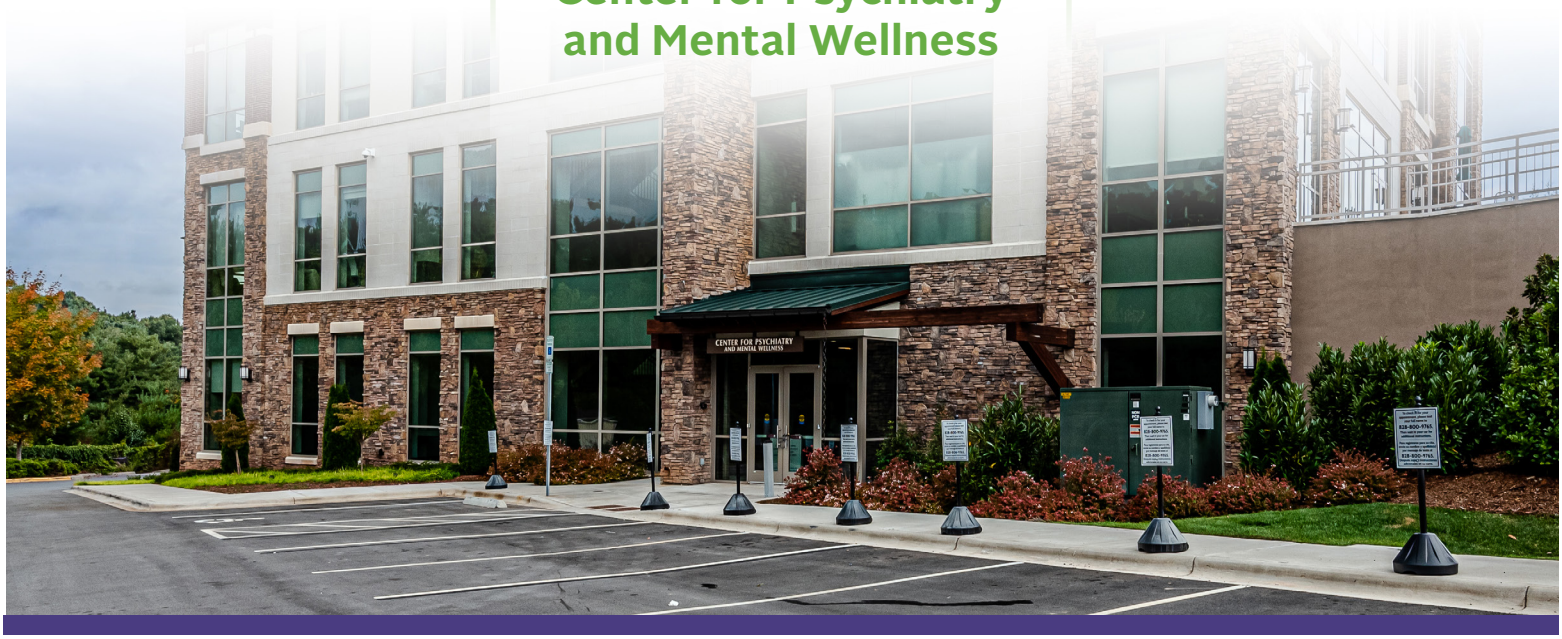
MAHEC

Center for Psychiatry and Mental Wellness



WELCOME TO OUR PRACTICE

We are happy you have chosen us for your care!

All of our providers and team members look forward to welcoming you to our practice! We have enclosed the necessary paperwork for you to complete before your visit.

OFFICE HOURS
Monday - Friday 8:00 am - 5:00 pm

AFTER HOURS
Providers are 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 mental health and medical emergencies, you should call 911 or reach out to RHA Mobile Crisis Services at 888-573-1006.

