MAHEC

Center for Psychiatry and Mental Wellness

WELCOME TO OUR PRACTICE

All of our providers and staff look forward to welcoming you to our practice! We have enclosed the necessary paperwork for you to complete at home and bring with you to your appointment.

PLEASE REMEMBER TO:

1. **Bring your completed paperwork** to your appointment or your appointment may be rescheduled.
2. **Arrive 30 minutes prior** to your appointment time or your appointment may be rescheduled.
3. **Bring current insurance cards** (such as Medicare, Medicaid, etc.) if you are covered by insurance. If you do not bring these to your appointment, you may have to be rescheduled.
4. **Check with your insurance company**, if you are covered by insurance, prior to your appointment to make sure that your provider is participating with your plan.

MAHEC Center for Psychiatry and Mental Wellness
Mary C. Nesbitt Biltmore Campus, 125 Hendersonville Road, Asheville, NC 28803

Phone: 828-398-3601 | **Fax:** 828-333-5465

MAHEC

CENTER FOR PSYCHIATRY AND MENTAL WELLNESS PATIENT REGISTRATION FORM

Please complete the following information using BLACK ink. ****This information is confidential****

Name _____ SS #_____

Address _____ City_____State_____ Zip_____

Home county _____E-mail address _____

Home phone _____Work phone _____Cell phone _____

By providing a phone number, mobile phone number or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Birth Date _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ In a relationship ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

In case of emergency, contact:

Name_____ Relationship _____ Phone #_____

IF PATIENT IS CHILD (18 & UNDER): Responsible Party Name:_____

Relationship to patient _____ Phone #_____

Please list: Special hearing needs: _____ Special vision needs: _____

What is your race / ethnicity? (check all that apply):

❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander

❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Other (please describe):_____

Preferred Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Other_____

INSURANCE INFORMATION

Insurance company _____Policy ID# _____

Insurance company phone number _____

Policy holder's name _____ Policy holder's date of birth _____

Policy holder's relationship to patient: _____

Policy holder's address: _____

_____

Policy holder is ❑ male ❑ female

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to MAHEC Family Health Center and I authorize them to file insurance on my behalf. I also authorize them to release medical/and or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand MAHEC Family Health Center:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice

.

I have read and understand the above: _____ Date_____

Patient or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient, Parent or Guardian Signature _____ Date_____

VERBAL COMMUNICATION CONSENT

MAHEC is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

_____ _____

_____ _____

Today's Date: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature _____ Date_____

MAHEC

Center for Psychiatry and Mental Wellness
New Patient Intake Form

Patient Name: _____ Date of Birth: _____

Form Completed by: _____ Date of Today's Visit: _____

Have you received medical care from another physician in the last 5 years? ☐ Yes ☐ No If yes, please give name and location.

Physician name: **Physician city and state:**

_____ _____

_____ _____

_____ _____

What is the reason for your visit today? _____

ALLERGIES

Do you have any allergies or bad reactions to medicines, foods or latex? ☐ Yes ☐ No If yes, please list them below.

Medicine, food, latex or other substance: **Reaction caused:**

_____ _____

_____ _____

MEDICATIONS

Please list ALL medications you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement:	Dosage (ex: how many mg or tablets you take)	How often you take it:

Are you taking a multivitamin with folic acid? ☐ Yes ☐ No

Local Pharmacy: _____ Mail Order: _____

MEDICAL HISTORY

Have you ever had any the following? Please check the boxes of all that apply to you.

- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disorder
- ☐ Bladder problems
- ☐ Blood clots
- ☐ Breast cancer, when: _____
- ☐ Colorectal cancer, when: _____
- ☐ Cancer, other: _____
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ GERD/Reflux
- ☐ Heart attack, when: _____
- ☐ Heart failure
- ☐ Hepatitis, choose: ☐ A ☐ B ☐ C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Skin cancer, when: _____
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Other: _____

Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- ☐ Amputation, where: _____ Year: _____
- ☐ Appendix removed Year: _____
- ☐ Artificial joints, where: _____ Year: _____
- ☐ Back surgery Year: _____
- ☐ Breast surgery ☐ Left ☐ Right Year: _____
- ☐ Cataract extraction ☐ Left ☐ Right Year: _____
- ☐ Catheterization of heart Year: _____
- ☐ Gall bladder removed Year: _____
- ☐ Heart surgery Year: _____
- ☐ Hernia repair ☐ Left ☐ Right Year: _____
- ☐ Knee surgery ☐ Left ☐ Right Year: _____
- ☐ Neck surgery Year: _____
- ☐ Ovaries removed ☐ Left ☐ Right Year: _____
- ☐ Stress test of heart Year: _____
- ☐ Tonsils removed Year: _____
- ☐ Tubes tied Year: _____
- ☐ Uterus removed Year: _____
- ☐ Vasectomy Year: _____

Description of surgery or any other surgeries you have had: _____

_____

REPRODUCTIVE HISTORY

How many pregnancies have you had? _____ Number of live births: _____ Number of living children: _____

Number of C-Sections: _____ Number of miscarriages: _____ Number of still births: _____ Number of abortions: _____

Menopause ('change of life') since: _____

IMMUNIZATION HISTORY

Are your childhood vaccinations up to date? ☐ Yes ☐ No ☐ Unsure Have you had the following vaccines?

- Flu (this year) ☐ Yes ☐ No Date: _____
- Hepatitis B ☐ Yes ☐ No Date: _____
- Pneumonia (Prevnar) ☐ Yes ☐ No Date: _____
- Pneumonia (Pneumovax) ☐ Yes ☐ No Date: _____
- Pertussis ("whooping cough") ☐ Yes ☐ No Date: _____
- Shingles ☐ Yes ☐ No Date: _____
- Tetanus ☐ Yes ☐ No Date: _____
- Others: _____ ☐ Yes ☐ No Date: _____

FAMILY MEDICAL HISTORY

Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

- ☐ Alcohol abuse Who? _____
- ☐ Anesthesia complications Who? _____
- ☐ Anxiety Who? _____
- ☐ Asthma Who? _____
- ☐ Blood clots Who? _____
- ☐ Breast cancer, how old: _____ Who? _____
- ☐ Colon cancer, how old: _____ Who? _____
- ☐ Cancer, other: _____ Who? _____
- ☐ Depression Who? _____
- ☐ Diabetes, how old: _____ Who? _____
- ☐ Drug abuse Who? _____
- ☐ Eczema Who? _____
- ☐ Heart attack, how old: _____ Who? _____
- ☐ High blood pressure Who? _____
- ☐ High cholesterol Who? _____
- ☐ Kidney disease Who? _____
- ☐ Lung problems Who? _____
- ☐ Melanoma Who? _____
- ☐ Migraines Who? _____
- ☐ Osteoporosis Who? _____
- ☐ Other mental illness Who? _____
- ☐ Prostate cancer, how old: _____ Who? _____
- ☐ Seizures Who? _____
- ☐ Stroke, how old: _____ Who? _____
- ☐ Thyroid trouble Who? _____
- ☐ Other: _____ Who? _____

If your father is deceased, how old was he when he died? _____ What did he die from? _____

If your mother is deceased, how old was she when he died? _____ What did she die from? _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Please indicate your marital or relationship status.

☐ Single ☐ Married since: _____

☐ Not married, living together since: _____

☐ Separated since: _____

☐ Divorced since: _____

☐ Widowed since: _____

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

What is the gender of your sexual partner(s)? _____

Age you became sexually active: _____

Number of sexual partners in the last year: _____

What is your gender identity? _____

What is your sexual orientation? _____

ALCOHOL & DRUG USE

On average, how many alcoholic beverages do you drink per week? _____

Men under 65:
How many times in the past year have you had 5 or more drinks in a day?

☐ None ☐ 1 or more

Women (and men over 65):
How many times in the past year have you had 4 or more drinks in a day?

☐ None ☐ 1 or more

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons?

☐ None ☐ 1 or more

TOBACCO USE

☐ I have never used tobacco

☐ I have smoked, started at age: _____

☐ I still smoke _____ packs per day

☐ I quit _____ (date) but used to smoke ____ packs per day

☐ I have tried to quit _____ times

☐ I chew or use smokeless tobacco

☐ I vape or use e-cigarettes

☐ I am exposed to second-hand smoke

The following people make up my household.

Name: _____ Year born: _____ Relation to me: _____

Name: _____ Year born: _____ Relation to me: _____

Name: _____ Year born: _____ Relation to me: _____

Name: _____ Year born: _____ Relation to me: _____

Name: _____ Year born: _____ Relation to me: _____

Name: _____ Year born: _____ Relation to me: _____

OCCUPATION

☐ Currently employed at: _____

Doing: _____

_____ Since: _____

☐ Homemaker since: _____

☐ Retired since: _____

☐ Former job: _____

☐ Disabled due to: _____ Since: _____

HEALTHY HABITS

Are you exposed to sun without protection?

