdependent household member, receive money wages and/or salaries through:

Employment? YES ☐ NO ☐ Full-time ☐ Part-time ☐ Monthly Amount: $____________

Non-farm self-employment? YES ☐ NO ☐ Monthly Amount: $______________________

Social Security, railroad retirement, unemployment compensation? YES ☐ NO ☐ Monthly Amount: $____________

Strike benefits from union funds, workers' compensation? YES ☐ NO ☐ Monthly Amount: $____________________

Veterans' payments, public assistance, Supplemental Security Income, and non-Federally-funded General Assistance or General Relief and training stipends? YES ☐ NO ☐ Monthly Amount: $_____________________

Alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household? YES ☐ NO ☐ Monthly Amount: $_____________________

Private pensions, government employee pensions, insurance or annuity payments, dividends, interest, rental income:?
YES ☐ NO ☐ Monthly Amount: $_____________________

College or university scholarships, grants, fellowships, and assistantships? YES ☐ NO ☐ Monthly Amount: $________

Net royalties from estates or trusts, net gambling or lottery winnings? YES ☐ NO ☐ Monthly Amount: $___________

Family Size: ____________
(Family equals the number of individuals contributing to and/or dependent upon the income as defined in the preceding section).

NOTE: *In the case of an adult client living with his/her parents or other family, where only the income of the client was listed, then the family size should be listed as "01" to indicate the client only and not the parents. However, if the adult client has dependents also living with him/her in the parents' household, then the dependents should be reported in the number while still excluding the parents of the adult client.*

____ ______________________
Client Signature Date

2719 Graves Drive, Suite 5
Goldsboro, NC 27534
(919) 330-4367 (919) 330-4375 FAX