MarillacHealth
Committed to a healthier you.

Patient Registration/Update Form

Patient Label

Today's Date _____

Patient Information

Patient Last Name _____ **First** _____ **Middle** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____ **Social Security #** _____ **Email Address** _____

Home Phone _____ **Cell Phone** _____

Marital Status (Circle One) Divorced Domestic partner Legally separated Married
Significant other Single Unknown Widowed Other

Emergency Contact and Parent/Legal Guardian

Emergency Contact Name _____ **Phone** _____ **Relation** _____

Parent/Guardian (If Applicable)

Last Name _____ **First** _____ **Middle** _____

Home Phone _____ **Cell Phone** _____

Social Security # _____ **Date of Birth** _____ **Relation** _____

Legal Sex (Circle One) Female Male Nonbinary Unknown

Sexual Orientation (Circle One) Straight/Heterosexual Bisexual Lesbian Pansexual Queer
Gay Omnisexual Asexual Don't know Choose not to disclose Something else

Gender Identity (Circle One) Female Male Transgender female Transgender male
Questioning X Choose not to disclose Non-binary/Genderqueer Other
Two-Spirit

2333 N. 6th St. Grand Junction, CO 81501
2139 N. 12th St., Ste. 2 Grand Junction, CO 81501
510 29 ½ Rd. Grand Junction, CO 81504

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Pronouns (Circle One) she/her/hers he/him/his they/them/theirs ey/em/eirs ze/hir/hirs
xe/xem/xyrs ve/vir/vis Other Decline to answer Unknown

Race (Circle One) Alaskan Native American Indian Black/African-American
White/Caucasian Native Hawaiian Pacific Islander Patient refused Unknown

Ethnicity (Circle One) Hispanic or Latino/a Non-Hispanic or Latino/a Unknown Other

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Household Status (Circle One) Not homeless At risk for homeless Transitional housing
Child at risk for homeless Currently not homeless, was in last 12 months Living in shelter
Homeless Unknown Shelter Living with others Permanent supportive housing
Single-Occupancy Hotel Street, Camp, Bridge Veteran at Risk for Homeless

***Family Size _____ ***Household Income $_____ (Annual)

***Please note – This does not replace our Sliding Fee Application for Sliding Fee Discount. If you would like to apply for our sliding fee discount, please inquire with one of our team members to apply.

Seasonal or Migrant Worker (Circle One) Yes No

Employment Status (Circle One) Full-time Not employed On active military duty Child
Part-time Retired Seasonal Self-employed Student full-time
Student part-time Unemployed due to disability Unknown

Insurance Information

Primary Insurance _____ **Subscriber's Name**_____ **Date of Birth**_____

Subscriber's SSN _____ **Group #** _____ **Member ID #** _____

Co-payment $_____ **Relationship to Subscriber** _____

Secondary Insurance _____**Subscriber's Name** _____ **Date of Birth** _____

Subscriber's SSN _____ **Group #** _____ **Member ID #** _____

Co-payment $ _____ **Relationship to Subscriber** _____

Patient/Parent/Legal Guardian Signature_____**Date**_____

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Verbal Communication Consent

Patient Label

Patient Last Name _____ **First** _____ **Middle** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security #_____ **Date of Birth** _____ **Phone number** _____

Verbal Disclosure

I authorize MarillacHealth to leave messages regarding medical information pertaining to my care by the following methods and will assume responsibility to notify Marillac Health when the information changes. (Check all that apply.)

Home Phone _____ Work Phone _____ Cell Phone _____ Voicemail/Answering Machines _____

Disclosure to other persons

I authorize Marillac Health to speak with the following individual(s) regarding my current care and treatment:

Name _____Relation _____Phone #_____

Name _____Relation _____Phone #_____

Name_____Relation _____Phone #_____

All health information, including billing, may be communicated to the above listed individuals except for the following:

Diagnosis or reference to behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS); human immunodeficiency virus (HIV); sexually transmitted infection (STI); or drug and/or alcohol abuse.

This authorization will automatically expire 1 year from the date signed below unless I request an expiration date less than one (1) year.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.

Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.

My signature is required to validate this authorization. If I do not sign this authorization Marillac Health will still provide treatment and seek payment for services provided. According to State Statures, this care site may change for copies of medical records.

Patient or Parent/Legal Guardian Signature_____ Date _____

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Behavioral Health Disclosure

Patient Name: _____ DOB: _____

As a patient of MarillacHealth, you may be offered behavioral health services and we are disclosing information on our providers and their credentialing. Each of these providers may be reached at the following business address and phone number: 2333 N. 6th Street, Grand Junction, CO 81501, 970-200-1600.

