Carolina Psychiatry, P.C.

Adult Intake Form and Authorization for Treatment

Today's Date: _____

Vitals
Height _____ BP_____
Weight_____ Pulse_____

Patient Information

Patient's Name_____ DOB: _____ Age_____
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Home Phone: _____ Cell Phone: _____
Email: _____
SSN: _____Who is responsible for this account? _____
Sexual Orientation: _____ Gender Identity: _____ Race: _____
Are you currently pregnant? ( ) Yes ( ) No
Marital Status: _____ Spouse's Name: _____

Employment Information

Patient's Employer: _____ Occupation: _____
Employer's Address: _____
Employer's Phone: _____
If Military Affiliated, which one? ( ) Beneficiary/Dependent ( ) Active ( ) Retired

Insurance Information

Do you currently have medical insurance? ( ) Yes ( ) No
If no, how will you be paying? ( ) Cash ( ) Check ( ) Credit/Debit Card
If yes, please fill out the information below:
Primary insurance: _____
Policy Number: _____Group Number: _____
Phone Number: _____Primary Holder's Name: _____
DOB: _____ Guarantor's SSN: _____

Secondary Insurance: _____
Policy Number: _____Group Number: _____
Phone Number: _____ Primary Holder's Name: _____

Emergency Contact Information

Name: _____ Relationship: _____
Phone Number: _____Work Phone _____

Pharmacy Information

Name: _____ Phone Number: _____
Address: _____

Mental Health Intake Form

Please check any current symptoms:

Depressed Mood	( )	Racing Thought	( )	Excessive worrying	( )
Unable to enjoy activities	( )	Impulsivity	( )	Anxiety attacks	( )
Sleep Pattern Disturbance	( )	Avoidance	( )	Fatigue	( )
Loss of Interest	( )	Increased Libido	( )	Decreased Libido	( )
Concentration/Forgetfulness	( )	Decreased need for sleep	( )	Suspiciousness	( )
Change in appetite	( )	Excessive Energy	( )	Hallucinations	( )
Increased risky behavior	( )	Increased Irritability	( )	Crying Spells	( )
Excessive Guilt	( )	Other _____			

Suicide Risk Assessment

Have you ever has feelings or thoughts that you did not want to live? ( ) Yes ( ) No

If yes, please answer the following. If no, please skip to the next section.

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale from 1- 10 (10 being the strongest) how long is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought how you would kill yourself? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain _____

Past Medical History:

Allergies: _____ Current Weight: _____ Height_____

List ALL current prescription medications and how often you take them: (If none, write none)

Medication	Total daily dosage	Estimated start date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current over the counter medications or supplements: _____

_____

Current Medical problems: _____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when? _____

What were the results of the EKG? ( ) Normal ( ) Abnormal ( ) Unknown

For women only:

Date of last menstrual period: _____. Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No Are you planning to get pregnant in the near future? ( ) Yes ( ) No

How many times have you been pregnant? _____ How many live births? _____

Birth control method _____ Date started_____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of your last physical exam: _____

Personal (please check those that apply)

Thyroid Disease	( )
Anemia	( )
Liver Disease	( )
Chronic Fatigue	( )
Kidney Disease	( )
Diabetes	( )
Asthma/respiratory problems	( )
Stomach or Intestinal problems	( )
Cancer	( )
Fibromyalgia	( )
Heart Disease	( )
Epilepsy or Seizures	( )
Chronic Pain	( )
High Cholesterol	( )
High blood pressure	( )
Head Trauma	( )
Liver problems	( )
Other	( )

Is there any additional personal or family medical history? ( ) Yes ( ) No - If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No - If yes, please describe when, by whom and nature of treatment.

Psychiatric Hospitalization ( ) Yes ( ) No - If yes, describe the reason, when and where.

