Malcom Behavioral Health
Clint P. Malcom, APRN BC

Today's Date: ____ /____ /_____

*** *** *** *** *** **PLEASE PRINT CLEARLY** *** *** *** *** ***

Patient's Name: _____

Preferred Name (if different from above): _____

Date of Birth:____-_____-_____

Age:____ yrs old

Gender (circle one): M F

Social security #: _____-_____-_____

Address: _____

City:_____ **State:** _____ **Zip:**_____

Phone #: Home (_____)_____-_____

Mobile (_____)_____-_____

Prefer reminder calls (check ONE): ___ Call Home ___ Call Cell ___ Text Cell ___ E-mail

E-Mail : _____

GUARDIAN (if appropriate):

Name: _____ Relationship to patient: _____

Date of Birth: _____-_____- _____ Social Security #: _____-_____-_____

Phone #: Home (____)_____-_____

Mobile (____)_____-_____

Work (____)____-_____

Address: _____City:_____ State: ____ Zip: _____

Other Members of Household:

Name	Age	Relationship to *Patient*
_____	_____	_____
_____	_____	_____
_____	_____	_____

OCCUPATION (Patient): _____

Veteran: __ yes __ no

Employment Status(circle one): Full-time Part-time Unemployed Homemaker Student Other

INSURANCE

Policy Holder: _____ Subscribers DOB: ___/____/____ SS#: ____-___-____

Insurance Provider, Medicaid, or Self Pay: 1) _____ 2) _____

ID #: 1) _____ 2) _____

Group #: 1) _____ 2) _____

Marital Status(circle one): Single Married Separated Divorced Widowed

Religious Preference (optional): _____

Education (highest grade earned): ____Grade ____High School ____College-Degree: _____

COUNCELING

Are you currently receiving other counseling: ___yes ___ no

Current counselor:

Name:_____ Facility:_____

PREVIOUS Counseling Experiences (Mental Health Medication or Therapy):

Name	Location	Approximate Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

REFERED BY: _____

IN CASE OF EMERGENCY notify:

Name: _____ Relationship: _____

Phone#: Mobile (____)_____-_____

Home (____)_____-_____

Work (____)_____-_____

Primary Care Physician: _____Facility:_____

MEDICATION:_____

_____

_____

Existing Medical Conditions:_____

_____

ALLERGIES: _____

Special Treatment (if any): _____

PHARMACY:_____ City:_____ , NE

All of the above information is current to the best of my knowledge:

_____ _____

Patient or Guardian Signature Date

Consent to Treatment

Malcom Behavioral Health
Clint P. Malcom, APRN BC
2315 West 39th Street, Suite 106
Kearney, NE 68845
Phone: 308-233-3847
Fax: 308-233-5921

Patient Name:_____ **Date of Birth:**_____

Introduction:
Malcom Behavioral Health, Kearney, Nebraska, is hereinafter referred to as "the Practice."

Any and all physicians, physician assistants, nurse practitioners providing care and treatment including consultation during the course of my admission to the Practice are hereinafter referred to as "the Clinicians."

1. **Consent to Treatment:** I may have a condition requiring diagnosis and treatment of I have requested that a healthcare professional assess or evaluate my condition as part of a routine checkup. I hereby consent to and authorize medical treatment, laboratory, routine diagnostic tests and therapeutic procedures by the healthcare professional, his or her assistants or designees, including personnel of the Practice. I agree to the supervised participation of health care students (e.g., medical students, nursing students, and physical therapy students) in my care. I understand that no guarantees have been made to me concerning the results of this treatment or examination.
2. **Certification of Information/Authorization for Medicare and Medicaid Benefits:** I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act or under any other governmental health care program or from any other third-party payer is correct. Furthermore, I authorize anyone having medical or other information about me pertinent to my qualification for Medicare or Medicaid programs or benefits to release to and to secure from the Social Security Administration, the Nebraska Medical Assistance Program or to other agencies or entities administering the Medicare and Medicaid programs, or to intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf to the Practice, to the Clinicians, and to any other health care provider qualifying for reimbursement for such medical care and treatment, including consultations, provided to me.
3. **Financial Responsibility/Guarantee of Payment:** The undersigned authorizes, whether he/she signs as agent or as patient, billing by and direct payment to the Practice of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of the patient or the undersigned for these services at a rate not to exceed the Practice's regular charges. The term "insurance benefits" as used herein includes all insurance benefits including but not limited to health insurance, accident, worker's compensation benefits and motor vehicle insurance, casualty insurance, medical health coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for all charges. In consideration of goods and services provided, he/she gives the Practice an irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or in his/her behalf for services provided by the Practice or its employees and others working under an arrangement with the Practice. He/she directs all insurance companies, health plans, governmental agencies and programs and their agents or contractor, and attorneys to make such payment directly to the Practice. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient or the undersigned.