OUR COMPREHENSIVE MENTAL HEALTH SERVICES INCLUDE

- Medication Management
- Psychotherapy
- Intellectual and developmental disabilities (IDD) behavioral health support
- Substance use disorder treatment
- Medication for opioid use disorder
- Transcranial Magnetic Stimulation (TMS)
- Peer Support Services
- Collaborative Care Management Programs
- School Based Therapy
- Acceptance and commitment therapy
- Cognitive behavioral therapy
- Mindfulness-based stress management
- On-site laboratory services
- Parent-child interaction therapy
- Play therapy
- Long acting injectable medication support
- Trauma-informed care

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

Welcome to MAHEC!

Thank you for choosing us for your healthcare. MAHEC has been a part of Asheville since 1974 and we proudly continue our tradition of award-winning care. Our providers and staff welcome the opportunity to care for your entire family at our Family Health Centers, Internal Medicine office, OB/GYN offices, Dental offices and Center for Psychiatry. We proudly serve all patients regardless of income or insurance status.

- MAHEC is expanding our financial assistance program to go above and beyond what we have offered before. In order to facilitate this change we are asking all existing and new patients to complete a new patient information packet.
- Our Patient Financial Advocates are available to guide you through signing up for assistance offered through our Sliding Scale Discount Program. Eligibility is based on family income and family size. Payment is expected at time of service for amounts you are responsible for. We can assist with payment options if you are unable to pay in full.

BEFORE YOUR VISIT

This welcome packet includes forms you need to read and complete before your visit.

It is **VERY** important that you fill out each form completely and give the entire packet to the front desk staff when you arrive for your appointment. Please arrive **15 minutes before you appointment** to complete the check-in process.

Other documentation you need to bring with you:

- Insurance card and driver's license (or other valid photo ID)
- Pertinent medical history or records
- Current List of medications or medication bottles
    - Drug name
    - Prescribed dosage(s)
    - How long you have been taking the drug(s)

MAHEC's Patient Portal

We are pleased to provide all patients with an online tool that provides 24/7 access to your personal health record. With the portal, you can securely email your provider, see lab results, review your medical records and much more. We will use the email address you provide to give you access to the portal if you don't currently have it. Just watch for an email with instructions that will come to you after your appointment.

Thank you for choosing us for your healthcare!

Mountain Area Health Education Center
www.mahec.net

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!

Name: _____

DOB: _____

MRN#: _____

Who may we speak with?

This form will allow MAHEC to **discuss** your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. **You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.**

Person #1 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #2 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #3 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

OR

☐ I do not wish to list anyone at this time.

_____ _____

Signature of patient, parent, or legal guardian Date

MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

☐ Psychiatry ☐ Internal Medicine ☐ FHC Biltmore ☐ FHC Cane Creek ☐ FHC Enka/Candler ☐ FHC Newbridge ☐ Ob/Gyn Biltmore
☐ Pharmacy at Enka ☐ Pharmacy at Biltmore ☐ Ob/Gyn Franklin ☐ Women's Care Brevard ☐ Deerfield ☐ Givens

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Birth Sex: ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ SS#: _____

Home County: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work 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.

Special Hearing Needs:

_____ **Uses Wheelchair:** ☐ Yes ☐ No

Special Vision Needs: **Speech Impaired:** ☐ Yes ☐ No

_____ **Veteran Status:** ☐ Yes ☐ No

Race (select one):
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian/Chamorro
- ☐ Samoan
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race

Ethnicity (select one):
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Hispanic/Latino/Spanish
- ☐ Non-Hispanic/Latino/Spanish

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Other
- ☐ Choose not to disclose

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Other: _____

Marital Status:
- ☐ Single
- ☐ In a relationship
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Special Populations

Migratory ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No
Homeless ☐ Yes ☐ No

Homeless Status (select one):
- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Permanent Supportive Housing
- ☐ Other

EMERGENCY CONTACT INFORMATION

MRN #: _____

Name: _____

Relationship: _____ Phone#: _____

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _____

Relationship: _____ Phone#: _____

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

_____ # of Individuals in Household: _____

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC 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 that MAHEC:

- 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.

