Psychological Mobile Services PA

2401 Wooten Boulevard Suite-K
WILSON, NC 27893
P: (252) 291 – 0735
F: (252) 291 – 2890
www.PsychologicalMobile.com

Clinical Intake Assessment

Client (legal name): ..... **Date:** .....
Date of Birth: ..... **Age:** .....
SS#: ..... **Time:** .....

Demographics:

Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian /Euro American
☐ Native American/Alaska Native ☐ Latino ☐ Native Hawaiian/Pacific Islander
☐ Other: .....
Veteran: ☐ Yes ☐ No
Legal Involvement: ☐ DJJ ☐ DSS ☐ Other: .....
Address: .....
Phone(s): .....
Legal guardian(s): ☐ Self ☐ Other: .....
School or Occupation: .....
Highest Achieved Education Grade Or Current Grade: .....
Referral Source: .....

Please Provide Copies Of All Insurance Cards (Front And Back) Or Provide Your Insurance Information Below:

Primary Insurance: .....
Insurance/Subscriber #: .....
Insurance Group #: .....
Policy Holder's Name: .....
Policy Holder's DOB: .....
Policy Holder's Name SS#: .....
Claims Mailing Address: .....

Secondary Insurance: .....
Insurance/Subscriber #: .....
Insurance Group #: .....
Policy Holder's Name: .....
Policy Holder's DOB: .....
Policy Holder's Name SS#: .....
Claims Mailing Address: .....

Treatment Consent

I authorize the evaluation and/or treatment of the patient identified above and agree to pay all charges for the evaluation and/or treatment provided. I hereby authorize the release of information related to the services provided to my insurance and/or managed care company and authorize payment by the insurance and/or managed care company directly to Psychological Mobile Services, P.A. A copy of this authorization can be used in place of the original.

....
Client/Guardian's Signature Date

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Chief complaint / presenting problem / reason for referral:

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Mental Health/Substance Abuse/Developmental Services Details & History

Psychiatric Hospitalization: ☐ Yes ☐ No

Total psychiatric hospital admissions: .....

Psychiatric hospitalizations in last 2 years: .....

Psychiatric Hospitalization details: .....

Out-patient Services & Enhanced Services:

☐ 1:1 Therapy ☐ Family Therapy ☐ Group Therapy
☐ Medication Therapy ☐ Psychological Testing
☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy
☐ Day Program ☐ Psychosocial Rehabilitation
☐ Case Management ☐ Care Coordination ☐ CAPS
☐ Developmental Therapy ☐ Vocational Rehab
☐ 1-1 Rehab Services ☐ Respite ☐ ADVP ☐ Personal Care
☐ Person Assistance ☐ Day Treatment
☐ Intensive In-Home Services ☐ Community Support Team
☐ ACTT
☐ Other or Details: .....

Out-of-Home Placement:

☐ Foster Care ☐ L2 ☐ PRTF ☐ Group Home ☐ Detention
☐ Jail ☐ Prison ☐ AFL ☐ Supervised Living
☐ Other or Details: .....

Substance Abuse Services:

☐ Counseling ☐ AA ☐ NA ☐ SAIOP ☐ Community Residential
☐ Half-way House ☐ Detox ☐ In-patient Program
☐ Other or Details: .....

Consent for Emergency Care

I consent to Emergency Medical Care: This is to authorize Psychological Mobile Services, PA to seek emergency medical care if needed. It is understood and agreed that the staff and Psychological Mobile Services, PA will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported. If the director of the program deems emergency medical care necessary, and neither I nor any person named below can be reached, I authorize the person in charge to procure medical care and to act on my behalf in granting permission for the above named individual/client to receive treatment or surgery.

In case of emergency contact:

Name: ..... Relationship: ..... #: .....

Name: ..... Relationship: ..... #: .....

Emergency care information:

Physician: ..... #: .....

Hospital Preference: ..... #: .....

....

Consumer/Legally Responsible Person Signature — Date

....

Witness — Date

We Deal With Adversity Together

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Consumer Grievance Procedures

A. In the event an individual has a complaint regarding services received from Psychological Mobile Services, PA they shall follow the plan below. Any consumer or guardian of a consumer has the right to file a grievance without interference or retaliation

B.

1. A written statement of the complaint shall be sent to the Clinic Administrator. A copy of the letter shall also be sent to the Clinical Director.
2. The Clinical Administrator shall respond to the individual that made the written complaint within twenty-four (24) hours of receiving the complaint.
3. If the individual is not satisfied with the response given by the Clinical Administrator, the letter of complaint shall be discussed with the Clinical Director.
4. The Clinical Director shall respond to the individual within twenty-four (24) hours of receiving the complaint.
5. If the individual is not satisfied with the response, he/she shall send the written complaint to review with the Community Advisory Board. All actions at this level are considered final.

C. A copy of the grievance procedure shall be given to any individual served by Psychological Mobile Services.

D. An individual may contact the Governor's Advocacy Council at (919) 733-9250 or the Eastpointe MCO/LME.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you to obtain payment for services we provide, and for other professional activities (known as "health care operations.") Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do not agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance to the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Client/Guardian's Signature _____ Date _____

NOTICE OF RIGHTS, PRIVACY, & POLICIES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Psychological Mobile Services, PA's Notice of Rights, Privacy and Policies. I understand that if I have any questions regarding the Notice of my rights and/or privacy I can contact Psychological Mobile Services, PA.

Signature of Client/Guardian or Personal Representative* _____ Date _____

*If you are signing as a personal representative of an individual please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

Patient/client refuses to acknowledge receipt: _____

Staff Member - Witness _____ Date _____