Cathy Troublefield LCMHC, LCAS

REGISTRATION

DATE: _____

DEMOGRAPHICS: `

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ CELL: _____

E-MAIL ADDRESS: _____

EMPLOYER/SCHOOL NAME: _____ PHONE: _____

SOCIAL SECURITY NUMBER: _____

SEX: PLEASE SELECT

MARITAL STRUS: PLEASE SELECT

RACE: PLEASE SELECT

PRIMARY LANGUAGE: PLEASE SELECT

EMERGENCY CONTACTS:

LEGAL GUARDIAN/RELATION: _____ PHONE: _____

EMERGENCY CONTACT/RELATION: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION:

☐ NONE
☐ MEDICAID NUMBER: _____
☐ MEDICARE NUMBER: _____
☐ PRIVATE NUMBER: _____
☐ OTHER NUMBER: _____

REFERRAL SOURCE:

☐ PHYSICIAN: _____ ☐ MENTAL HEALTH AGENCY: _____
☐ FRIEND/FAMILY ☐ PASTOR ☐ BUTTERFLY HOUSE ☐ SELF/NO REFERRAL ☐ OTHER: _____

REGISTRATION CONTINUED

IS THERE ANY MEDICATIONS CURRENTLY BEING TAKEN? (If so, for how long)

PAST SURGERIES/HOSPITALIZATIONS

CRISIS SITUATIONS/STRESS WITHIN THE PAST TWO YEARS

REASONS FOR YOUR VISIT WITH US

ANY KNOWN DRUG ALLERGIES OR OTHER ALLERGIES

Client Name: _____ Client ID: _____

AUTHORIZATION/CONSENT FORM

AUTHORIZATION FOR TREATMENT: I voluntarily request and consent to routine diagnostic, preventive, and therapeutic services and procedures by Cathy Troublefield LCMHC, LCAS, healthcare providers, and its contract agencies. I authorize the performance of appropriate treatment, including diagnostic and therapeutic that may be deemed necessary or beneficial by the provider in the care of the consumer. I understand that the practice of behavioral medicine is not an exact science and acknowledgment that no guarantees have been made as to the results of treatment or care. I further understand this consent shall remain in effect until I notify Cathy Troublefield LCMHC, LCAS in writing of my desire to withdraw my consent.

AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize Cathy Troublefield LCMHC, LCAS or its contract agency staff to obtain emergency treatment from the consumer's physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum health information, written or verbal, may be released to emergency treating providers to meet the needs of the emergency.

CONSUMER RIGHTS AND RESPONSIBILITIES: I have received Cathy Troublefield LCMHC, LCAS *Disclosure Statement* that explains the consumer rights and responsibilities that includes the consumer grievance process, I understand that I may ask for clarification if I have questions or concerns and understand the possible benefits and/or risk involved in the process. I agree to keep all information about other consumers confidential and will not disclose or discuss with any person or agency outside of Cathy Troublefield LCMHC, LCAS.

NOTICE OF PRIVACY PRACTICES: I have also received and had the opportunity to read the *Notice of Counselor Policies and Practices to Protect the Privacy of Your Health* that explain how confidential information is used and disclosed by Cathy Troublefield LCMHC, LCAS. I understand that I should ask questions or discuss any concerns at the time of my first contact with my provider or other designated staff. I understand that I may request restriction(s) on how confidential information may be used or disclosed, and that in specific situations my request for restriction(s) may not be honored because of State or Federal laws or other special situations. ***My signature indicates receipt of a copy of Notice of Counselor Policies and Practices.***

METHODS OF CONTACTING: During and after treatment, in the following way(s):

☐ Home Telephone	☐ Home answering machine	☐ Mail to Home Address
☐ Work Telephone	☐ Work answering machine	
☐ Cell phone	☐ Cell phone answering service	☐ Other telephone: _____

I understand it is my responsibility to inform Cathy Troublefield LCMHC, LCAS in writing when I desire changes in the method of contacting me.

_____ _____

(Client - Please input signature above) (Guardian/Legally Appointed Representative)

_____ _____

(Witness - Please input signature above) (Date)

AUTHORIZATION TO DISCLOSE CONFIDENTIAL RECORDS/INFORMATION

CLIENT NAME: _____
DATE OF BIRTH: _____ CLIENT SOCIAL SECURITY NUMBER: _____ - _____ - _____
RELEASE TO/EXCHANGE FROM: Cathy Troublefield LCMHC, LCAS
RELEASE TO/EXCHANGE FROM: _____ (NAME OF AGENCY/DOCTOR/PRACTITIONER)

REQUEST FOR RELEASE OF INFORMATION

I HEREBY GIVE PERMISSION FOR THE ABOVE-NAMED AGENCY/DOCTOR/PRACTITIONER TO RELEASE ALL OF MY PERTINENT PSYCHOLOGICAL, PSYCHIATRIC, MEDICAL, AND EDUCATIONAL RECORDS, WHICH MAY ALSO INCLUDE, BUT IS NOT LIMITED TO: (CLIENTS INITIALS REQUESTED)

☐ **DETAILS OF DRUG/ALCOHOL TREATMENTS**
☐ **PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSIS**
☐ **HIV/AIDS (IN ACCORDANCE WITH DISEASE LAWS GS120A-143**

AREAS OF ARTICULAR INTEREST INCLUDE:
☐ **PSYCHOLOGICAL TESTING RESULTS**
☐ **PSYCHOLOGICAL/PSYCHIATRIC HISTORY AND EVALUATIONS**
☐ **MEDICAL HISTORY AND PHYSICAL EXAMINATIONS**
☐ **ADMISSION AND/OR DISCHARGE SUMMARIES**
☐ **PROGRESS SERVICE NOTES**
☐ **OTHER: _____**

THE PURPOSE OF THIS DISCLOSURE IS:
☐ **TO PROVIDE A THOROUGH PSYCHOLOGICAL EVALUATION**
☐ **TO PROVIDE BACKGROUND INFORMATION FOR A TREATMENT PROGRAM**
☐ **OTHER: _____**

RELEASE FROM LIABILITY

I AGREE TO HOLD CATHY TROUBLEFIELD LCMHC, LCAS AND THE ABOVE NAMED AGENCY/DOCTOR/ PRACTITIONER HARMLESS AND FREE FROM LEGAL LIABILITY FOR THE RELEASE OF THIS INFORMATION. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY WRITTEN NOTICE. I UNDERSTAND THAT THIS CONSENT, UNLESS PREVIOUSLY REVOKED IS VALID FOR TWELVE MONTHS FROM THE DATE OF SIGNING. A PHOTOCOPY OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL.

_____ _____
(CLIENT - Please insert signature above) **(GUARDIAN/LEGAL APPOINTED REPRESENTATIVE)**

_____ _____
(WITNESS - Please insert signature above) **(DATE)**