Cumberland Behavioral Care
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Patient Information Form - CHILD

Robert C Pennebaker, MSN, RN, PMHNP-BC, LCSW
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Ashley Clocher, MSW, LCSW
Haley Giles, LCMHC-A

Name (Last, First, Middle)				
Preferred Name				
Date of Birth and SSN				
Address 1				
Address 2				
City, State, Zip				
Home Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
Mobile Phone		Is it ok to text this number? Is it ok to leave a voicemail at this number?	❑ YES ❑ YES	❑ NO ❑ NO
Work Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
Other Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
EMAIL				
Administrative Sex	❑ MALE ❑ FEMALE			
Gender Identity	❑ MALE ❑ FEMALE ❑ TRANSGENDER ❑ CHOOSE NOT TO ANSWER			
Race	❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ ASIAN ❑ AFRICAN AMERICAN ❑ HISPANIC/LATINO ❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ WHITE ❑ CHOOSE NOT TO ANSWER			
Language Preferred				
Marital Status	❑ MARRIED ❑ SINGLE ❑ PARTNERSHIP ❑ WIDOWED ❑ DIVORCED ❑ SEPERATED			
Employment	❑ EMPLOYED ❑ FULL-TIME STUDENT ❑ PART-TIME STUDENT ❑ UNEMPLOYED / RETIRED			
Place of Employment/School				
Address				
City, State, Zip				

Insurance Information

Insurance Provider (Primary)			
Member/Subscriber ID		Group Number	
Sponsor's Information	Name	DOB	SS#
Insurance (Secondary)			
Member/Subscriber ID		Group Number	
Sponsor's Information	Name	DOB	SS#
Insurance (Tertiary)			
Member/Subscriber ID		Group Number	
Sponsor's Information	Name	DOB	SS#

Does the patient have Medicare? ❑ YES ❑ NO ID:

Please complete the portion below only if the patient is a minor

Primary Parent/Legally Responsible Person's Name	
Relationship to primary person named above	
Address (if different than child's address above)	
Contact Number (Home)	
Contact Number (Work)	
Contact Number (Mobile)	
Email	
Secondary Parent/Legally Responsible Person's Name	
Relationship to secondary person named above	
Address (if different than child's address above)	
Contact Number (Home)	
Contact Number (Work)	
Contact Number (Mobile)	
Email	

Pharmacy Name: _____ Phone: _____ Address: _____

If there is a custody order for this child, it must be presented on the first visit.
A legally responsible adult must remain on site with minor children during treatment.

Updated 5/3/2024

Questions for all patients, regardless of age.	
Reason for seeking treatment. (i.e., anxiety, depression, suicidal, self-harm, substance abuse, developmental disability, marital problems, etc.)	
Were you referred to our practice?	
If so, by whom?	
Does anyone have power of attorney regarding your health care?	
If yes, please explain.	
Have you received mental health services from another provider within the last year?	
If so, from whom? (Provider & Clinic)	
Address of provider?	
Check any of the following that you have completed within the last 2 years.	❑ PSYCHOLOGICAL TESTING ❑ PSYCHIATRIC EVALUATION ❑ PSYCHIATRIC HOSPITALIZATION ❑ INDIVIDUALIZED EDUCATION PLAN (IEP)
If you checked any boxes above, please list the provider information.	
Are there any current legal issues/court involvement (i.e., adoption, custody, separation/divorce, open CPS case, etc.)?	

CONSENT TO TREAT AND PARTICIPATE IN TREATMENT AND ASSESSMENTS

On behalf of myself, or the consumer if a minor, I hereby consent and agree to the following conditions of participation in Clinical assessment and treatment with providers of Robert C Pennebaker, PLLC dba Cumberland Behavioral Care ("Practice"):

VOLUNTARY PARTICIPATION: ***I voluntarily consent to participate in such counseling services as may be deemed necessary and appropriate by the staff of this Practice***. I understand that I will be kept informed of plans for my treatment and may withdraw my consent in writing at any time. I am aware that the practice of Professional Counseling is not an exact science and I acknowledge that no guarantees have been made to me as to the outcomes of Clinical assessments and treatments.

