Micah Foster LCMHCA

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 STATUS: 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

Micah Foster LCMHCA

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 Micah Foster LCMHCA, 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 Micah Foster LCMHCA in writing of my desire to withdraw my consent.

AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize Micah Foster LCMHCA, 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 Micah Foster LCMHCA *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 Micah Foster LCMHCA. 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 Micah Foster LCMHCA, 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)

Micah Foster LCMHCA

AUTHORIZATION TO DISCLOSE CONFIDENTIAL RECORDS/INFORMATION

CLIENT NAME: _____
DATE OF BIRTH: _____ CLIENT SOCIAL SECURITY NUMBER: _____ - _____ - _____
RELEASE TO/EXCHANGE FROM: Micah Foster LCMHCA
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 MICAH FOSTER LCMHCA, 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)**

My supervisor, Dr. Christa Phipps PHD, LCMHCS, requires me to audio/video record counseling sessions as a part of my supervision. I hold the content of the recording to the same confidentiality standards as stated in my professional disclosure statement. It will only ever be viewed by my supervisor or other mental health professionals that are also in supervision.

- The video is for my continued learning.
- It is only for supervisory purposes
- If at any point you want to stop the recording, I will.
- The session will only be viewed if I have learning questions.
- This is for your benefit as it allows seasoned counselors to assist in your treatment.

If you are willing to comply with the audio/video recording, please sign below.

Client Printed Name: _____

Client: _____ Date: _____

Counselor: __Micah Foster LCMHA_____ Date: _____

Legal Guardian: _____ Date: _____

Legal Guardian: _____ Date: _____

Micah Foster Counseling and Consulting PLLC
4310 Thermal Ave Suite A
Midland, NC 28104
T: 980-734-6568

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand that, just like an in-person session, my Telehealth session time is reserved exclusively for my child or me. In accordance with our Cancellation Policy provided to all new clients, if I cannot attend my scheduled appointment, I will contact the Practice at least 24 hours before the session to cancel or reschedule or the full cancellation fee will apply.

6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

7. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

8. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:
• That I have read or had this form read and/or had this form explained to me.
• That I fully understand its contents including the risks and benefits of the procedure(s).
• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ Client Name (Please Print) Date: _____

_____ Client/Legal Guardian Signature