Application Date: ___________________________

MONTGOMERY COUNSELING CENTER

323 12th Ave Rd
Nampa, ID 83686
Telephone: (208) 463-0212; Facsimile: 461-5452

SERVICE APPLICATION-INTAKE PACKET

Revised June 9, 2014

MONTGOMERY COUNSELING CENTER

MONTGOMERY COUNSELING CENTER
APPLICATION FOR SERVICES

1. GENERAL INFORMATION

APPLICANT FULL NAME: ______________________________

HOW WERE YOU REFERRED? ______________________________

APPLICATION DATE: ____________________ **Date of Birth (DOB):** __________

PHYSICAL ADDRESS: ______________________________
(Street) (City) (Zip)

MAILING ADDRESS: ______________________________
(Street) (City) (Zip)

HOME PHONE: __________ **CELL PHONE**: __________ **WORK PHONE**: __________

SOCIAL SECURITY NUMBER: ____________________ **Age**: __________

APPLICANT E-MAIL ADDRESS: ______________________________

APPLICANT'S EMPLOYER: ______________________________

SPOUSE NAME: ______________________________ **PHONE:** ______________

SPOUSE EMPLOYER: ______________________________

GUARDIAN FULL NAME: ☐ SELF ☐ OTHER: ______________________________

Guardian – Legally Authorized (Entity or Person) Contact Information:

Name: ______________________________:____________________

Address: ______________________________
Street City State Zip

PHONE: ______________________________

Responsible Person(s) Contact Information (PCS Provider; Foster Care Provider; etc.):

Name: ______________________________

Address: ______________________________
Street City State Zip

PHONE: ______________________________

For office use only: Account #: ____________________

Applicants Children:

Name: ________________________________ Name:________________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

Name: ________________________________ Name: _______________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

Applicants Sibling(s):

Name: ________________________________ Name:________________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

Name: ________________________________ Name: _______________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

Name: ________________________________ Name:________________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

Name: ________________________________ Name: _______________________________

Age: ___________ DOB: _______________ Age: ________ DOB:__________________

In Case of Emergency, Please Notify:

Primary Contact:

Name: ____ Relationship: ____________________

Address: ____

Street City State Zip

Telephone: __________________________ Secondary Telephone:______________________

Secondary Contact:

Name: ____ Relationship: ____________________

Address: ____

Street City State Zip

Telephone: __________________________ Secondary Telephone:_____________________

MONTGOMERY COUNSELING CENTER

APPLICATION FOR SERVICES

2. ADDITIONAL GENERAL INFORMATION

Please attach copies of the following to service application:

- ☐ Medicaid Card (If Medicaid Eligible - Required)
- ☐ Medicare Card
- ☐ Other Insurance Card (Required)
- ☐ Guardianship Documentation (If relevant)
- ☐ Medical Documentation (including primary diagnosis, if available)

Primary and/or Secondary Diagnosis (please attach documentation verifying DX):

Primary DX: ____

Secondary DX: ____

Current Living Arrangement:

☐ Family Residence	☐ Institution or ICF-MR	☐ Supported Living
☐ Group Home	☐ PCS Home	☐ Foster Home
☐ Correction Facility	☐ Nursing Home	☐ Assisted Living

☐ Other: ____

Marital Status:

☐ Married	☐ Single	☐ Divorced	☐ Separated
☐ Widowed	☐ Engaged	☐ Annulled	☐ Cohabitating
☐ Deceased			

Are you presently taking any prescription or non-prescription medication(s) – if so, please list:

Medication(s):	**Dosage**	**Frequency/Time**		**Purpose**
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________
____________	______	____________	☐AM☐PM	________

Have you ever been hospitalized due to mental health issues? ☐ Yes ☐ No

If yes, please provide information related to hospitalization:

____
____
____
____

Have you received services from a different Mental Health Clinic or counseling provider in the past? ☐ Yes ☐ No

If yes, please provide name of provider: ______________________________________

Service Needs:

Current Issues/Concerns (please identify any and all current issues and/or concerns):

☐ Depression ☐ Stress/Anxiety ☐ Drug-Alcohol ☐ Employment-Career
☐ Health ☐ Sleep Disturbances ☐ Eating-Diet
☐ Interpersonal Relationships ☐ Thoughts of Harm to Self
☐ Thoughts of Harm to Others ☐ Family Issues ☐ Victimization
☐ Financial ☐ OCD ☐ Sexual Behavior
☐ Other (please specify): ____

Please describe the primary problem, issue, or concern as to why you are seeking services?

____
____
____

How long have you been aware of this problem, issue, or concern?
☐ Within 1 week ☐ Less than 30 Days ☐ Less than 3 months
☐ More than 6 months ☐ More than 1 year
If more than 1 year, how long?____
Have you ever experienced problem(s) with drugs or alcohol addiction? ☐ Yes ☐ No

MEDICAL HISTORY

Does the applicant suffer from any chronic medical conditions; if so, please list:

____

____

Please list any known allergies? ____
____

Please list any recurring illnesses; or, injuries: ___________________________________

MONTGOMERY COUNSELING CENTER

APPLICATION FOR SERVICES

PROFESSIONAL-MEDICAL CONTACT INFORMATION:

Name of Primary Care Physician: ______________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Caseworker (if relevant): ______________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of TSC Agency (if relevant): ______________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of PSR Agency (if relevant): ______________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Counselor-Therapist (if other):__________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Psychiatrist (if relevant): ______________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Other Specialist: ____________________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Other Specialist: ____________________________________ (Tel): ____________

Address: ____ (Fax): ____________

Name of Other Specialist: ____________________________________ (Tel): ____________

Address: ____ (Fax): ____________

MONTGOMERY COUNSELING CENTER

APPLICATION FOR SERVICES

Consent Disclosures:

- Informed Consent – Privacy Exclusions
- Informed Consent – Attendant Services to be Received – Expected Benefits and Risks
- Informed Consent – Right to Refusal of Services
- Informed Consent – Choice of Service Providers
- Informed Consent – Choice of Service Providers – Developmental and Cultural Sensitivity
- Informed Consent – Participant Rights
- Informed Consent – Participant Choice and Informed Consent
- Informed Consent – Inability to Provide Consent
- HIPPA Notice of Privacy Practices, additionally, signing below indicates MCC provided you with a copy of the agency HIPPA privacy statement, as well.

Please be aware, Montgomery Counseling Center does not provide twenty-four (24) hour crisis services. Life threatening emergencies, medical emergencies, etc. need to be referred to crisis providers. Please call 911 in case of emergencies.

By signing below, you are indicating the above information related to privacy exceptions and notices was reviewed with you by MCC personnel; that you have received the information in written terms and/or verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

☐ I requested and received a copy of the written terms.

☐ I decline the receipt of written consent terms.

________________________________ ______________________
Participant Signature Date (Month-Date-Year)
Parent, Legal Guardian or Foster Parent

________________________________ ______________________
Montgomery Counseling Center Representative Date (Month-Date-Year)

MONTGOMERY COUNSELING CENTER

Montgomery Counseling Center, Inc.
323 12th Ave Rd, Nampa, ID 83686
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Release of Records Exchange

REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS OR HEALTH INFORMATION

By my signature below, I ____authorize Montgomery Counseling Center, Inc. to ***release***; and/or, ***obtain*** personal health information to/from:

For the following PARTICIPANT: ____(DOB: ________

Provider Name: ____

Address: ____

Telephone: ____

Facsimile: ____

And have access to; or, release the following records: ______________________________

- ☐ Current Medical Information and/or Medical Records
- ☐ Evaluation, Assessment, or Diagnostic Reports or Documentation
- ☐ Treatment Plan(s); or, Update, Addendums to Treatment Plan(s)
- ☐ Other (please specify): ____
- ☐ IEP or school-related reports
- ☐ Progress-Session Notations

For the purpose(s) OR need: For Treatment Purposes; as well as, maintain current, accurate documentation in participant record

AUTHORIZATION STATEMENT:

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Montgomery Counseling Center. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, this written authorization will have an expiration date of one (1) calendar year from the authorized signature below.

MCC may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the Informed Consent form(s) provided.

With my signature below, I understand what this document states and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records, if requested.