CONFIDENTIALITY: ***I give permission for the office staff of this Practice to provide clinical information to my insurance company or its designee, at their request, for the purpose of justifying my need for assessment/treatment and/or continued assessment treatment.*** Other verbal or written information regarding my treatment is protected by Federal law and regulations and may be released only with my specific written consent to qualified personnel for research, audit or evaluation purposes, when in the opinion of clinic staff, there is a medical emergency and release of information would be in my behalf, aid in my treatment, or protect the safety of myself and/or others or by court order.

Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

FOLLOW-UP PROTOCOL: ***I agree that the office staff members of this Practice may call or write if I fail to keep an appointment in order to assess my need for further treatment.*** I also agree that the office staff members of this practice may contact me via letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services I received at this practice.

Should you need emergency psychiatric services after the normal operating hours of this practice, you can call 9-1-1 or the nearest after-hours emergency service. Our Crisis Line can be reached by calling (910) 977-1396.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE OF SIGNATURE

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

Mental Health Questionnaire			
Please complete the *current symptom* checklist. **One** check for any symptom; **two** checks for major symptom.			
❑❑ Depressed Mood	❑❑ Racing Thoughts	❑❑ Excessive Worry	❑❑ Unable to Enjoy Activities
❑❑ Impulsivity	❑❑ Anxiety Attacks	❑❑ Increased Risky Behavior	❑❑ Sleep Pattern Disturbance
❑❑ Avoidance	❑❑ Fatigue	❑❑ Loss of Interest	❑❑ Increased Libido
❑❑ Hallucinations	❑❑ Crying Spells	❑❑ Concentration/Forgetful	❑❑ Decreased Need to Sleep
❑❑ Suspiciousness	❑❑ Excessive Energy	❑❑ Change in Appetite	❑❑ Increased Irritability
❑❑ Excessive Guilt	❑❑ Decreased Libido	❑❑ Other:	

Medical History			
❑ **Allergies** *(please list allergy and reaction)*			
Current Weight		Current Height	
Have you ever had an EKG? ❑ Yes ❑ No		If so, what was the approximate date?	
Was the EKG….	❑ Normal	❑ Abnormal	❑ Unsure
Please List ***ALL*** Current Medications including strength and dosage (Ex. Amitriptyline 10mg 1 tablet at night)			
Current Medical Problems & Surgeries (list dates for Surgeries)			
For Women Only			
Last Menstrual Period _____ /_____ /_____		Are you pregnant or planning to become pregnant? ❑ Yes ❑ No	
Birth Control Method			
How many times have you been pregnant?		Number of Live Births?	

Personal and Family Medical History						
Condition	You	Family		Condition	You	Family
Thyroid Disease				Epilepsy or Seizures		
Anemia				Chronic Pain		
Liver Disease				High Cholesterol		
Chronic Fatigue				High Blood Pressure		
Kidney Disease / Problems				Head Trauma		
Diabetes				Asthma / Respiratory Problems		
Stomach / Intestinal Problems				Cancer		
Fibromyalgia				Heart Disease / Problems		

If you checked any of the above boxes in Personal and Family Medical History, please elaborate here. Also, add any additional pertinent medical history in which we should be made aware.

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

Personal and Family Medical History (cont.)			
Family Psychiatric History			
Has anyone in your family ever been treated for…	If yes, who?	YES	NO
Bipolar Disorder?			
Schizophrenia?			
Depression?			
Post-Traumatic Stress Disorder (PTSD)?			
Anxiety?			
Alcohol Abuse?			
Anger Issues?			
Other Substance Abuse?			
Suicide / Homicide Tendencies?			
Violence?			

Personal Psychiatric History		
Have you ever…		
had outpatient treatment?	YES	NO
experienced psychiatric hospitalization?	YES	NO
been treated for alcohol abuse?	YES	NO
If yes, when and where?		
been treated for drug abuse?	YES	NO
If yes, when and where?		