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants:	**Date**	**Dosage**	**Response/Side-Effects**
Prozac (Fluoxetine)			
Zoloft (Sertraline)			
Luvox (Fluvoxamine)			
Paxil (Paroxetine)			
Celexa (Citalopram)			
Lexapro (Escitalopram)			
Effexor (Venlafaxine)			
Cymbalta (Duloxetine)			
Wellbutrin (Bupropion)			
Remeron (Mirtazapine)			
Serzone (Nefazodone)			
Anafranil (Clomipramine)			
Pamelor (Nortrptyline)			
Tofranil (Imipramine)			
Elavil (Amitriptyline)			
Other			
Mood Stabilizers:			
Tegretol (Carbamazepine)			
Lithium			
Depakote (Valproate)			
Lamictal (Lamotrigine)			
Topamax (Topiramate)			
Other			

Past Psychiatric Medication (Continued)

Antipsychotics/Mood Stabilizers:	**Date**	**Dosage**	**Response/Side-Effects**
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)			
Other			
ADHD Medication:			
Adderall (Amphetamine)			
Concerta (Methylphenidate)			
Ritalin (Methylphenidate)			
Strattera (Atomoxetine)			
Other			
Antianxiety Medication:			
Xanax (Alprazolam)			
Ativan (Lorazepam)			
Klonopin (Clonazepam)			
Valium (Diazepam)			
Tranxene (Clorazepate)			
Buspar (Buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic Stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol Abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other Substance Abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No – If yes, who was treated, what medication did they take and how effective was the treatment? _____.

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substance? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

		If yes, how long and when did you last use?
Methamphetamine	( ) Yes ( ) No	_____
Cocaine	( ) Yes ( ) No	_____
Stimulants (Pills)	( ) Yes ( ) No	_____
Heroin	( ) Yes ( ) No	_____
LSD or Hallucinogens	( ) Yes ( ) No	_____
Marijuana	( ) Yes ( ) No	_____
Pain killers (not prescribed)	( ) Yes ( ) No	_____
Methadone	( ) Yes ( ) No	_____
Tranquilizer/sleeping pills	( ) Yes ( ) No	_____
Alcohol	( ) Yes ( ) No	_____
Ecstasy	( ) Yes ( ) No	_____
Other	( ) Yes ( ) No	_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas_____ Tea _____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No, How many packs per day on average? _____. How many years? _____

In the past? ( ) Yes ( ) No, How many years did you smoke? _____. When did you quit? _____

Pipe, Cigars, or chewing tobacco: Currently? ( ) Yes ( ) No. In the past? ( ) Yes ( ) No

What kind? _____. How often per day on average? _____. How many years? _____

Family Background and Childhood History:

Were you adopted ( ) Yes ( ) No – Where did you grow up? _____

List your siblings and their age: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No – If yes, how old were you when they divorced? _____

If your parents' divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

Please describe when, where and by whom: _____

_____

Education History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ( ) Yes ( ) No – If yes, what branch and when? _____

Honorable discharge ( ) Yes ( ) No ( ) other type of discharge _____

Relationship History and Current Family:

Are you currently ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed – How long? _____

If not married, are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) Straight/Heterosexual ( ) Lesbian/Gay/Homosexual ( ) Bisexual ( ) Transsexual

( ) Unsure/Questioning ( ) Asexual ( ) Other ( ) Prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ( ) Yes ( ) No – If yes, how many? _____

Do you have children? ( ) Yes ( ) No – If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Legal History:
Have you ever been arrested? ( ) Yes ( ) No
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during illness or does the involvement make things more difficult or stressful for you? ( ) More helpful ( ) More stressful

Is there anything else that you would like for us to know?

_____
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Signature _____ Date _____

Guardian Signature (If under age 18) _____ Date _____

Emergency Contact _____ Phone _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Carolina Psychiatry, P.C.

Patient Pre-screening Questionnaire For Covid-19

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

Have you traveled outside the U.S. in the past 30 days? ( ) Yes ( ) No

- If yes, where? _____

Have you traveled to a U.S. city/state with reported cases of Covid-19 in the past 30 days? ( ) Yes ( ) No

- If yes, where? _____

Have you been in personal contact with a person infected with Covid-19 or who has traveled to an area with widespread and ongoing transmission of Covid-19 in the past 30 days? ( ) Yes ( ) No

Have you been vaccinated against Covid-19? ( ) Yes ( ) No

- If yes, which vaccine did you receive and when? _____

IN THE LAST 48 HOURS:

Have you had a fever (99.5 +)? ( ) Yes ( ) No

Have you experienced any of the following?

