REGISTRATION

Client Name _____

Address _____

City_____ State_____ Zip_____

Date of Birth_____ Social Security Number_____

Gender [ ] Male [ ] Female Marital Status _____

Employer or School_____ Employment Status_____

Home Phone_____ Cell Phone #_____ Work Phone _____

May we contact you via email to send paperwork, for scheduling and to send invoices?

[ ] Yes [ ] No If yes, email address _____

Legal Guardian Name (if patient is under 18)_____ _____

Address _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone #_____ Work Phone _____

Referred by _____ Phone # _____

[ ] Self-Pay (pay at time of service) [ ] Grant funded

[ ] Private Insurance (pay deductible/co-pays at time of service)

How do you intend to pay your deductible and co-pays? [ ] Cash [ ] Check [ ] Paypal

******Please attach copy of current Insurance card******

Insurance Company: _____ Phone No: _____

ID Number: _____ Group No: _____

Insured Name: _____ DOB: _____

Secondary Insurance: _____ Phone No: _____

ID Number: _____ Group No: _____

Insured Name: _____ DOB: _____

If you have Medicaid, the following information must be provided before the initial evaluation appointment:

1. Copy of current Medicaid card
2. Primary Care Physician *full* name_____
3. Primary Care Physician's Practice Name._____

I, _____(name of adult client or guardian of minor client) agree to pay *Pathway Growth & Learning Center, LLC* at the current rate for the services provided to me (or the client named above for whom I have legal responsibility). I understand that I am responsible for these charges and that fees are due at the time service is provided, unless I make arrangements in advance. If grant-funded, these policies only apply to late cancellation/missed appointment fees.

_____ _____

Client's Signature (or parent/guardian/responsible party) Date

Pathways Growth & Learning Center, LLC.

Medical History

Client's Full Name:_____ Date of Birth:_____

Street Address,_____

City, State, Zip:_____

Phone(s): H:_____ W:_____ C:_____

Height:_____ Weight:_____ Tetanus Shot: Y[ ] N[ ]

Medications & Dosage	Taken Since	Prescribed by (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any areas of medical concern. If "yes," please explain in the Comments section

Areas	Yes	No	Comments
Auditory	☐	☐	_____
Visual	☐	☐	_____
Speech	☐	☐	_____
Cardiac	☐	☐	_____
Circulatory	☐	☐	_____
Pulmonary	☐	☐	_____
Neurological	☐	☐	_____
Muscular	☐	☐	_____
Orthopedic	☐	☐	_____
Allergies/Asthma	☐	☐	_____
Learning Disability	☐	☐	_____
Psychological Impairment	☐	☐	_____
Diabetes	☐	☐	_____
Other _____	☐	☐	_____

By signing this form, I, _____ (please print parent/guardian/ adult client name) certify all information to be complete and true to the best of my knowledge.

Client's Signature: _____ Date:_____

Parent/Guardian's Signature (If client is minor):_____ Date:_____

Pathways Growth & Learning Center, LLC.

Emergency Information & Health Care Consent

Parent/Guardian_____Phone Numbers _____

*1st Emergency Contact_____ Relationship to Client _____ Phone _____

*2nd Emergency Contact_____ Relationship to Client _____ Phone _____

*(*client's or parent/guardian's first choice for us to call if parent/guardian is unavailable in a medical emergency)*

Patient's Primary Physician_____ Phone Number_____

Preferred Medical Facility: _____

Emergency Medical <u>Consent</u>

The undersigned hereby grants to any *Pathways Growth & Learning Center, LLC.* affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the client named below and to make emergency health care decisions with respect to the client if the undersigned is unavailable to obtain such information or make such decisions.

Client's Name_____ Phone:_____

Address:_____

Date:_____ Signature:_____
(parent, guardian, or adult client)

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Emergency Medical <u>Non-Consent</u>

If the undersigned <u>does not</u> desire to grant any *Pathways Growth & Learning Center, LLC*. affiliate/employee/intern/volunteer information or to make health care decisions for the client if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the client becomes ill or is involved in an accident and the undersigned is unavailable.

_____ I Do Not Consent to any *Pathways Growth & Learning Center, LLC*. affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the client.

Procedures to be followed:_____

_____

_____

Date:_____ Signature:_____
(parent, guardian, or adult client)

Consent for Release of Information

Client's Name:_____ Date of Birth:_____ Age:_____
Parent/Guardian Name:_____

I hereby authorize *Pathways Growth & Learning Center, LLC* to release and/or exchange protected health information for the above stated client for the duration of services received from *Pathways Growth & Learning Center, LLC* with:

Name of Applicable Professional:_____
Organization:_____
Street Address:_____
City & State:_____ Zip Code:_____
Office Phone:_____ Fax Phone:_____

The protected information to be released and/or exchanged include:

___ Admission Assessment	___ Substance Abuse Info	___ Mental Status
___ Evaluation	___ Discharge Plan	___ Diagnoses
___ Treamtent Plan(s)	___ Progess Notes	___ Psychological Records
___ Court/Agency Documents	___ Communicable Disease	___ Educational Records

___ Other (please explain):_____

Purpose of Contract: This form implements the requirements for client authorization/consent to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), and state confidentiality law governing mental health, development disabilities, and substance abuse services (G.S. 122C).

Redisclosure: Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information protected by federal law (42C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

Revocation and Expiration: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization, I must do so in writing.) If not revoked earlier, this authorization expires automatically upon _____ (Date or event that related to the client or the purpose of the use or disclosure) when treatment episode ends or one year from the date it is signed, whichever is earlier. Notice of Voluntariness: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that *Pathways Growth & Learning Center, LLC* will not deny or refuse treatment because of my refusal to sign.

_____ _____
Signature of Client or Legal Guardian* Date

_____
*Relationship of Legal Guardian to client