Substance Use (Past and Present)			
How many days per week do you drink any alcohol?			
What is the LEAST number of drinks you have in one day?			
What is the MOST number of drinks you have in one day?			
Have you ever felt that you should "cut down" on your drinking or drug use?		YES	NO
Have people annoyed you or criticized you about your drinking or drug use?		YES	NO
Have you ever felt bad or guilty about your drinking or drug use?		YES	NO
Do you feel that you may have an alcohol or drug problem?		YES	NO
Have you used any "street drugs" in the past 3 months?		YES	NO
If so, what kind(s)?			
Have you ever abused prescription medication?		YES	NO
If so, what kind(s)?			
Have you ever smoked cigarettes?		YES	NO
Do you currently smoke cigarettes?		YES	NO
If yes, how many packs (on average) per day?			
How many years have you been smoking cigarettes?			
Do you use (or have you ever used) a pipe, cigars, or chewing tobacco?		CURRENTLY	IN PAST
If current, which one(s)?			
How often, per day, on average?			
How many years?			

Have you ever tried ANY of the following…

Methamphetamine	Y	N	LSD or Hallucinogens	Y	N	Tranquilizers	Y	N
Cocaine	Y	N	Marijuana	Y	N	Methadone	Y	N
Stimulants (pills)	Y	N	Ecstasy	Y	N	Pain Killers (without Rx)	Y	N
Heroin	Y	N	Alcohol	Y	N	Other (list below)	Y	N

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

Psychiatric Medication History
If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were. (Even if you cannot remember all of the details, please list all information that you can remember)
Antidepressants
Prozac (fluoxetine)
Zoloft (sertraline)
Luvox (fluvoxamine)
Paxil (paroxetine)
Celexa (citalopram)
Lexapro (escitalopram)
Effexor (venlafaxine)
Cymbalta (duloxetine)
Wellbutrin (bupropion)
Remeron (mirtazapine)
Anafranil (clomipramine)
Elavil (amitriptyline)
Mood Stabilizers
Tegretol (carbamazepine)
Lithium
Depakote (valproate)
Lamictal (lamotrigine)
Topamax (topiramate)
Antipsychotics/Mood Stabilizers
Seroquel (quetiapine)
Zyprexa (olanzepine)
Geodon (ziprasidone)
Abilify (aripiprazole)
Clozaril (clozapine)
Haldol (haloperidol)
Prolixin (fluphenazine)
Risperdal (risperidone)
Sedative/Hypnotics
Ambien (zolpidem)
Sonata (zaleplon)
Rozerem (ramelteon)
Restoril (temazepam)
Desyrel (trazodone)
ADHD Medications
Adderall (amphetamine)
Concerta (methylphenidate)
Ritalin (methylphenidate)
Strattera (atomoxetine)
Anti-Anxiety Medications
Xanax (alprazolam)
Ativan (lorazepam)
Klonopin (clonazepam)
Valium (diazepam)
Tranxene (clorazepate)
Buspar (buspirone)

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

REVIEW OF SYMPTOMS

Please check the box if you are *currently* having any of the symptoms listed below.

