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

Child & Adolescent Referral

Date: ____________________

Needs: (Check All that apply): Therapy_____Assessment/Evaluation _______

Demographic Information:

Name of Client: ____

DOB: _______________ Age: _______ Gender (circle one): Male Female

Primary Caregiver(s): ______________________________ Relation to Client: __________________

Address: ____

Primary Phone #: ________________________ Secondary Phone #: __________________

Email ______________________ Address: ____

Child's School: ___________________ Grade: _____ Best Teacher to Contact: ________________

Referral Source:

Name: ___________________________ Cell #: ________________ Phone #:_______________

Agency: ____ Fax #: ___________________________

Reason for Referral (Presenting Problem, Symptoms, Concerns, 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.

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

Mentor Behavioral Healthcare	Phone	(828) 268-2172
249 Wilson Drive Suite 5	Fax	(877) 211-7323
Boone NC 28607		MentorBHC@gmail.com

You might be responsible for a $25-$50 payment for any appointment cancelled or missed without 24 hours' advance notice

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CONSENT FOR EVALUATION and TREATMENT (rev. 1/11/22)

Client's Date of Birth: ______________________

I, (Parent or Legal Guardian) _____________________________, give my consent for (Child) ___________________________ to complete a Psychological Evaluation and receive 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 or your child 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 or your child feels uncomfortable from treatment, please inform your therapist. If you experience a mental health emergency, you can contact your therapist any time, day or night.

You might be responsible for a $25-$50 payment for any appointment cancelled or missed without 24 hours' advance notice

PRIVACY POLICY

Mentor BHC will only release or share information on your child with your written consent except in 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 and to communicate with you, we normally use FAX, E-MAIL, and TEXT MESSAGING, which may not be secure. **Please initial** the following communication methods you give permission for us to use:

_______Fax ________E-Mail ________Text message

RELEASE OF FINAL REPORT (when 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 _________(one year from now). I understand I may revoke this consent at any time.

_______________________________________ _______________________________________

Parent or Guardian 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/or obtain from the persons or organization below, information about the client.

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

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

☐ Psychological Evaluation	☐ Treatment Plan/PCP	☐ STD related Information
☐ Psychiatric Evaluation	☐ Financial/Reimbursement Info	☐ Hepatitis Related Information
☐ Service Notes	☐ Medication Information	☐ Tuberculosis Related Informatior
☐ Referral Form	☐ School Records/IEP	☐ HIV/AIDS Treatment
☐ Discharge Summary	☐ Diagnosis	☐ Substance Use Treatment
☐ Other Information:		

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

☐ Psychological Evaluation	☐ Treatment Plan/PCP	☐ STD related Information
☐ Psychiatric Evaluation	☐ Financial/Reimbursement Info	☐ Hepatitis Related Information
☐ Service Notes	☐ Medication Information	☐ Tuberculosis Related Informatior
☐ Referral Form	☐ School Records/IEP	☐ HIV/AIDS Treatment
☐ Discharge Summary	☐ Diagnosis	☐ Substance Use Treatment
☐ Other Information:		

<u>**Purpose of disclosure**</u>**:**

☐ Coordination/Continuity of care	☐ At request of client	☐ Referral
☐ 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: