DEMOGRAPHIC INFORMATION PLEASE PRINT CLEARLY

Full Legal Name:

Preferred Name:

Date of Birth: Age: SSN: Male Female

Home Phone: Cell Phone: Work Phone:

Street Address:

City: State: Zip Code:

Email:

Mailing Address:

INSURANCE INFORMATION

Insurance Carrier Name:

Policy Holder/ or Guarantor: If different from above

Name: Date of Birth:

Relationship to Patient: Telephone:

If you have Tricare please write the sponsor Social Security Number: – –

Emergency Contact Name (must be over 18 years of age)

Name:

Relationship to Patient: Phone Number:

*****Present your insurance cards and drivers license to the front desk for photocopying.**

Marital Status: Married Single Divorced Seperated Partnered

Other (describe)

Number of Marriages: Name of Spouse/Partner:

Do you have concerns related to your relationship? Yes No

Names and Ages of Children:

	Name:	Age:	Live with you?	Yes	No
1.	Name:	Age:	Live with you?	Yes	No
2.	Name:	Age:	Live with you?	Yes	No
3.	Name:	Age:	Live with you?	Yes	No
4.	Name:	Age:	Live with you?	Yes	No

Do you have concerns related to your parenting? (if yes, please explain) Yes No

Employer: Job:

Level of Education: <12 12-14 14-16 16-20 20+

Degrees Attained:

Military Status: Active Duty Reserved/Guard Retiree
Veteran Dependent None

Branch of Service: USMC USA USN USAF Coast Guard

Total years of Service: Number of Deployments:

Where/When:

Do you have concerns related to your military experience/stresses of military life? Yes No

How do you define your race and/or ethnic background?

Do you have concerns related to your race/ethnicity? Yes No

Spiritual/Religious Background:

Do you have concerns related to your spirituality or religious practices? Yes No

CLIENT BACKGROUND INFORMATION

Have you ever sought mental health or behavioral health care before? Yes No

If yes, for what reason?

Have you ever been prescribed medications for depression, anxiety, sleep problems, mood swings, attention/concentration, or other mental health reasons? Yes No

If yes, list medications?

Pease list all ***current*** medications, nutritional supplements, and vitamins:

Please list all allergies:

Have you ever been involved with the legal system? (DWI, Divorce, Misdemeanor, Felony) Yes No

If yes, please describe:

Are you currently involved in the legal system? Yes No

If yes, what is the status of your case?

On average, how much alcohol do you drink? **A standard drink is defined as 12oz beer, 1oz liquor, or 4oz wine**

None Less than 2 drinks/week 2-6 drinks/week 6-10 drinks/week

10-15 drinks/week More than 15 drinks/week

Do you feel you should cut down on your alcohol consumption? Yes No

How much caffeine do you consume per day? Include coffee, tea, energy drinks, soda, and pills

Question		
Do you engage in recreational drug use? If yes, what kind?	Yes	No
Do you smoke cigarettes or use smokeless tobacco?	Yes	No
If yes, how much per day?		
Have you had a head injury resulting in concussion, memory problems, and unconsciousness?	Yes	No
Have you ever attempted suicide?	Yes	No
If yes, when?		
Have you ever had thoughts of harming yourself?	Yes	No
If yes, when was the last thought?		
Are you having thoughts of harming yourself today?	Yes	No
Have you ever engaged in cutting yourself, burning yourself, or other self-injury?	Yes	No
How many hours of sleep do you get per night?		
Do you feel rested when waking?	Yes	No

How often do you exercise? Days per week for min (average)

What is your preferred exercise? Height: Weight:

Do you have concerns regarding your weight? If so, explain:

Please list any medical problems you have:

Would you like to learn how behavioral health can assist with your medical problems: Yes No

Name of primary care physician: Date of last physical:

How would you rate your health: Excellent Good Poor

To your knowledge, has anyone in your family (Mother, Father, Grandparents, Brother, Sister, Children) been diagnosed or treated for issues such as depression, anxiety, bipolar disorder, schizophrenia, ADHD, etc.) Yes No

If yes, please give brief explanation:

Has anyone in your family attempted or completed suicide? Yes No

If yes, who?

Please circle any of the problems for which you are seeking help today:

Anger	Anxiety	Depression	Mood Swings	Alcohol Drugs
Financial Concerns	Job Concerns	Parenting Relationship	Sleep Problems	Self Harm
Low Energy	Obesity	Anorexia/ Bulimia	Weight Loss	Self Image
Death of a Loved One	Separation/ Divorce	Military Issues	Stress Management	Diabetes
Heart Disease	Thyroid Chronic	Pain Migraines	High Blood Pressure	Cancer
Pos-partum Concerns	Exercise	Attention/ Concentration	Legal Concerns	

Please explain, very briefly, any items you circled:

Do you have any other concerns we may be able to help you with that were not listed above?
If so, please list and give short explanation:

What would you like to get from therapy? What goals do you have?