General	**Eyes**	**Mouth**	***Women Only***
❑ Fever	❑ Vision Problems	❑ Sores in Mouth	❑ Pre-eclampsia or High Blood Pressure in Pregnancy
❑ Chills	❑ Double Vision	❑ Dry Mouth	
❑ Weight Gain	❑ Red Eye or Pink Eye	❑ Dental Problems	❑ History of Miscarriage
❑ Weight Loss	❑ History of Pink Eye as an Adult	❑ Loss of Taste	❑ Vaginal Discharge
❑ Night Sweats		❑ Difficulty Swallowing	❑ Vaginal Dryness
❑ Fatigue	❑ Eye Pain	❑ Bleeding Gums	❑ Vaginal Ulcers
❑ Weakness	❑ Dry Eyes	❑ Sore Throat	***Men Only***
Endocrine	❑ Sandy, Gritty Eyes	❑ Hoarseness in Voice	❑ Penile Discharge
❑ Cold Intolerance	**Ears**	**Allergies**	❑ Penile Ulcers
❑ Heat Intolerance	❑ Hearing Loss	❑ Frequent Sneezing	❑ Prostate Trouble
❑ Excessive Thirst	❑ Earache	❑ Seasonal Allergies	❑ Erectile Dysfunction
❑ Excessive Urination	❑ Ear Pain	❑ Increased Infections	**Blood / Lymph**
❑ Excessive Sweating	❑ Swelling in the Ear	**Lungs**	❑ Swollen Lymph Nodes (status post biopsy)
❑ Flushing	❑ Red Ears	❑ Shortness of Breath	
Skin	❑ Floppy Ears	❑ Coughing	❑ Blood Clots
❑ Rash (purple or red)	❑ Ringing in the Ears	❑ Coughing Blood	❑ Bleeding Tendency
❑ Spots / Pigment Change	❑ Drainage from Ears	❑ Wheezing	❑ Bruising
❑ Hair Loss	❑ Vertigo	❑ Chest Pain with Breathing / Pleurisy	❑ Blood Transfusions
❑ Thickening of Skin	**Nose**		**Psychology**
❑ Tightening of Skin	❑ Runny Nose	**GI / Abdomen**	❑ Depression
❑ Calcium Deposits	❑ Nasal Congestion	❑ Abdominal Pain	❑ Anxiety / Panic Attacks
❑ Fingers/toes Turn Colors in the Cold / Heat	❑ Nose Bleeds	❑ Heartburn	❑ Insomnia / Disturbed Sleep
	❑ Deformity of Nose	❑ Nausea	
❑ Nodules	❑ Swelling of the Nose	❑ Vomiting	❑ Waking Unrefreshed
❑ Psoriasis	❑ Red Nose	❑ Difficulty Swallowing	❑ High Stress Level
❑ Nail Problems	❑ Dry Nose	❑ Diarrhea	**Other**
❑ Dry Skin	❑ Nose Sores	❑ Constipation	❑
Neurologic	❑ Loss of Smell	❑ Blood in Stools	
❑ Migraines	❑ Sinusitis	❑ Black, Sticky Stools	❑
❑ Headaches	**Heart**	❑ Mucus in Stools	
❑ Numbness / Tingling	❑ Chest Pain	❑ Jaundice	❑
❑ Muscle Weakness	❑ Awakened by Shortness of Breath	❑ History of Food Poisoning	
❑ Incontinence			❑
❑ Seizures	❑ Irregular / Rapid Heart	**Urology**	
❑ Muscle Cramps	❑ Lightheadedness	❑ Pain / Burning with Urination	❑
❑ Difficulty Thinking or Remembering	❑ Sleep on 2+ pillows due to Shortness of Breath		
		❑ Difficulty Urinating	❑
Scalp / Head	❑ Leg/Ankle Swelling	❑ Urinary Incontinence	
❑ Hair Loss	❑ Color Changes in Legs/Feet	❑ Cloudy Urine	❑
❑ Scalp Tenderness	❑ Leg Cramps with Walking	❑ Blood in Urine	
❑ Headache	❑ Heart Murmur	❑ History of Sexually Transmitted Disease(s)	❑
❑ Jaw Pain with Chewing	❑ Stabbing Pain / Pericarditis		

Explanation to any of the above if necessary:

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ◯ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____

	Not At All	Several Days	More than Half the Days	Nearly Every Day
① Little interest or pleasure in doing things	0	1	2	3
② Feeling down, depressed, or hopeless	0	1	2	3
③ Trouble falling or staying asleep, or sleeping too much	0	1	2	3
④ Feeling tired or having too little energy	0	1	2	3
⑤ Poor appetite or overeating	0	1	2	3
⑥ Feeling bad about yourself – maybe that you are a failure or have let yourself or your family down	0	1	2	3
⑦ Trouble concentrating on things such as reading or watching television	0	1	2	3
⑧ Moving or speaking slowly so that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot or more than usual.	0	1	2	3
⑨ Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.	0	1	2	3
		+	+	
		(Total)	(Total)	(Total)
Total Score				

⑩ If you checked any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

ANXIETY QUESTIONNAIRE (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ⓧ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____

	Not At All	Several Days	More than Half the Days	Nearly Every Day
① Feeling nervous, anxious, or on edge	0	1	2	3
② Not being able to stop or control worrying	0	1	2	3
③ Worrying too much about different things	0	1	2	3
④ Trouble relaxing	0	1	2	3
⑤ Being so restless that it is hard to sit still	0	1	2	3
⑥ Becoming easily annoyed or irritable	0	1	2	3
⑦ Feeling afraid, as if something might happen	0	1	2	3
		+	+	
		(Total)	(Total)	(Total)
	Total Score			

