



Appalachian Therapy and Evaluation (DBA)

249 Wilson Drive, Suite 5
Boone, NC 28607
Phone: 828.268.2172
Fax: 877.211.7323
mentorbhc@gmail.com

Adult Referral

Date _____

Demographic Information: Please check: Evaluation Therapy

Name of Client: _____

DOB: _____ Age: _____ Gender (circle one): Male Female Other

Address: _____

Cell #: _____ Home #: _____ e-mail address: _____

Primary Provider(s): _____

Referral Source:

Name: _____ Phone #: _____

Agency: _____ Fax #: _____

Reason for Referral (Presenting Problem, Symptoms, Needs, etc.): _____

Funding Source: (PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF ALL HEALTH INSURANCE CARDS YOU USE)

Blue Cross/Blue Shield _____ Medicare _____ Medicaid _____

Other: _____

We must verify the funding source before the client can be scheduled.

****You may be charged \$25-\$50 for missing an appointment without at least 24-hour notice of cancellation.****

PLEASE **MAIL** or **FAX** to:

Mentor Behavioral Healthcare
249 Wilson Drive Suite 5
Boone NC 28607

Phone (828) 268-2172
Fax (877) 211-7323

MentorBHC@gmail.com



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CONSENT FOR EVALUATION and/or TREATMENT (rev. 4/28/21)

Date of Birth: _____

I, _____, give my consent to complete a Psychological Evaluation and/or treatment through Mentor Behavioral Healthcare I understand that the information provided is strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. I am aware, however, that information may be released without consent in the case of a medical emergency or if the information is court ordered. I am also aware that Mentor Behavioral Healthcare is legally required to report incidence of child abuse and disabled adult abuse. I grant Mentor staff permission to seek emergency medical care from a hospital or physician if deemed necessary by Mentor staff. I am aware I have the right to refuse or withdraw from evaluation or treatment any time.

TELEHEALTH - _____ I give consent to receive these services through telehealth, if necessary and/or requested. **(initial above)**

During the initial appointment, we will ask for the history of the problem, try to define the problem, and determine what services may be appropriate. We ask that individuals be honest and attempt tasks presented to the best of their ability.

If therapy is recommended, your therapist will work with you and/or your child to find solutions to the problem(s). Most people experience relief and success after 2 months of therapy. Any additional emotional stress you may experience from therapy would be part of the natural change process and should not be greater than the stress or problems that led to seeking treatment in the first place. If you feel uncomfortable from treatment, please inform your provider. If you experience a mental health emergency, you can contact your provider any time, day or night.

****You may be charged \$25-\$50 for missing an appointment without at least 24-hour notice of cancellation.****

PRIVACY POLICY

Mentor BHC will only release or share information with your written consent. Except for the following two circumstances

- 1) For billing insurance reimbursement
- 2) In situations where he/she presents imminent danger to self or others

YES ___ NO ___ I want to receive a copy of Mentor's full privacy practices.

COMMUNICATION

To gather and share information, we normally use FAX and E-MAIL
YES ___ Use Fax and E-Mail. I understand e-mail is not secure.
NO ___ Do not use Fax or E-Mail

RELEASE OF FINAL REPORT (if applicable)

A copy of the final report will be sent to you. Copies of the report should also be sent to _____, _____ and _____.
This consent is voluntary and is valid until _____ (1 year from today). I understand I may revoke this consent at any time.

Consumer Date Witness Date

CONSENT TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION

NOTE: When requesting information from multiple sources, separate consents are required

Client Name:	Medicaid/Insurance#:
DOB:	
If the client is a child, authorized parent/guardian:	

As the client, parent, guardian or representative identified above, I request and authorize Mentor Behavioral Healthcare to disclose to and obtain from the persons or organization below, information about the client.

Names of the persons or organization:	Telephone and Fax Number; Address

Specific information **to be disclosed by** the Mentor to the persons and/or organization identified above:

<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Treatment Plan/PCP	<input type="checkbox"/> STD related Information
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Financial/Reimbursement Info	<input type="checkbox"/> Hepatitis Related Information
<input type="checkbox"/> Service Notes	<input type="checkbox"/> Medication Information	<input type="checkbox"/> Tuberculosis Related Information
<input type="checkbox"/> Referral Form	<input type="checkbox"/> School Records/IEP	<input type="checkbox"/> HIV/AIDS Treatment
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Substance Use Treatment
<input type="checkbox"/> Other Information:		

Specific information **to be obtained from** the persons and/or organization identified above:

<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Treatment Plan/PCP	<input type="checkbox"/> STD related Information
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Financial/Reimbursement Info	<input type="checkbox"/> Hepatitis Related Information
<input type="checkbox"/> Service Notes	<input type="checkbox"/> Medication Information	<input type="checkbox"/> Tuberculosis Related Information
<input type="checkbox"/> Referral Form	<input type="checkbox"/> School Records/IEP	<input type="checkbox"/> HIV/AIDS Treatment
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Substance Use Treatment
<input type="checkbox"/> Other Information:		

Purpose of disclosure:

<input type="checkbox"/> Coordination/Continuity of care	<input type="checkbox"/> At request of client	<input type="checkbox"/> Referral
<input type="checkbox"/> Other:		

*REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Also, GS 130A-143 states that HIV/Aids information must be protected and that information can only be released if the consumer gives specific permission to do so.

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Mentor Behavioral Healthcare cannot deny or refuse to provide services and/or treatment on my refusal to sign.

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire on _____ (up to 1 year from today).

Signature of client: (or parent/guardian)	Date:
Signature of staff member/clinician: (who obtained and witnessed the authorization)	Date: