

IF A US FEDERAL INCOME TAX RETURN HAS NOT BEEN FILED FOR THE PREVIOUS CLAENDAR YEAR AND/OR WILL NOT BE FILED FOR THE CURRENT YEAR, I DO HEARBY SWEAR THAT MY ANNUAL INCOME IS BELOW THE LEGAL LIMIT FOR FILING FOR LAST YEAR AND IS ANTICIPATED TO REMAIN BELOW THE LEGAL LIMITS THIS CURRENT YEAR.

Client Signature

Date

Third party payors:

I do hereby certify that I have no third party capability; therefore I am responsible for all charges for services provided to me.

Client Signature

Date

I do hereby certify that I accept responsibility for all charges provided to the above client

Responsible Individual Signature

Date

Demographic Information

Sex: M F Race: White African/American Spanish/American Asian/American American Indian Other
Marital Status: Single Married Divorced Widowed Separated Unknown Other
Grade in School: _____
School: _____
Legal Guardian: _____

MEDICAL RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process **Medicare, Medicaid, Champus/VA, or**

Private insurance claims for _____ for services provided to
(Client's Name)
them with a starting date of _____ and request payment of benefits to:
(Admission Date/Update)

***BERKELEY COMMUNITY MENTAL HEALTH CENTER
P.O. BOX 1030
MONCKS CORNER, SC 29461***

Client's Signature (authorized person)
REV: BCMHC 9/06/07

Witness

CONSENT TO EXAMINATIONS AND TREATMENT

Consent and authority is hereby given to this mental health facility and its professional staff to perform or have performed examinations and / or psychotherapy and / or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

Witness

Signature of Patient

Date

Signature of Parent or Legal Guardian

I have been provided copies of the SCDMH Notice of Privacy Practices and Client Rights and an opportunity to ask questions:

(If not signed, staff to state reason on line and initial)

Signature

Date

**SIGNIFICANT OTHER PARTICIPANTS INVOLVED
IN THE IDENTIFIED PATIENT'S SERVICES**

I agree to participate in therapy focused on the patient signing above. I understand that any information that I give may be included in the patient's record and disclosed as allowed by law. I also understand that if I want to receive therapy or other treatment services, a separate consent to examination and treatment is required.

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

The staff who obtain the other participant signature above enter initials and signature here.

Staff Initials

Staff Signature

Staff Initials

Staff Signature

SOUTH CAROLINA

VOTER REGISTRATION DECLINATION FORM

If you are not registered to vote where you live now, would you like to register to vote here today?

YES

NO

Already registered to vote

Will use registration by mail application.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application from in private.

If you decided to register to vote, that decision will remain confidential and be used only for voter registration purposes.

If you register to vote, information regarding the office in which the application was submitted will remain confidential, again, to be used only for voter registration purposes.

Signature of Declinee/Applicant

Date

If you believe that someone has interfered with your right to register or to decline to vote, your right to privacy in deciding whether to register or in applying to vote, you may file a complaint with the following:

**Executive Director
State Election Commission
P.O. Box 5987
Columbia, S.C. 29250
(803) 734-9060**

Berkeley Community Mental Health Center

CLIENTS WHO ARE COURT ORDERED TO TREATMENT

If you have been court ordered to treatment, this means that the Mental Health Center has a responsibility to work with the Court to ensure that you are in compliance with the order to treatment. We will need to contact the Court to let them know that you have entered treatment and that you are or are not following treatment recommendations. If you should cease your compliance with the order from the Court, we are required to contact the Court with this information. This may result in a supplementary hearing by the Court to decide the next course of action. The Mental Health Center desires a good working relationship with clients who are court ordered to treatment; however, clients should be aware of the requirements of their court order. If records or your counselor are subpoenaed to court information may be released by court order without your permission. All information requested by the judge must be released, but only the specific information requested is released.

I have read and understand the above information.

SIGNATURE

DATE

WITNESS

CLIENT NAME

CID

**BERKELEY COMMUNITY MENTAL HEALTH CENTER
CLIENT EMERGENCY INFORMATION**

We appreciate your choosing Berkeley Community Mental Health Center. In an effort to better serve you, please help us by completing the following information.

TODAY'S DATE: _____ PHONE# _____

YOUR BIRTH DATE: _____ SOCIAL SECURITY#: _____

YOUR NAME: _____

YOUR ADDRESS: _____

MAILING ADDRESS IF DIFFERENT FROM ABOVE: _____

SCHOOL ATTENDED (Children only): _____ Grade _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____ Relationship _____

TELEPHONE NUMBER: _____

I agree for BCMHC to contact the above person for notification of appointments and to leave messages/voice mail concerning appointments

ALLERGY INFORMATION (Please list all known allergies.) _____

Marital Status _____

Highest Grade of School Completed _____

Family Size _____

Registered Voter _____

How many children _____

Military _____

Race _____

Primary Care Physician _____

Thank you for taking the time to complete this information. We appreciate your help.

CID: _____