☐ Sometimes ☐ Rarely ☐ Never

Do you always wear a seat belt? ☐ Yes ☐ No

Do you ever use your phone to text while driving (including while stopped)? ☐ Yes ☐ No

In general, how many days do you exercise per week? _____

On those days, how long do you exercise? _____ minutes

When you exercise, what is the intensity?

☐ Mild (stretching or slow walking)

☐ Moderate (brisk walking)

☐ Heavy (jogging or swimming)

☐ Vigorous (fast running or stair climbing)

☐ Combination

Do you drink caffeine daily? ☐ Yes ☐ No

If yes, how many servings of the following per day?

___ sodas ___ cups of coffee ___ energy drinks ___ tea

HOUSEHOLD

Are any of the following problems present in your household?

☐ Alcohol or other substance abuse

☐ Financial problems

☐ Difficulties being a caregiver

☐ Marital or relationship problems

☐ Recent significant loss of a family member

☐ Transportation issues

☐ Other household problems, explain: _____

_____

Patient Name: _____ Date of Birth: _____

REPRODUCTIVE LIFE PLANNING

Would you like to become pregnant in the next year?

☐ Yes ☐ No ☐ Okay either way ☐ Unsure

Are you using any method to prevent pregnancy?

☐ Yes ☐ No

If yes, what: _____

Do you use condoms? ☐ Yes ☐ No

WOMEN'S HEALTH

Have you ever had an abnormal pap test? ☐ Yes ☐ No

When was your last pap? _____

Was it normal? ☐ Yes ☐ No

When was your last mammogram? _____

Was it normal? ☐ Yes ☐ No

When was your last bone density (DEXA) scan? _____

Was it normal? ☐ Yes ☐ No

COLORECTAL HEALTH

Date of most recent colonoscopy: _____ Was it normal? ☐ Yes ☐ No

Date of other colorectal cancer screening: _____ Was it normal? ☐ Yes ☐ No

ADVANCED CARE PLANNING

Have you filled out forms to indicate your desires for end of life care? Living Will: ☐ Yes ☐ No

Durable power of attorney for healthcare ("DPOA"): ☐ Yes ☐ No If yes, who: _____

COMPREHENSIVE REVIEW OF SYSTEMS

Please check the boxes of any symptoms you have had in the past 2 weeks.

General
- ☐ Fatigue
- ☐ Fevers
- ☐ Loss of appetite
- ☐ Unplanned weight gain
- ☐ Unplanned weight loss

Skin
- ☐ New sore or lesion
- ☐ Non-healing sores
- ☐ Rashes

Eyes/Ears/Nose/Throat/Mouth
- ☐ Began wearing glasses or contacts
- ☐ Change in vision
- ☐ Bad teeth
- ☐ Dentures
- ☐ Frequent stuffy nose
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Seasonal allergies
- ☐ Sinus pain
- ☐ Snoring

Lungs
- ☐ Breathing problems
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing

Breasts
- ☐ Breast lump
- ☐ Breast pain

Cardiovascular
- ☐ Chest pain or pressure
- ☐ Heart beats fast
- ☐ Heart skips
- ☐ Short of breath with exercise
- ☐ Short of breath lying down
- ☐ Waking at night short of breath
- ☐ Swelling or edema

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black tarry stool
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea

Gastrointestinal, continued
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Women's Health
- ☐ Bleeding after menopause
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Pain or burning with urination
- ☐ Problems with sex
- ☐ Trouble with periods

Men's Health
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Discharge from penis
- ☐ Excessive urination at night
- ☐ Problems with sex or erection

Muscles and Skeleton
- ☐ Backache
- ☐ Muscle pain
- ☐ Painful joints

Neurological
- ☐ Fainting or passing out
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Sense of room spinning
- ☐ Tremor
- ☐ Unsteadiness or imbalance
- ☐ Weakness

Mental Health
- ☐ Change in sleep pattern
- ☐ Feeling nervous, anxious or on edge

Endocrine
- ☐ Excessive thirst
- ☐ Hot flashes

Blood
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen glands

Other: _____

_____

_____

_____

DEPRESSION SCREENING (PHQ-2)

Over the past two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure in doing things:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed or hopeless:	☐ 0	☐ 1	☐ 2	☐ 3

Patient Name:_____ Date of Birth: _____

Circle the number beside your choice from the group of four statements in each question that best describes how you have been feeling during the past few days.