Patient or Parent/Guardian Signature: _____ Date: _____

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

MRN #: _____

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 at any MAHEC facility. 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 or Parent/Guardian Name (please PRINT): _____

Patient or Parent/Guardian Signature: _____ 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) in accordance with MAHEC's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Primary Care Provider: _____

Copy of insurance card obtained? ☐ Yes ☐ No

MAHEC

Center for Psychiatry and Mental Wellness
New Patient Intake Form

Patient Name: _____ Date of Birth: _____

Form Completed by: _____

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:**

Local Pharmacy: _____

FAMILY MEDICAL HISTORY

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? _____

SURGICAL HISTORY

Please list the date(s) and description(s) of any past surgeries you have had:

_____

_____

_____

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: _____

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: _____

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please check the box if you have ever been diagnosed with or experienced the following.

- Alcohol Use Disorder ❑
- Anemia ❑
- Arthritis ❑
- Asthma ❑
- Bladder Problems ❑
- Blood Clots ❑
- Cancer - Breast ❑
- Cancer - Colorectal ❑
- Cancer - Skin ❑
- Cancer - Other, please specify ❑
- COPD/Emphysema ❑
- Diabetes ❑
- Drug Use Disorder ❑
- GERD/Reflux ❑
- Heart Attack ❑
- Heart Failure ❑
- Hepatitis A ❑
- Hepatitis B ❑
- Hepatitis 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 ❑
- Stroke ❑
- Thyroid Trouble ❑
- Hypothyroidism ❑
- Other, please specify ❑

Please specify the other health condition(s).

_____

Please specify the location of cancer.

_____

Please specify when you experienced cancer.

_____

Please specify when you had a heart attack.

_____

Patient Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

Please check the appropriate box if any of your blood-relatives have been diagnosed with or experienced the following mental health problems.

	Mother	Father	Sister	Brother	Daughter	Son
Alcohol Use Disorder	❑	❑	❑	❑	❑	❑
Anxiety Disorder or Panic	❑	❑	❑	❑	❑	❑
Aduistoisrmde or Autism Spectrum Disorder	❑	❑	❑	❑	❑	❑
Bipolar Disorder, Manic Episodes, or Manic Depressive Disorder	❑	❑	❑	❑	❑	❑
Drug Use Disorder	❑	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑	❑
Intellectual or Developmental Disability	❑	❑	❑	❑	❑	❑
Major Depression or Clinical Depression	❑	❑	❑	❑	❑	❑
Obsessive-Compulsive Disorder	❑	❑	❑	❑	❑	❑
Personality Disorder	❑	❑	❑	❑	❑	❑
Post-Traumatic Stress Disorder	❑	❑	❑	❑	❑	❑
Psychiatric Hospitalization	❑	❑	❑	❑	❑	❑
Schizophrenia, Schizoaffecive Disorder, or another Paranoid or Delusional Disorder	❑	❑	❑	❑	❑	❑
Suicide Attempt	❑	❑	❑	❑	❑	❑
Completed Suicide	❑	❑	❑	❑	❑	❑

Other Mental Health Condition (please specify) _____

_____

_____

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

Family Health Centers
Financial Advocate
Phone: (828) 771-5502 | Fax: (828) 579-4208

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443 | Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd, Asheville, NC 28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771- 5466 | Fax: (828) 579-4212

Mailing Address:
125 Hendersonville Rd, Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918 | Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd. Asheville, NC 28803

Internal Medicine
Financial Advocate
Phone: (828) 771-3507 | Fax: (828) 579-3748

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

English **Español**

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate

INCOMING TO MAHEC

MAHEC

MRN: _____

Centralized Medical Records Department

121 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 Centralized Medical Records Department ❑ Family Medicine ❑ OB/Gyn ❑ Internal Medicine ❑ Dental ❑ Psychiatry ❑ Community Pharmacy
ADDRESS:	**121 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.