⑧ If you checked any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ❑ Not difficult at all
- ❑ Somewhat difficult
- ❑ Very difficult
- ❑ Extremely difficult

Patient Name _____ Self-Evaluation Form Patient DOB _____

SNAP IV (Teacher and Parent Rating Scale)

For each item, select the box that best describes the child. Put only one check per item.	**Date of Completion**	_____ / _____ / 20____

Age:	Grade:	Period of Time Covered by Rating: ❑ Past Week ❑ Past Month ❑ Past Year ❑ Lifetime

For **Teachers Only**	Completed by:	Type of Class:	Class Size:
For *Parent(s) Only*	Completed by:	# Parents living in home:	Family Size:

1	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	0	1	2	3
2	Often has difficulty sustaining attention in tasks or play activities	0	1	2	3
3	Often does not seem to listen when spoken to directly	0	1	2	3
4	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties	0	1	2	3
5	Often has difficulty organizing tasks and activities	0	1	2	3
6	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (ex. schoolwork or homework)	0	1	2	3
7	Often loses things necessary for tasks or activities (ex. toys, school assignments, pencils, books, or tools)	0	1	2	3
8	Often is distracted by extraneous stimuli	0	1	2	3
9	Often is forgetful in daily activities	0	1	2	3
10	Often fidgets with hands or feet or squirms in seat	0	1	2	3
11	Often leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12	Often runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
13	Often has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14	Often is “on the go” or often acts as if “driven by a motor”	0	1	2	3
15	Often talks excessively	0	1	2	3
16	Often blurts out answers before questions have been completed	0	1	2	3
17	Often has difficulty awaiting turn	0	1	2	3
18	Often interrupt or intrudes on others (ex. butts into conversations/games)	0	1	2	3
			+	+	
			(Total)	(Total)	(Total)
	Total Score				

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

SUBSTANCE ABUSE RISK (ORT)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ◯ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____

		Place a "✓" if the statement applies	FEMALES ONLY	MALES ONLY
① Family History of Substance Abuse	Alcohol	❑	1	3
	Illegal Drugs	❑	2	3
	Prescription Drugs	❑	4	4
② Personal History of Substance Abuse	Alcohol	❑	3	3
	Illegal Drugs	❑	4	4
	Prescription Drugs	❑	5	5
③ Age (Mark the box if 16-45 years old)		❑	1	1
④ History of Preadolescence Sexual Abuse		❑	3	0
⑤ Psychological Disease	Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia	❑	2	2
	Depression	❑	1	1
			+	
			(Total)	(Total)
	Total Score			

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Patient Name _____ **Self-Evaluation Form** Patient DOB _____

ALCOHOL SCREENING QUESTIONNAIRE (AUDIT)

One Drink Equals:	**Date of Completion**	_____ / _____ / 20____			
 **Beer** 12 oz  **Wine** 5 oz  **Liquor** 1.5 oz	0 points	1 point	2 points	3 points	4 points
① How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4 or more times a week
② How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7-9	10 or more
③ How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
④ How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑤ How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑥ How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑦ How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑧ How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑨ Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
⑩ Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, in the last year
		+ (Total)	+ (Total)	+ (Total)	(Total)
	Total Score				

Patient Name _____ **Consent Form** Patient DOB _____

Consent for Treatment and Assessment

On behalf of myself, or the consumer if a minor, I hereby consent and agree to the following conditions of participation in Clinical assessment and treatment:

1. VOLUNTARY PARTICIPATION: I voluntarily consent to participate in such counseling services as may be deemed necessary and appropriate by the staff of this Agency. I understand that I will be kept informed of plans for my treatment and may withdraw my consent in writing at any time. I am aware that the practice of Professional Counseling is not an exact science and I acknowledge that no guarantees have been made to me as to the outcomes of Clinical assessments and treatments.

2. CONFIDENTIALITY: I give permission for the office staff of this Agency to provide clinical information to my insurance company or its designee, at their request, for the purpose of justifying my need for assessment/ treatment and/ or continued assessment treatment. Other verbal or written information regarding my treatment is protected by Federal law and regulations and may be released only with my specific written consent to qualified personnel for research, audit or evaluation purposes, when in the opinion of clinic staff, there is a medical emergency and release of information would be in my behalf, aid in my treatment, or protect the safety of myself and/or others or by court order. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

3. FOLLOW-UP PROTOCOL: I agree that the office staff members of this Agency may call or write if I fail to keep an appointment in order to assess my need for further treatment. I also agree that the office staff members of this Agency may contact me via letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services I received at this Agency.