What are your personal strengths that will help you obtain these goals?

What may be some obstacles to obtaining these goals?

CLIENT RIGHTS AND RESPONSIBILITIES

This document summarizes your rights and responsibilities as a client of Valor Horses For Heroes, PLLC. Please take a moment to review this information. If you have any questions, we will be happy to discuss them with you. After you sign this document, you may receive a copy for your records.

Client Rights

1. You have the right to confidentiality of your personal and treatment related information. Our Notice of Privacy Practices provides detailed information on how we use your personal information. A copy of our Notice of Privacy Practices will be provided to you at the beginning of your treatment.
2. You have the right to care that is coordinated with your other health care providers. Upon signed release of information, Valor Horses For Heroes will work closely with your primary care physician and other medical providers as indicated. In some instances, it may be helpful for Valor Horses for Heroes to speak to your spouse /life partner, family member, or close friend; however, this would occur only with your knowledge and signed consent. Please do not hesitate to discuss this with Valor Horses For Heroes should you have any questions.
3. You have a right to privacy, security, and respect for property.
4. You have the right to be protected from abuse, neglect, exploitation, or humiliation. You have the right to contact Disability Rights North Carolina.

   Disability Rights North Carolina
   Toll-Free: 877-235-4210
   Phone: 919-856-2195
   TTY: 888-268-5535
   Fax: (919) 856-2244
   Email: *info@disabilityrightsnc.org*
   Mailing Address: 2626 Glenwood Avenue, Suite 550 Raleigh, NC 27608
5. You have the right to be free from retaliation for making complaints or reports over suspected abuse, neglect, or exploitation.
6. You have the right to have timely access to, review, and obtain copies of pertinent information needed to make decisions regarding treatment or services. You have a right to an individualized written treatment plan. Our Notice of Privacy Practices provides greater detail regarding your right to access information in your clinical chart. To gain access to your medical records you need to request either verbally or in writing from either front office staff or your provider.
7. You have the right to make informed consent, to refuse care, and to express choices andpreferences regarding your participation in your treatment to the extent permitted by law.
8. You have the right to access or obtain a referral to legal representation.
9. You have the right to access self-help, support, and advocacy services.
10. You have the right to investigation and resolution of complaints and alleged infringement upon your rights. You have the right to a grievance procedure that includes the right to: make complaints, be informed of decisions in response to complaints, and be informed of procedures to appeal decisions. Our grievance procedures are as follows:

    Complaints / grievances may be made verbally or in writing; Complaints / grievances may be made to your treatment provider or to the office manager, Full efforts are made to resolve complaints immediately upon notification; Complaints /grievances are reviewed by your treating clinician, the office manager, and the owner of the practice as applicable; You will be informed of the result of the complaint / grievance investigation within 2 weeks. On request, this will be provided in writing.

You may appeal the results of this decision to the owner of the practice. Appeals must be in writing. You will be informed of the decision of the appeal in writing within 2 weeks.

11 You have the right to receive treatment in the least restrictive environment.

12 You have the right to adequate and humane care.

13 You have the right to evidence-based information about alternative treatment/services.

14 You have the right to information about the cost of services that will be billed to your insurance carrier(s) or to you directly.

15 You have the right to access to 24-hour crisis intervention. To access crisis services, callValor Horses For Heroes on call number at 252-631-8150. You may also call mobile crisis at 855-345-1200. If you are experiencing a medical emergency, please dial 911 or visit your closest emergency room.

16 You have the right to equal access to treatment / services regardless of race, ethnicity, gender, age, sexual orientation, or source of payment. You have a right to medical care and habilitation regardless of your degree of disability.

Client Responsibilities

The following are your responsibilities as a client in treatment with Valor Horses For Heroes

1 You have a responsibility to provide accurate information to your treating clinician(s) to the best of your knowledge, including information about your history, symptoms, past and current treatment, medications, side effects, and other matters related to you or child's health.

2 You have the responsibility to provide us with the name and contact information for a person you would like us to contact in the event of an emergency.

3 You have the responsibility to let your clinician(s) know if you understand the treatment and what is expected of you.

4 You have the responsibility to inform us if there are any changes in your insurance, contact information, or health status.

5 You have the responsibility to pay any balances owed for fees or copayments at the time of service. If you are unable to make these payments, we will make efforts to develop a payment plan with you.

6 You have the responsibility to be considerate of the rights or other individuals receiving services within the office building of Valor Horses For Heroes and their staff. This includes control of noise, smoking (only permitted outside and away from the doors), and managing the behavior of accompanying guests/children. We request that all cell phone usage be kept to a minimum in the waiting area and that cell phone be turned off or placed in silent mode in treatment areas.

7 You have the responsibility to comply with you and your child's treatment plan, including follow up care. This includes keeping appointments on time and notifying the provider when appointments cannot be kept. If you are unable to keep your scheduled appointment, please call or text as soon as you are aware that you cannot make your appointment. Missing 2 scheduled appointments without notifying Valor Horses For Heroes in advance could result in restricted scheduling of future appointments. A Valor Horses for Heroes Services does realize extenuating circumstances may result in missed appointments, and these circumstances will be taken into consideration.

8 You have the responsibility to report recommendations, questions, or concerns about your treatment to your provider.

9 Participation in illegal or disruptive behavior on Valor Horses For Heroes property is prohibited. Any defacing, destruction, or theft of personal property of Valor Horses For Heroes Services, our staff/providers, or other clients will not be tolerated. Any threat or act of violence directed towards staff, other clients, or visitors is grounds for immediate dismissal from services at Valor Horses For Heroes.

10 Weapons Prohibited: All persons who enter these premises are restricted from carrying a handgun, fire-arm, or prohibited weapon of any kind **regardless of whether the person is licensed to carry a handgun or not**. Prohibited weapons include any form of weapon or explosive restricted under local, state, or federal regulation including all firearms, illegal knives, or other weapons covered by the law. Violations will result in dismissal from my practice.

11 Selling, distribution, or use of drugs on the property of Valor Horses For Heroes is grounds forimmediate dismissal from services. Medication samples provided to you by your doctor are for your use only and may not be shared, sold, or transferred to another person under any circumstances.

12 Please do not leave your purse, phone, tablet or other valuables in the waiting room unattended. Valor Horses For Heroes is not responsible for loss, theft, or damage of any personal property.

I have had the opportunity to review and ask questions about these rights and responsibilities. I understand that I can request a copy of this document at any time.

Client/Patient Signature **Date**

Assignment

Financial Responsibility

All services rendered are charged to the patient and are due at the time of services, unless other payment arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment

I hereby assign all medical and behavioral health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payments directly to Valor Horses For Heroes for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I hereby authorize Valor Horses For Heroes to: (1) release information necessary to insurance carriers regardless my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Valor Horses For Heroes on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in fully immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered valid as the original.

Patient/Responsible Party Signature **Date**

For Office Use Only:

Does Patient have a copy of the Privacy Policy: Yes No

Please explain why the patient was unable to sign and acknowledgment form and efforts by A Valor Horses for Heroes Services in trying to obtain the patient's or guardian's signature:

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

By signing this form, you acknowledge that Valor Horses For Heroes has given you a copy of it's Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after May 1, 2021. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this as soon as we can after the emergency.

Check all that are true:

I have Valor Horses For Heroes Privacy Notice.

Valor Horses For Heroes has given me the chance to discuss my concern and questions about the privacy of my mental health information.

CONSENT TO PARTICIPATE IN INDIVIDUAL THERAPY AND/OR MEDICATION MANAGEMENT

I hereby provide consent forValor Horses For Heroes, PLLC and its providers to provide evaluation and/or treatment to myself, my minor child, dependent, or to an adult for whom I am legal guardian.

Signature **Date**

ADDENDUM TO PRIVACY PRACTICES PERMISSION TO SHARE INFORMATION

Name of Patient: Date of Birth:

Valor Horses For Heroes is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Consent to Communicate with Persons Listed

Name	DOB	Relationship	Consent To Release Information		
			Basic Medical	Yes	No
			Financial	Yes	No
			Basic Medical	Yes	No
			Financial	Yes	No
			Basic Medical	Yes	No
			Financial	Yes	No
			Basic Medical	Yes	No
			Financial	Yes	No

Consent of Method of Communication

Method	Preferred	OK to leave Voicemail?		Best Time to Call
Call Work Phone		Yes	No	
Call Cell Phone		Yes	No	
Call Home Phone		Yes	No	
Email Reminders		Yes	No	
Text Reminders		Yes	No	

Patient Information

I understand that I have the right to revoke this authorization at any rime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT IN WRITING.**

Signature of Patient of Personal Representative **Date**

Description of Personal Representative's Authority: