Core Recovery

Name:		Todays Date:
DOB:	Age:	Marital Status:
Address: City: Zip Code:		SSN: Home Phone: Cell Phone:
Gender: ☐ Male ☐ Female ☐ Transgender		Email Address:
Who may we thank for referring you to Core Recovery?		

In the event of an emergency, call:

Name:	Relationship to client:
Home Phone:	Cell Phone:

What is the primary reason you are seeking services today?
(check all those that apply)

☐ Depressed	☐ Agitated/Restless	☐ Anxious	☐ Confused	☐ Bored
☐ Fearful	☐ Angry	☐ Ashamed	☐ Hostile	☐ Hopeless
☐ Marital/Relationship	☐ Parenting/Child	☐ Divorce/Seperation	☐ Other Family issues	☐ Emotional/Psychological
☐ Sex	☐Work Related	☐ I need a referral	☐ I am in Crisis	☐ I need medication
☐ Someone close to me needs help	☐ It would help to talk to someone	☐ Grief & Loss	☐ Other	☐ Financial
☐ School	☐ Memory	☐ Religious	☐ Health	☐ Drug/Alcohol

Are you considering doing harm to yourself or others? ☐ Yes ☐ No
Please Explain:

For you to consider your counseling experience successful, what are you hoping to accomplish? Please Explain:

Name: Date:

Ongoing Medical conditions: (i.e. asthma, high blood pressure, diabetes, chronic pain etc.)

Please list your Doctors/Therapists/All Out Patient Providers (include the person who prescribed your medications)

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

What medications are you currently prescribed? ☐ **None**

Medication:	Dose: (important)	How long at dose:	What is the medication for?

Is there a history of mental illness in your family? ☐ Yes ☐ No

Please Explain: (specify which relative and what the diagnosis is)

Legal

Are you here because of a current domestic related charge? ☐ Yes ☐ No	
List violations beginning with the most current:	
Current charge:	Date:
Court:	Result of charges (indicate if they are pending):
Have you ever been convicted of a felony? ☐ Yes ☐ No	Are you presently on parole or probation? ☐ Yes ☐ No

Patient's Consent for Treatment

Signature(s) required below to accept and begin treatment

Core Recovery, LLC has a number of licensed clinicians on staff. Core Recovery, LLC in the consent for treatment document can be defined as the inclusion of all clinicians which provide counseling services for Core Recovery, LLC patients.

Unless otherwise indicated, I have voluntarily chosen to seek services at Core Recovery LLC. I understand I may refuse or withdraw consent for receiving counseling before counseling is initiated. I understand that confidentiality will be held and released in accordance with those laws, which regulate the confidentiality of records and information. State and local laws require my counselor to report all cases where:

- **Physical or sexual abuse or neglect of minors or elderly exists.**
- **Where there exists a danger to one self or others.**

I understand Core Recovery LLC., takes all precaution's to safeguard confidentiality. Patients will not be photographed but will be required to provide photo identification such as a driver's license at time of intake service. Where client services are reimbursed and/or overseen by insurance companies, managed care companies and plan administrators, Core Recovery, LLC., may be required as a condition of providing these services to report information to case managers and/or other principles in the above-mentioned organizations. Further, if by accident Core Recovery, LLC. transmits through facsimile and/or telephonic voice mail, answering machine, email or text message any unauthorized people or entities intercept this information, the client waives any and all claims to breach of confidentiality. Core Recovery, LLC. may contact me through any of the ways of information I have provided unless I have otherwise stated.

Termination: You have the right to terminate treatment at any time. Core Recovery may terminate treatment with you if payment is not made, or if there is a refusal to follow therapeutic recommendations (such as remaining sober, filling prescriptions, etc.) If this occurs, you will be provided a recommendation for continued care.

This notice is effective September 1, 2010 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain.

Consent for treatment of Minor(s) (under 18 years Old)

I, (parent or legal guardian's name)_____, give my permission to Core Recovery, LLC., to provide counseling services for my child(ren). My signature further indicates that I am the legal guardian and am authorized to give this consent.

Parent/Guardian's Signature: _____Date: _____

Area below is to be completed when you meet with your counselor ONLY. Thank You

This section must be completed and signed by the counselor and patient prior to starting service. Counselor: Please check each item below to verify the following information has been explained and that a COPY of each item listed below has been distributed to the client.