Should you need emergency psychiatric services after the normal operating hours of this Agency, you can call 9-1-1 or the nearest after-hours emergency service. Our Crisis Line can be reached by calling (910) 977-1396.

Patient Signature: _____ Date: _____

Authorization to Pay

Payment for services to this Agency is due when services are provided. As a courtesy to our clients and families, we will bill your insurance company in accordance with information you provide to us. It is your responsibility to keep our staff informed of any changes to your insurance coverage. You are obligated to pay any deductible or any co-pay required under your insurance plan, at the time of service.

Charges are based on the type of service provided to you. If additional time or services (such as telephone sessions) are provided, a pro-rated fee will be charged. You remain legally responsible for all charges. Below, are a list of common services and fees that clients may encounter. Your provider will discuss these fees with you at the time of the request.

Letters/Reports for your insurance company or another agency	up to $ 50.00 per hour
Court related costs-letters, testimony, forensic reports, etc. (Costs for testifying include travel time “door-to-door”)	up to $175.00 per hour
Services that are not covered by your insurance company (Certain types of testing, phone sessions, etc.)	up to $150.00 per hour

You may be charged for missed appointments. With sufficient notice, an appointment can generally be rescheduled. Failure to give 24-hour notice of cancellation may result in a “NO SHOW” charge of up to $75.00. Note: Per CMS rules, Medicaid recipients will not be charged “no show” fees, but will be responsible for all other fees/charges that are contractually agreed to. If the consumer has only Medicaid coverage, there is no co-payment or co-insurance requirements. However, if Medicaid does not cover the services, the consumer will be financially responsible for services received. If the consumer has coverage under NC Health Choice, a co-payment may be required based on NC Health Choice Guidelines. I authorize payment directly to this Agency. I agree to be fully responsible for all lawful debts incurred by myself or my legal dependents listed above for services received from this Agency whether covered by insurance or not. I authorize the release of any information necessary to process claims on my behalf or on the behalf of my legal dependent listed in this Registration Packet. I further understand

that I am responsible for any co-pay, co-insurance, and/or deductible amount as per my particular insurance coverage on my account, and I understand that, although my claims are filed, it is not a guarantee of payment for services. Changes in my insurance coverage will be reported immediately.
For DSS Workers only: For treatment of minors in DSS custody, DSS will not be held financially responsible for costs not covered by insurance.

Patient Signature: _____ **Date**: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**
This Agency uses an EHR, which allows providers to use information more effectively to improve the quality and efficiency of your care, but EHRs will not change the privacy protections or security safeguards that apply to your health information. EHRs and Your Health Information EHRs are electronic versions of the paper charts in your doctor's or other health care provider's office. The federal government put in place the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to ensure you have rights over your own health information, no matter what form it is in. The government also created the HIPAA Security Rule to require specific protections to safeguard your electronic health information. A few measures that have been built into our EHR system include: "Access control" tools like passwords and PIN numbers, to help limit access to your information to authorized individuals. "Encrypting" your stored information. That means your health information cannot be read or understood except by those using a system that can "decrypt" it with a "key." An "audit trail" feature, which records who accessed your information, what changes were made and when.

You have the right to:
•Get a copy of your paper or electronic medical record
•Correct your paper or electronic medical record
•Request confidential communication
•Ask us to limit the information we share
•Get a list of those with whom we've shared your information
•Get a copy of this privacy notice
•Choose someone to act for you
•File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:
•Tell family and friends about your condition
•Provide disaster relief
•Include you in a hospital directory
•Provide mental health care
•Market our services
•Raise funds

We may use and share your information as we:
•Treat you
•Run our organization
•Bill for your services
•Help with public health and safety issues
•Do research
•Comply with the law
•Respond to organ and tissue donation requests
•Work with a medical examiner or funeral director

Notice of Privacy Practices (cont)

•Address workers' compensation, law enforcement, and other government requests
•Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
•You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
•We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
•You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.
•You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
•You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
•If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
•You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

•If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
•You can complain if you feel we have violated your rights by contacting us using the information provided.
•You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
•We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
•Share information with your family, close friends, or others involved in your care
•Share information in a disaster relief situation
•Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:
•Marketing purposes
•Sell patient information
•Most sharing of psychotherapy notes

In the case of fundraising:
•We may contact you for fundraising efforts, but you can tell us not to contact you again.