____ ______________________
Participant Signature (if applicable) Month/Date/Year

____
Print Participant Name

____ ______________________
Signature of Legally Authorized Representative (if applicable) Month/Date/Year

____
Print Legally Authorized Representative Name

____ ______________________
Representative, Montgomery Counseling Center Month/Date/Year

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PARTICIPANT-CLIENT MEDICAL OR HEALTH-RELATED INFORMATION

MONTGOMERY COUNSELING CENTER honors a participant's right to confidentiality of medical or health-related information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, MCC may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

Montgomery Counseling Center
323 12th Ave Rd, Nampa, ID 83686

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact MONTGOMERY COUNSELING CENTER for further information.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact MONTGOMERY COUNSELING CENTER representatives.

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Verification of Insurance Benefits

Client's Name: ____

CLIENT'S DOB: ______________________ Sponsor SSN (Tri-Care Only) __________

Members Name: ______________________ Relationship to Client: ______________

Members Address: ____
Street City State Zip

Member's DOB: __________________

Insurance Company: ____

Subscriber Number: ____

Group Number: ____

Deductible: ____

Maximum Visits Per Year: ____

Insurance Information Supplied By: ____

Responsibility for Payment/Payment Policy:

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY – You are responsible for payment of all charges for mental health services provided by MCC, including any co-payments or deductibles. You are also required to provide an insurance card – this is necessary to validate coverage of benefits. You are ultimately responsible for any service provided that is not covered by your policy. INSURANCE – You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. It is your responsibility to notify us of any changes in your insurance plan. Any co-payments, deductibles, or services not covered by insurance are your financial responsibility. Any service denied because of a change in benefits becomes your responsibility.

Montgomery Counseling Center's hourly professional fee is $85.00 per hour. Any written documentation requested to be produced by our professionals will be billed to the client at $20.00 per fifteen (15) minute increment.

With this consent, I acknowledge I am fully responsible for payment of services rendered by MCC. I acknowledge I am fully responsible for understanding my insurance benefits, coverage and whether or not mental health benefits are part of the medical benefits provided through my insurance company.

______________________________________ ______________________
Participant Signature (if applicable) Month/Date/Year

____
Print Participant Name

MONTGOMERY COUNSELING CENTER

ATTENDANCE POLICY

Consistent attendance is crucial for you, your child, or other family members to achieve therapeutic goals and objectives and for the therapist and client(s) to develop and maintain a positive and beneficial therapeutic relationship to help promote growth and change.

Our agency will make reminder calls the day prior to the scheduled appointment, if your appointment is on Monday reminder calls will be made the previous Friday (excluding holidays), however, the responsibility to attend your scheduled appointments is ultimately your own responsibility.

Please provide twenty-four (24) hours notice if you will not be able to attend the schedule appointment. If you cancel two (2) appointments; or, fail to attend your scheduled appointment in a two months period, we will be required to explore alternatives; or, simply discontinue services.

If any scheduled appointment is not canceled with twenty-four (24) hours notice, you may be charged a **LATE CANCELLATION FEE** of $**35.00**. If you fail to show for a scheduled counseling session without contacting our office in advance (which, requires you to either speak directly with a representative of our agency or leave a message and receive confirmation your message has been received) you may be charged a **NO SHOW FEE** of $**35.00**.

LATE CANCELLATION FEE and NO SHOW FEE do not apply to MEDICAID/OPTUM clients due to state and federal regulations; however, if a MEDICAID/OPTUM client does not abide by the cancellation policy; or, no shows for two (2) appointments, you will be discharged from services.

I have read the Montgomery Counseling Center attendance policy and understand the contents of the policy. I agree to abide by Montgomery Counseling Center attendance policy.

__________________________________ ___________________

Participant Signature Date (Month-Date-Year)
Parent, Legal Guardian or Foster Parent

____ ______________________

Montgomery Counseling Center Representative Date (Month-Date-Year)

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APPLICANT - DO NOT COMPLETE!

TO BE COMPLETED BY THE PSYCHOTHERAPIST AT COMPLETION OF INITIAL VISIT WITH CLIENT/PARTICIPANT FOR DX AND BILLING PURPOSES:

DIAGNOSIS (p= principle diagnosis)			
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V	*Current C-GAS/GAF:*	*Highest C-GAS/GAF Past Year:*	*Current CAFAS/PECFAS (children):*
Diagnosis Rendered By:		***Credentials:***	***Date:***