4. **Acknowledgement of/and Consent to Release of Information:** While I understand that my consent or authorization is not required to use and disclose my health care information for the following purposes and I acknowledge that such disclosure will occur, I also consent to such use and disclosure to:

   --Medical personnel or facilities for the purpose of providing treatment or evaluation of my condition;

   --any insurance company or third-party payer including governmental health care programs for utilization review purposes and for the purpose of processing my claim and obtaining payment of the account of the Practice and of the Clinicians for medical care and treatment provided to me.

   --to other entities as part of the payment activities of the Practice;

   --another health care provider for his/her payment activities;

   --to entities or persons to perform health care operations activities of the Practice such as, but not limited to, quality improvement, credentialing providers, medical review, general management and administrative activities; or

   --to another health care provided for limited use in health care operations including, but not limited to, its peer review of practitioners, credentialing of practitioners, training, accreditation and licensing activities and monitoring compliance with health care fraud and abuse laws.

5. **Acknowledgement of Receipt of Notice of Privacy Practices:**

   I have received a copy of the Notice of Privacy Practices and have indicated so by initialing here
   Patient's initials_____ Patient Representative's Initials _____

   Or

   The undersigned certifies that he/she a good faith effort to provide a Notice of Privacy Practices to the patient, but that the patient either was unable to or unwilling to acknowledge receipt of such Notice of Privacy Practice for the reason noted below:

   - Patient refused
   - Patient unable to sign because of medical condition
   - There was not a personal representative of the patient available to sign
   - Other (explain):_____

My signature below indicates that I have read this document or have had it read to me and that I (as the patient or the patient's representative) hereby accept and agree to the terms stated above.

_____	_____	_____
Signature of Patient, Relative or Legal Guardian	Date	Time
_____	_____	
If other than Patient, Relationship to Patient	Reason, if other than patient	
_____	_____	
Signature of Policy Holder/ Guarantor if other than Patient	Witness/Office Staff	

Rev 8.16.13

Release of Information

Malcom Behavioral Health

Clint P. Malcom, APRN BC
2315 West 39th Street, Suite 106
Kearney, NE 68845
Phone: 308-233-3847
Fax: 308-233-5921

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize release of records for: _____ _____
Patient Name Date of Birth

Between: Malcom Behavioral Health **And:** _____

2315 West 39th Street, Suite 106 _____

Kearney, NE 68845 _____

Phone (308)233-3847 Fax (308)233-5921 _____

To share the following information: (Please mark which items may be shared)

FROM: Malcom Behavioral Health

___ Discharge Summary
___ History/Pretreatment/Initial Assessment
___ Progress Notes
___ Medications
___ Verbal information
___ Other information

TO: Malcom Behavioral Health

___ Discharge Summary
___ History & Physical/Pretreatment Assess.
___ Psychological Report
___ Initial Evaluation/Progress notes
___ Verbal information
___ Other information

This information is to be used for the purpose of continuity of care.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked this consent will terminate one year from date signed.

I understand that my records may include drug and/or alcohol abuse information, which is protected under the Federal Confidentiality regulations (42 CFR, Part 2). Any further disclosure of my records other than what is outlined above is prohibited without my specific written consent, or as otherwise permitted by such regulations.

_____ _____ _____
Client Signature **Guardian Signature** **Date**

_____ _____
Guardian's Relationship to Client **Witness**

Privacy of Information Policies

Malcom Behavioral Health
Clint P. Malcom, APRN BC
2315 West 39th Street, Suite 106
Kearney, NE 68845
Phone: 308-233-3847
Fax: 308-233-5921

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 4-14-03

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, counseling session, or medication management session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints
If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the

_____Nebraska Dept. of Health and Human Services_____. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Malcom Behavioral Health

2315 W39TH ST., SUITE 106 KEARNEY, NE 68845

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signed by (please check one): ____Client ____Guardian ____Personal Representative

Signature: _____

Date: ____/_____/_____ (mm/dd/yyyy)