- Coughing ( ) Yes ( ) No
- Sore Throat ( ) Yes ( ) No
- Difficulty Breathing ( ) Yes ( ) No
- Muscle Aches ( ) Yes ( ) No
- Stomach Pain ( ) Yes ( ) No

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Term effects which may occur after taking the medication for a long period or terminating the medication, including Tardive Dyskinesia or withdrawal. Finally, we will discuss the effect of sudden withdrawal of the drug against medical advice. Side effects of such medications like Antabuse and Depo-Injectable when used for non-FDA approved uses should be thoroughly explained when such medications are necessary.

As many psychiatric conditions have an underlying biological basis, medication can be an important component of treating certain illness. It is our beliefs that a bio-psycho-social model to treatment- incorporating biological factors and social components- provides most patients the best chances of improving. We will examine all areas through the course of our treatment and together we can decide which interventions are specifically best for you.

Session

Our normal practice is to conduct a thorough evaluation in the initial interview. This comprehensive assessment is necessary whether we will provide you with therapy, medication, or both, as it will allow us to better understand your history, your symptoms, and your reasons for seeking treatment. Before the end of your first visit, your provider will determine whether or not you will benefit from further evaluation or begin treatment. If we feel that you would benefit from psychotherapy, will usually schedule a one hour session as needed at a mutually agreed time. We may agree to vary session length and frequency.

Late show/Cancellations and no-show policy

-Addendum: Effective 08-16-2016

Once your appointment is scheduled, you will be expected to keep your appointment date and time. If you do not cancel or reschedule by at least the workday prior to the appointment or fail to show for a scheduled appointment, you will be responsible for the $25.00 "No call, No show" or "Late cancellation" fee. Please note, insurance companies will NOT reimburse for the fee of a missed appointment. If you accumulate 3 "No call, No show", you will have to pay $75.00 before you can reschedule your appointment. Patients with Medicaid cannot be charged, but understand that "No call, No show" will be looked at as part of your compliancy. After 3 "No call, No show", you may be discharged from our facility. In addition, if a late cancellation or no show does not apply to you at the time, please try to be on time for your appointment. Everyone's appointment is important even though some sessions will run longer than others. However, the providers strive to stay on time. If you are more than 15 minutes late, you will have to reschedule.

Billing and payments

You will be expected to pay for each visit, at the time of the visit. Credit cards, personal checks and cash are accepted. Please note, there is a $35.00 fee for any returned checks. Once a check is returned to us for insufficient funds, we will no longer accept personal checks from you as a method of payment. We will bill your insurance for all services during that office visit.

Patient Initials _____

Carolina Psychiatry, P.C.

24 Hour Crisis Information

In the event you are experiencing a crisis during office hours, you may call the office at 910-484-3400. Your provider will be immediately notified and they will speak directly to you regarding your crisis to make a decision on the appropriate course of action. We also have an answering service, CentraCom, which can be called at 910-485-3234 to reach providers after hours or on weekends and holidays.

Confidentiality

Confidentiality is the cornerstone of mental health treatment and is protected by the law. We can only release information about our work to others with written permission. Some information about your diagnosis and treatment may be required as a condition of your insurance coverage or in the event of an audit. There are certain exceptions to confidentially where disclosure is required by law:

- If there is threat of serious bodily harm to others, we are required to take proactive actions, which may include notifying the potential victim, notifying the police or seeking appropriate hospitalization.
- If there is threat to harm yourself, we are required to seek hospitalization for the client, or to contract family member's or others who can help provide protection.
- If there is any indication of abuse to a child, an elderly person or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency.
- If you are involved in judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony.
- If due to mental illness, you are unable to meet your basic needs, such as clothing, food and shelter, we may have to disclose information in order access services to provide for your basic needs.

These situations have rarely arisen in our clinical practice, but should such situations occur, we will make every effort to fully discuss it with you before taking any action. We may occasionally find it helpful to consult with any other professionals. In these circumstances, we will make every effort to avoid revealing the identity of our patient. The consultation is also legally bound to keep the information confidential.

Patient Initials_____

Carolina Psychiatry, P.C.

Treatment Consent Form

Your signature below indicates that you have read the treatment consent form, which contains information on psychiatric services, sessions, professional fees, cancellation and no-show polices, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, practice status and you agree to abide by its terms during our professional relationship.