1	**0 – I do not feel sad** **1 – I feel sad** **2 – I am sad all the time and I can't snap out of it** **3 – I am so sad or unhappy that I can't stand it**	**12**	**0 – I have not lost interest in other people** **1 – I am less interested in other people than I used to be** **2 – I have lost most of my interest in other people** **3 – I have lost all of my interest in other people**
2	**0 – I am not particularly discouraged about the future** **1 – I feel discouraged about the future** **2 – I feel I have nothing to look forward to** **3 – I feel that the future is hopeless and that things cannot improve**	**13**	**0 – I make decisions about as well as I ever could** **1 – I put off making decisions more than I used to** **2 – I have greater difficulty in making decisions than before** **3 – I can't make decisions at all anymore**
3	**0 – I do not feel like a failure** **1 – I feel I have failed more than the average person** **2 – as I look back on my life, all I can see is a lot of failure** **3 – I feel I am a complete failure as a person**	**14**	**0 – I don't feel that I look any worse than I used to** **1 – I am worried that I am looking old or unattractive** **2 – I feel there are permanent changes in my appearance that make me look unattractive** **3 – I believe that I look ugly**
4	**0 – I get as much satisfaction out of things as I used to** **1 – I don't enjoy things the way I used to** **2 – I don't get any real satisfaction out of anything anymore** **3 – I am dissatisfied or bored with everything**	**15**	**0 – I can work about as well as before** **1 – It takes an extra effort to get started at doing something** **2 – I have to push myself very hard to do anything** **3 – I can't do any work at all**
5	**0 – I don't feel particularly guilty** **1 – I feel guilty a good part of the time** **2 – I feel quite guilty most of the time** **3 – I feel guilty all the time**	**16**	**0 – I can sleep as well as usual** **1 – I don't sleep as well as I used to** **2 – I wake up 1-2 hrs earlier than usual and find it hard to get back to sleep** **3 – I wake up several hrs earlier than I used to and cannot get back to sleep**
6	**0 – I don't feel like I am being punished** **1 – I feel I may be punished** **2 – I expect to be punished** **3 – I feel I am being punished**	**17**	**0 – I don't get more tired than usual** **1 – I get tired more easily than I used to** **2 – I get tired from doing almost anything** **3 – I am too tired to do anything**
7	**0 – I don't feel disappointed in myself** **1 – I am disappointed in myself** **2 – I am disgusted with myself** **3 – I hate myself**	**18**	**0 – My appetite is no worse than usual** **1 – My appetite is not as good as it used to be** **2 – My appetite is much worse now** **3 – I have no appetite at all anymore**
8	**0 – I don't feel I am any worse than anybody else** **1 – I am critical of myself for my weaknesses or mistakes** **2 – I am disgusted with myself** **3 – I hate myself**	**19**	**0 – I haven't lost much weight, if any, lately** **1 – I have lost more than five pounds** **2 – I have lost more than ten pounds** **3 – I have lost more than fifteen pounds** **(score 0 if you have been purposely trying to lose weight)**
9	**0 – I don't have any thoughts of killing myself** **1 – I have thoughts of killing myself, but I would not carry them out** **2 – I would like to kill myself** **3 – I would kill myself if I had the chance**	**20**	**0 – I am no more worried about my health than usual** **1 – I am worried about physical problems such as aches, pains, upset stomach, or constipation** **2 – I am very worried about physical problems, its hard to think of much else** **3 – I am so worried about my physical problems, I cannot think about anything else**
10	**0 – I don't cry any more than usual** **1 – I don't cry more now than I used to** **2 – I cry all the time** **3 – I used to be able to cry, now I can't even though I want to**	**21**	**0 – I have not noticed any recent change in my interest in sex** **1 – I am less interested in sex than I used to be** **2 – I am much less interested in sex now** **3 – I have lost interest in sex completely**
11	**0 – I am no more irritated by things than I ever am** **1 – I am slightly more irritated now than usual** **2 – I am quite annoyed or irritated a good deal of the time** **3 – I feel irritated all the time now**		**1-10 These ups and downs are considered normal** **11-16 Mild mood disturbance** **17 – 20 Borderline clinical depression** **21 – 30 Moderate depression** **31 – 40 Severe Depression** **Over 40 Extreme Depression**

Informed Consent to Audio and/or Video record Psychiatric and/or Therapy Interview & Treatment sessions

Mountain Area Health Education Center (MAHEC) provides a variety of services to individuals and their families. It also supports the teaching and training mission of its residency programs and the University of North Carolina School of Medicine. Because MAHEC provides a teaching-training function, permission is frequently requested of its clients to audiotape and/or videotape the interview or treatment sessions that are conducted by the professionals in training. Audio taping and video recording the sessions are a significant component of resident and medical student training. However, no recording is ever done unless the client has given permission to do so. Therefore, we use this consent form to obtain your permission to audiotape and/or video. Feel free to ask your provider any questions about the purpose of taping and use of the tapes.