Notice of Privacy Practices (cont)

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.
- We can change the terms of this notice, and the changes will apply to all information we have about you. A copy of new practices will be made available to you upon request or in our office.

Patient Signature: _____ **Date**: _____

2931 Breezewood Drive
Suite 104
Fayetteville, NC 28304
P: (910) 491-1134
F: (910) 491-1332

Authorization to Release Protected Health Information

Patient Name: _____

Patient Chart Number: _____

Date of Birth: _____ / _____ / _____

Telephone Number: _____

I hereby authorize the release of my health information from:
Robert C Pennebaker, PLLC dba Cumberland Behavioral Care • 2931 Breezewood Avenue, Ste. 104 • Fayetteville, NC 28303 • (P) 491-1134

To:

	Legal Name	Relationship	Phone/Contact Number
1.		SELF	
2.			
3.			
4.			
5.			

I understand that my medical records may contain information from other facilities that may be sent out when requested. By signing this authorization to release personal health information you are granting Cumberland Behavioral Care permission to re-disclose records we have obtained from other facilities.

The Practice is required to respond to you within (30) days of your request to inform you whether it will agree to your request or to inform you if the Practice needs more time to respond to your request.

Pursuant to the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to request that CUMBERLAND BEHAVIORAL CARE (the "Practice") provide you with access to your protected health information. The Practice is not obligated to agree with your request in certain instances, including if (i) access to the information raises safety concerns, (ii) access to the information is limited by state law or court order, (iii) the PHI consists of psychotherapy notes, (iv) the PHI was compiled by the Practice or one of the Practice's Business Associates in anticipation of or for use in a legal proceeding, (v) the PHI was obtained from someone other than a covered health care provider under a promise of confidentiality and access would likely reveal the source of the information, or (iv) the PHI was created or obtained by a covered health care provider in the course of research and the individual consented to the denial of access when consenting to participate in the research. (v) CBC may not condition treatment, payment, enrollment or eligibility on signing the authorization.

I understand and authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric conditions and/or communicable diseases including Acquired Immunodeficiency Syndrome (AIDS) or tests for infection with Human Immunodeficiency Virus (HIV), if present.

I understand that I may take back/cancel this authorization at any time, except to the extent that action based on the authorization has been taken. This authorization will expire automatically one year from the date signed. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I fully understand this authorization and it is made voluntarily on my part.

_____ _____

Signature of Patient or Legal Representative Date

What is your Relationship to the Patient? ❑ Self ❑ Legal Representative ❑ Other _____

Do you have Medical Power of Attorney if needed for this patient or custody papers if you are not the legal parent?
❑ YES (Please provide us with a copy) ❑ NO

_____ _____

Signature of Witness Date

** RECORDS MAY NOT BE IMMEDIATELY AVAILABLE*
** THERE MAY BE A CHARGE FOR COPIES*

❑ RELEASED AT TIME OF REQUEST ❑ PICTURE ID CHECKED

For Office Use Only
Information Released

Date _____

Initials _____

Name: **DOB:** **Insurance ID:**

The following page is the signature page for your therapy treatment plan. Please DO NOT date the signature. Due to the use of electronic records, this is used to assist with telehealth signature capture. The plan will be dated when you develop and complete plan with your therapist. Thank you and have a great day!

Cumberland Behavioral Care administrative staff

Name: **DOB:** **Insurance ID:**

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this Treatment Plan. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this Treatment Plan.

Legally Responsible Person: Self: Yes ☐ No ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ _____ Date: __/__/____
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: __/__/____
(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE TREATMENT PLAN: The following signature confirms the responsibility of the LP for the development of this Treatment Plan. The signature indicates agreement with the services/supports to be provided.

Signature: _____ _____ Date: __/__/____
(Person responsible for the Treatment Plan) (Print Name)