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Name of Parent/Guardian (Print) _____

Signature of Parent/Guardian _____

Date _____

Office use only:

Name of Witness (Print) _____

Signature of Witness _____

Date _____

Carolina Psychiatry, P.C.

I_____ (Consumer/parent/legally responsible person), give my consent for Carolina Psychiatry PLCC to provide assessment, treatment and/or other services for the above named consumer. I reserve the right to withdrawal consent at any time. I also reserve the right to refuse, at any time, any services offered to me.

If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all modalities are refused, the voluntarily admitted consumer may be discharged.

A minor may seek and receive periodic services from a physician without parental consent for the prevention diagnosis and treatment of (1) venereal disease and other disease reportable under G.S.A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol and (4) emotional disturbance.

In a medical or health emergency, I authorize the agency to administer first aid as needed and to contact:

Name	Relationship	Contact Number
Name	Relationship	Contact Number

Patient Initial_____

Additionally, in an emergency, a voluntarily admitted consumer may be administered treatment or medication, despite the consumer or legally responsible person's refusal, even if the consumer's refusal is expressed in valid advanced written instructions.

I choose the following hospital, medical doctor, and dentist to provide services to me: *(If none, put N/A)*

Hospital Preference	Address	Contact Number
Medical Doctor	Address	Contact Number
Dentist	Address	Contact Number

If the above medical doctor or dentist cannot reached, I give my permission to be seen and treated by a licensed physician or I may be taken to the nearest emergency room by ambulance if necessary. I will not hold this provider/agency accountable for these expenses.

Consumer or Legally Responsible Person Signature	Date
Relationship to Consumer	Date

Office Use Only:

Witness Signature	Date

Carolina Psychiatry, P.C.

Consent to Receive of Controlled Substances

The purpose of this contract is to ensure understanding between client and psychiatrist.

I, _____, am entering into a contract with Carolina Psychiatry P. C. regarding the prescription(s) that are controlled substance(s). I understand that if I break this agreement, the medication(s) being prescribed for the diagnosis of _____ may be discontinued by my psychiatrist. If this happens, I understand that other physicians are not expected to continue this treatment.

I have agreed to the following conditions:

1. I understand that only my psychiatrist will prescribe controlled substance(s) for mental health for me at any given time. I will not request or accept controlled substance from any other physician while I am receiving such medication(s) from my provider at Carolina Psychiatry P. C.
2. I must come to my regularly scheduled appointments to my psychiatrist.
3. I understand that my controlled substance(s) will be prescribed at the lowest effective doses. There will be NO CHANGE IN MEDICATION MADE OVER THE PHONE. I will not change the dose of my medications without prior approval from my psychiatrist.
4. I am responsible for my controlled substance(s) medication(s). If the prescription or medications are misplaced, lost, stolen or if I use them up sooner than the scheduled due date.
5. I understand that individuals who take controlled substance can potentially develop psychological and/or physical dependence.
6. I understand that individuals who abruptly stop taking controlled substance(s) may result in withdrawal symptoms which can be prevented by gradually decreasing the dose before completely stopping it.
7. I understand that controlled substance(s) may impair mental and/or physical ability required to perform potentially hazardous tasks such as driving or operating machinery.
8. I agree to abstain from the use of alcohol or illicit substances, without exception, while being prescribed controlled substance(s). I also agree a random urine or blood screen used of non-prescribed medications, illicit substance and/or alcohol may be performed at any time. I agree that failure to comply with the treatment program the controlled substance(s) will be discontinued.
9. I agree to use random screens to provide documentation that I am taking the prescribed controlled substance(s). If my test results show that I am not taking my medication properly and responsibly, the controlled substance(s) will be discontinued, and alternative medication will be prescribed.

Patient Initial_____

Carolina Psychiatry, P.C.

Consent to receive of controlled substance(s) (continued):

10. I understand that if there is evidence of medication hoarding, receiving similar medication from other physician at the same time, unauthorized increase in the amount I am using or failure to comply with the treatment program the controlled substance(s) will be discontinued.

I have read this document, understand it and have had my questions answered satisfactorily. I agree to use the controlled substance(s) to help control my conditions stated above will result in the immediate discharge from Carolina Psychiatry P.C.