Your signature below indicates that you give MAHEC permission to be audio recorded / video recorded (circle one or both) and that you understand the following:

1. I can request that the audio and/or video recorder be turned off at any time and may request that the tape or any portion thereof be erased. I may terminate this permission to tape at any time.

2. The purpose of recording is to use it in training programs in which medical students, residents, or practitioners learn under supervision to practice or improve their skills as health care providers. A resident or medical student may consult with his or her assigned supervisor(s) in an individual or group supervision format, and either listen to the tape alone or in the presence of other residents and/or medical students. In addition, a recording may be used by a supervising practitioner to review a professional in training.

3. The contents of these taped sessions are confidential and the information will not be shared outside the context of individual and group supervision.

4. The recordings will be stored in a secure location and will not be used for any other purpose without my explicit written permission.

5. The recordings will be erased after they are no longer useful for training purposes.

_____ _____

Name of Patient (Please print) Date of Birth

_____ _____

Signature Date

INCOMING TO MAHEC

MAHEC Center for Psychiatry
Centralized Medical Records Department
125 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: _____ **Date of Birth:**_____

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	**MAHEC Center for Psychiatry Centralized Medical Records Dept.**
ADDRESS:	**125 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

- ❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- ❑ Only information related to *(specify)*: _____
- ❑ Only the period of events from: _____ to _____
- ❑ Entire medical record
- ❑ Exclusions
  - __ AIDS/HIV test results, diagnosis, treatment, and related information
  - __ Drug screen results and information about drug and alcohol use and treatments
  - __ Mental health notes
  - __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. _____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

OUTGOING FROM MAHEC

MAHEC Center for Psychiatry
125 Hendersonville Road, Asheville, NC 28803
Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

Patient Account#:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ALL SECTIONS of this form MUST be complete before your request can be processed.
Don't forget to sign and date at bottom before submitting.

Patient Legal Name: _____**DOB:**_____

I authorize the use or disclosure of the above named individual's health information as described below. **If the request is for more than 50 pages, the documents will be mailed and not faxed. Please confirm mailing address below.**

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY **MAHEC Center for Psychiatry**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **125 Hendersonville Road**	ADDRESS
CITY/STATE/ZIP **Asheville, NC 28803**	CITY/STATE PHONE #: FAX #:

The purpose or need for this disclosure is:

_____

I would like to receive my records via: ☐ Fax ☐ Mail ☐ In-Person (___ paper or ___ CD)

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

☐ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
☐ Only information related to *(specify)*: _____
☐ Only the period of events from: _____ to _____
☐ Entire medical record
☐ Exclusions __ AIDS/HIV test results, diagnosis, treatment, and related information
__ Drug screen results and information about drug and alcohol use and treatments
__ Mental health notes
__ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows.
_____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

MAHEC

Center for Psychiatry & Mental Wellness

NEW PATIENTS

New patients need to bring completed paperwork, a picture ID and insurance cards to first appointment. Patients are encouraged to contact their insurance company and verify mental health benefits prior to their first visit. We accept all insurance, but this does not guarantee that we are in network with your plan.

RETURNING PATIENTS

Returning patients should make sure all information is up to date at each visit. This includes name, address, phone number and insurance information.

TELEPHONE CONSULTATIONS

Telephone consultations are generally not available. Please discuss your healthcare needs during your visit. Should issues arise between appointments please contact our office to schedule an earlier appointment.

AFTER HOURS

One of our providers will be on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For medical emergencies, you should call 911.

PRESCRIPTION REFILLS

All medication refill requests need to be made during the patient's appointment. Please bring prescription bottles or a list of medications with you to each appointment. Prescription refill requests at other times will be completed within 3 business days.

BILLING

You are responsible for your annual deductible, co-pay/co-insurance, and any balance that your insurance does not pay. Co-pays are expected at the time of service. Please be aware that some services are not covered by insurance and you will be billed. We accept cash, check, and credit card payments. A service fee is assessed for returned checks. The billing office phone number is (828) 257-4725, option 3. If you have a billing question, please call the billing office and we will do our best to help you or direct you to someone who can.

I have read and agree to the above policy:

_____ ___/____/____ _____

Printed Name Date of Birth Today's Date

_____

Signature

Thank you for choosing us for your healthcare!

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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