CREDENTIALS
Ned Becker is a Licensed Professional Counselor in the state of Colorado. He received his Master's Degree in Counseling in 1994.
Brandi Byars is a Licensed Clinical Social Worker. She received her Master's Degree in Social Work in 2019 from University of Denver.
Steven Martinez is a Licensed Addiction Counselor and Licensed Clinical Social Worker in the state of Colorado. He received his Master's Degree in Social Work from University of Denver in 2019.
Connie Mercer-Cogburn is a Licensed Professional Counselor in the state of Colorado. She received her Master's Degree in Clinical Mental Health from Adams State University in 2017.
S. Rod Pyland is a Licensed Clinical Social Worker in the state of Colorado. He received his Master's Degree in Social Work from University of Denver in 1978. Acupuncture Detoxification Specialist (Registered Trainer) 2014.
Andrew Rossway is a Licensed Professional Counselor in the state of Colorado. He received his Master's Degree in Clinical Mental Health Counseling from Northern Arizona University in 2017.
CREDENTIALING
1. A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. 2. A Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. 3. A Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

The practice of licensed or registered persons in psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Registered Psychotherapist Examiner can be reached at (303)894-7800.

CLIENT'S RIGHTS: If you receive these services, you are entitled to receive information from the therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies, Division of Registrations, Mental Health Section. Your therapist will attend to any concern or complaint that you may have about psychotherapy. Another option is to contact the Mental Health Grievance Board.

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Behavioral Health Disclosure

Confidentiality: The information provided by you during therapy sessions is legally confidential. There are exceptions to this confidentiality, some listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA (Health Insurance Portability and Accountability) Notice of Privacy Rights available at the front desk. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental health Practice Act (CRS 12-43-101, et seq.) is available at https://dpo.gove/ProfessionalCounselor/Laws

- The counselor has an obligation to report "in good faith" any suspected child abuse or neglect to the appropriate departments of human services and/or law enforcement agency.
- The counselor must notify the proper authorities when a client/patient communicates a serious and imminent threat to harm him/herself or another person and refuses to seek treatment voluntarily.
- The counselor may disclose client information if the client makes or creates an articulable and significant threat against a school or occupants of a school.
- The counselor may disclose client information in response to a Grievance Board Inquiry.
- The counselor may disclose client information to respond to a lawsuit or complaint made against the counselor regarding the care or treatment of the client.
- A court in Colorado with competent authority may order the release of confidential client/patient information.
- If you are participating in counseling services in a medial setting, we claim the right of the counselor to discuss your case with other clinic staff as needed for continuity of care. By signing this form, you agree to have your therapy records kept in the agency's outpatient medical record. Client records may not be maintained after seven years pursuant to section 12-245-+226(1)(a)(II)(A) of the Colorado Revised Statutes.

I acknowledge this Behavioral Health disclosure, and I understand my rights as a patient or as the patient's responsible party if I receive these services.

Patient/Signature: _____ **Date**: _____

Parent or Guardian's Signature: _____ **Date:** _____

Relationship to Patient: _____

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Medical/Social Health History Questionnaire

(Not For Scanning)

Today's Date _____

Patient Last Name _____ DOB _____

Family History

Relationship	Health Problem	Age at Onset	Living Status
Mother			__ Alive __ Deceased
Father			__ Alive __ Deceased
Sister			__ Alive __ Deceased
Brother			__ Alive __ Deceased
Daughter			__ Alive __ Deceased
Son			__ Alive __ Deceased
Maternal Grandmother			__ Alive __ Deceased
Maternal Grandfather			__ Alive __ Deceased
Paternal Grandmother			__ Alive __ Deceased
Paternal Grandfather			__ Alive __ Deceased

Patient History

E-Cigarettes/Vaping (Circle one) Current Every-Day User Current Some-Day User Never Use

Former User Never assessed User-Current Status Unknown Unknown if Ever Used

E-Cigerette/Vaping Substance (Circle all that apply) Nicotine THC CBD Flavoring Other

Please list "Other" _____

E-Cigarettes/Vaping Devices (Circle all that apply) Disposable Pre-filled or Refillable Cartridge

Refillable Tank Other (Please list) _____

Tobacco Smoking (Circle one) Never Former Every Day Some Days Unknown

Smokeless (Circle one) Never Former Current Unknown

Passive Exposure (Second-hand smoke) (Circle One) Never Past Current

Would you like counselling on tobacco cessation? Yes No

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Medical/Social Health History Questionnaire

Alcohol

Do you drink Alcohol? Yes Not Currently Never

Drinks per Week? Glasses of Wine ___ Cans of Beer ___ Shots of Liquor ___ Drinks containing .05 oz of Alcohol ___

Did/do you ever drink excessively? Yes No Do you ever drive after drinking? Yes No

Drug Use (Circle one) Yes, Currently Not Currently Never **How many times per week?**_____

Types (Circle all that apply) Vaping Marijuana Opioids Heroin Methamphetamine

Amphetamines PCP ecstasy LSD Ketamine Mescaline Psilocybin Cocaine

Crack Nitrous Oxide Solvent Inhalants Barbiturates IV Other

Caffeine Intake

Do you drink/take caffeine? Yes No Number of cups/cans or amount taken per day? ____

Pharmacy Please list the name of your preferred pharmacy _____

Current Issues Please list all current medical and mental health issues.

Issue	Onset

Surgeries Please list all previous surgeries and/or procedures.

Surgery	Reason	When/Where

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Medical/Social Health History Questionnaire

Allergies Please list all allergies (medications, food, bee stings, etc.) and how they affect you.

Allergy	Reaction

Medications Please list all current medications that you are taking including over-the-counter medications.

Name	Strength	Frequency

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