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Name of Parent/Guardian (Print) _____

Signature of Parent/Guardian _____

Date _____

Office Use Only:

Name of Witness (Print) _____

Signature of Witness _____

Date _____

Carolina Psychiatry, P.C.

Patient Rights:

- Every patient has a right to considerate and respectful care.
- Every patient has the right to make decision regarding their healthcare, including the decision to refuse or discontinue treatment without threat or termination of service, to the extent permitted by law.
- Every patient has a right to privacy and confidentially of all information pertaining to his/her healthcare.
- Every patient has a right to receive an explanation of their condition, proposed treatment and alternative therapies, with their respective benefits and risks.
- Every patient has the right to treatment regardless of race, religion, ethnic origin, sex, age or disability.
- Every patient has the right to receive information about fees and charges established by Carolina Psychiatry.
- Every patient has the right to express any concerns they have about their care or services and have them addressed promptly.
- Every patient has the right to contact Disability Rights of North Carolina for persons with disabilities designated to protect and advocate the rights of person with disabilities.
- Every patient has the right to request a copy of their treatment plan by filing out consent to release personal and medical information at the front desk.
- Minors have the right to seek and receive periodic services from physician without parental consent in accordance with General Statute 90-21.5.

Responsibilities:

- Every patient must provide accurate and complete information concerning his/her present complaints, past medical, psychiatric and medication history, and any other matters relating to his/her physical and emotional health. It is also important that the attending physician know of a patients pregnancy status in order to provide the safest care.
- Every patient should keep their scheduled appointment time. In order to effectively treat our patients, Carolina Psychiatry does require at least a 24 hour notice when needing to reschedule or cancel an existing appointment. This allows us to schedule other patients who are waiting for an appointment. Failure to notify Carolina Psychiatry will result in a $25.00 cancellation fee, with the exception of missed therapy appointments, which result in a $50.00 cancellation fee. This fee is nonnegotiable and at the doctor's discretion only, if a patient does not notify Carolina Psychiatry properly of a missed appointment, this will result in termination from our office.
- Every patient should arrive to their scheduled appointment on time. If you are more than 15 minutes late for your appointment, you may have to reschedule. Patient should understand the sign-in sheet reflects arrival time and not the order in which patients will be seen. Arriving early to an appointment does not guarantee that you will be seen early. Patients are seen according to schedule.
- Every patient is responsible for keeping up with their appointment date and time. Appointment cards are given upon check-out and patients should bring these appointment cards with them to their next scheduled appointment. Patient should bring <u>ALL PRESCRIPTION BOTTLES</u> for medications that were prescribed from Carolina Psychiatry to each and every visit. Failure to bring medication bottles may result in needing the appointment rescheduled.

Patient Initial _____

Carolina Psychiatry, P.C.

- Every patient should fully participate in their treatment plan and follow the prescribed therapies and treatment set forth by their provider. If a patient refuses treatment or fails to follow their provider's instructions, the patient is responsible for the outcome.
- Every patient is responsible for their financial obligations for services provided, and these obligations should be addressed promptly. Co-pays must be paid before services rendered. If a patient has an outstanding balance, they may not be rescheduled until the obligation has been met. No exceptions.
- Every patient should be considerate of the right and property of other patients, providers and staff. Carolina Psychiatry has a zero tolerance policy with regard to inappropriate behavior including treatment of any kind in the office. Disruptive behavior is not adherence and could lead to discharge from Carolina Psychiatry.

Your signature acknowledges your receipt and adherence to the policies set forth by Carolina Psychiatry, P. C.

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Name of Parent/Guardian (Print) _____

Signature of Parent/Guardian _____

Date _____

Office Use Only:

Name of Witness (Print) _____

Signature of Witness _____

Date _____

Carolina Psychiatry, P.C.

Carolina Psychiatry P.C. Medical Records Process
The HIPPA Privacy Rule

The Health Insurance Portability and Accountability Act of 1996 (HIPPA; Pub.l.104-191, 110 Stat. 1936, enacted August 21, 1996) was enacted by the United States Congress and signed by President Bill Clinton in 1996. The HIPPA Privacy rule establishes national standards to protect individual's medical records and other personal health information and applies to health plans, health care clearinghouses and those health care providers that conduct certain health care transactions electronically. The rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the use and disclosures that may be made of such information without the patient authorization.