1. Patient has read and understands the above.
2. Patient has received a copy of the Patient's Rights.
3. Patient understands the limits of their financial responsibility for services provided, and acknowledges receiving a copy of the Financial Policies Agreement.
4. Patient has received a copy of the Notice of Privacy Practices (HIPAA compliance effective 9/1/2010).
5. Patient has received a copy of telephone numbers and addresses for Adult and Child Protective Services, Division of Behavioral Health Service's.
6. Patient has received a copy of the Grievance Policy.

Signatures required below to confirm understanding and acknowledgment of receipt of all the above.

Patient or Guardian Signature: _____Date:_____

Counselor Signature: _____ Date:_____

Print Counselor Name/Credentials:_____

Core Recovery, LLC
34225 North 27th Drive
Bldg. 5, Suite 146
Phoenix, Arizona 85085
602-810-1210

AUTHORIZATION FOR RELEASE OF CONFIDENTAL INFORMATION

PATIENT NAME:_____PATIENT DOB:_____

I hereby authorize; Core Recovery LLC, 34225 North 27th Dr., Bldg. 5, # 146, Phoenix, AZ 85085 to:

☐ RELEASE ☐ RECEIVE

Confidential information (via mail, telephone, email and/or fax) related to mental health treatment, and/or psychiatric/psychological treatment, including records of testing, medication, diagnosis, assessment and insurance records as applicable to/from the following organization:

☐ Desert Ridge Family Physicians: Dr. Name_____

☐ Dr. Rick Sloan

☐ STD/LTD Insurance Carrier Name:_____

☐ Other: (please list) _____

The extent of nature of information to be disclosed is:

☐ Psychiatric records ☐ Entire Chart, without restriction

☐ Progress/Session notes ☐Treatment Plan(s)

☐ Discharge Summary ☐ Financial Records

☐ Other (specify):_____

The purpose of, or need for, this disclosure is:

Continued Care _____Processing of Insurance Claim _____Application for Insurance _____Other_____

This Authorization will expire once treatment has been completed or terminated. This release will remain in effect until the completion of care or termination of care letter has been signed by the treating counselor. I understand that I may revoke my consent to allow the release of this information, except to the extent that action has been taken on the information released prior to the revocation of my consent.

Patient Print Name: _____ Date:_____

Patient Signature: _____

Witness Signature: _____

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents, in writing, to such re-discloser.

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FINANCIAL POLICIES AGREEMENT

Payments: Cash pay patients must pay for services in full at the time of service. Insurance patients must pay any co- payments, deductibles or co- insurance fees that apply at the time of service. For your convenience we accept cash, check, and most major credit cards. We can keep a secure credit card authorization on file.

Insurance Coverage: Current insurance information must be on file at all times. You will be required to provide your insurance card and a driver's license at your first appointment. You are also required to notify us of any changes in insurance coverage throughout your treatment. If you do not provide us with current and correct insurance information in a timely manner, you may be responsible for the balance of your claim(s).

Insurance Billing: We participate in several insurance plans. Core Recovery will verify if coverage is in effect, however, knowing and understanding your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

Core Recovery, LLC will submit claims to your insurance company for payment. If we are a contracted provider with your insurance plan, you will be responsible for copayments, deductibles and co-insurance amounts as determined and applied by your insurance plan. Upfront fees known to be the insurance company's allowable rates at time of service may be charged to cover copayments, deductibles, and co-insurance amounts. Patient balance billing will take place once the claim has been processed by your insurance company.

In the event, Core Recovery LLC is out of network for a specific plan, we will accept an upfront fee for service and submit the claim to your insurance provider for final determination. Core Recovery will accept the allowable payment rate as determined by your plan. Any difference in the amount of what is billed to the insurance company and what is paid will not be balance billed to you with the exception of co- insurance and deductible amounts as determined and applied by your insurance plan.

Late Arrival, No call-No show, and Cancellation Policy: If you are more than 15 minutes late for your appointment, we will have to cancel your appointment and reschedule you for a later time. In this event, a late cancellation fee of $50.00 will apply. We realize patients may need to change their appointments from time to time, however, we require a 24 hour notification for cancellations so we may offer that time to another patient. If you fail to call to cancel an appointment within 24 hours or fail to show for your appointment, a late cancellation or no show fee of $50.00 will apply.

Returned Checks: A $25.00 fee will apply for any returned checks.

Collection policy: If your account requires placement with a collection agency, all future visits would require payment in full at time of service. You will be held fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of the debt. These fees would be over and above the original balance due.

Patient_____ Date:_____

Witness_____ Date:_____

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started! By signing this form you give us permission to debit your account for the amount indicated at the time of your appointment and for each subsequent appointment thereafter. This permission applies to the upfront fees charged for Core Recovery services at time of appointment and any late cancellation/no show fees, however it does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Core Recovery, LLC to charge my credit card

indicated below for $_____at each appointment for the fees charged for counseling

services provided by Core Recovery, LLC.

Billing Address _____ Phone#_____

City, State, Zip _____ Email_____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX)_____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am the authorized user of this credit card and that I will not dispute payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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NOTICE OF PRIVACY PRACTICES

AUTHORIZATION FOR USE OR DISCLOSURE OF (PHI) PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____, authorize Core Recovery, LLC

to release and obtain my private health information to/from (check all that applies):

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: ____Yes ____ No

If yes: _____

_____No one other than myself may have access to my medical records

May our office leave a message on your voice mail or answering machine and/or transmit an email or text message regarding appointment reminders: ____ Yes ____ No

What is your preference for appointment reminders: _____ voice message _____text _____email

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient of Core Recovery, LLC. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Administrator at Core Recovery, LLC at 34225 N 27th Drive, Bldg 5, Suite 146, Phoenix, Arizona 85085. I understand that my revocation will not affect any actions taken with Core Recovery, LLC prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My clinician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective from the date signed until treatment is terminated, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative and relationship Date

Core Recovery, LLC
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PATIENT'S RIGHTS

All patients of Core Recovery are treated with dignity, respect and consideration.

1. A patient of Core Recovery you shall not be subjected to:

    a. Abuse
    b. Neglect
    c. Exploitation
    d. Coercion
    e. Manipulation
    f. Sexual Abuse
    g. Sexual Assault
    h. Restraint or seclusion
    i. Retaliation for submitting a complaint to the AZ Department of Health Services or another entity; or
    j. Misappropriation of personal and private property by a personnel member, employee, volunteer, or student

As a patient of Core Recovery, you have the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy during counseling;
4. To review upon written request, your own medical record according to ARS 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if our counseling facility is not authorized or not able to provide the behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, the counseling provided to the patient
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Patient:_____ Date:_____

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GRIEVANCE POLICY

The following procedure shall be implemented ***within thirty (30) days of incident occurrence*** when a patient of Core Recovery wishes to file a grievance:

- The patient shall put his/her grievance in writing and submit such grievance to his/her behavioral health service provider.

  The grievance shall be reviewed by both the patient and Provider within five (5) working days from the date of submission. After review, the Provider will do his best to resolve the issue.

  If the resolution is accomplished, the patient and Provider will submit in writing to the Provider's immediate supervisor a joint letter indicating the grievance and steps that will be taken to meet the agreed upon resolution. A time frame will be stated in the letter for such resolution. The letter will be signed by both patient and Provider.

  When the grievance is resolved; the patient and Provider will submit in writing to the Provider's immediate supervisor a joint letter indicating the resolution of the grievance. Both parties shall sign the letter. Copies of the above two letters shall be kept in the patient's case file and the Provider's employee file.

- When a patient grievance cannot be resolved between the patient and his assigned behavioral health service provider as outlined above, the patient and Provider will make an appointment with the Administrator at Core Recovery to discuss the grievance. The nature of the grievance will be presented in a letter by the patient.

  The Patient, Provider, and Administrator will meet and review the grievance within ten (10) working days of submission. The Administrator, in conjunction with the patient and Provider, will attempt to resolve the grievance to the best of their abilities.

  If a resolution is accomplished, the patient and Provider will submit in writing to the Administrator a joint letter indicating the resolution of the grievance. All three parties shall sign the letter. Copies of the above two letter shall be kept in the patient's case file and the Provider's employee file.

- When the above two procedures do not result in a resolution, or at any time during the grievance process, the patient may file a complaint with:

  Out-Patient
  Bureau of Medical Facilities Licensing
  150 North 18th Avenue, Suite 450
  Phoenix, AZ 85007-3242
  602-364-3242

- No discrimination shall occur to any staff, patient, or involved person when dealing with the participation or investigation of a grievance

Patient_____ Witness_____