1. Patient/Guardians must fill out a release form for medical records to be released:
   (Please see when a release form is required below)
   - A. Sharing information with other parties verbally.
     - I. Relatives calling for appointment dates and times
     - II. Coordination of care between providers or other parties
   - B. Permission for other parties besides parent/guardian to sit in a sessions if and only the provider agrees.
     - I. If a friend or relative besides parent/guardian brings a child to their appointment, we will need either guardianship paperwork or a release signed by parent/guardian.
     - II. If the patient is over 18 years old and is disabled, you will need to provide power of attorney documentation.
   - C. To receive or transfer medical records to other facilities and insurance companies.
2. Turnaround time to process medical records:
   - A. HIPPA requires healthcare providers to furnish patient with a copy of their medical records within 30 days of the request. Under the HITECH Act of 2013, patients have the right to request their health information in electronic form. The see imposed also cannot exceed the labor and supply cost of responding to the request.
     - I. Please keep in mind that if you are a patient/guardian paying for medical records, you will need to pay first.
     - II. Patients with Alliance as primary, secondary or tertiary insurance will not be charged.
3. FEES for medical records:
   (Please review our fee table to get an estimate of charges)
   - A. According to North Carolina General Statues 90-411
     - I. The maximum fee shall be 75c per page for the first 25 pages, 50c per page for pages 26- 100, and 25c per page after that. A 'reasonable professional fee" may be charged for reviewing and preparing a narrative summary of the patient's medical records. Minimum fee of $10.00 permitted, inclusive of copying costs. This section applies to claims for personal injury and Social Security Disability claims. North Carolina General Statutes, Section 11.3 & 90-411. Effective July 1, 1997.

By signing this document, you understand Carolina Psychiatry P. C. policies for obtaining and releasing medical records.

Name of Patient/Guardian _____ Date _____

Signature of Patient/Guardian_____

Carolina Psychiatry, P.C.

Payment Policy

Thank you for choosing us as your provider. We are committed to you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for service rendered, we have advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan, we also offer services under a self-pay rate. Payment in full is expected at each visit until we can verify your coverage under an insurance plan. Knowing your insurance benefits is the YOUR responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and deductibles at each visit.
3. Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay these services in full at the time of visit.
4. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid proof of insurance card. If you fail to provide us with the current insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage submission: If your insurance changes, please notify us before your next visit so we can make the appropriate changes. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment: If your balance is over 90 days past due, you will receive a letter stating that you have 20 days to make a payment on your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments: Our policy is to charge for missed appointments that have not been canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are a representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Name of Patient/Guardian (Print) _____ Date_____

Signature of Patient/Guardian _____

Carolina Psychiatry, P.C.
548 Sandhurst Dr. Fayetteville, NC 28304
Phone Number: 910-484-3400 Fax Number: 910-484-3404

Consent to Release Personal and Medical Information

I, _____ (Print name/Date of birth) hereby authorize Carolina Psychiatry P.C. to use or disclose my protected health information.

_____
Name of agency/person/program to who requested use/disclosure of records

_____
Address of agency/person/program City State Zip code

_____
Phone Number Fax Number

Information released may be verbal, electronic or written and allows for a reciprocal exchange of information. Released data may include records, treatment notes and other information.

Nature of records to be released: (Please initial each type of document to be released)

_____Medications _____Treatment Plans _____Admission Assessments
_____Psychiatric Evaluations _____Psychological Evaluations _____Treatment Recommendation
_____Discharge Summaries _____Aftercare Plans/Orders _____Progress/Psychotherapy Notes
_____Alcohol/Drug Treatment _____Acquired Immunodeficiency Syndrome (HIV) _____Lab Results
_____Other: _____

I understand the purpose of the request for records will be used for: _____
Information to be disclosed from: _____
Dates/Timeline of information to be released: _____

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health, intellectual and development disabilities information protected by state law (G.S 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that re-disclosure is prohibited except as permitted or required by these two laws. Our notice of privacy practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire_____ (specific date or condition) not more than 365 days from the date of signature.

I understand that I may refuse to sign this release of information form. I understand that Alliance Behavioral Healthcare may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form.

Minor Signature (Required for SA) _____ Date _____

Signature of client/legally responsible person _____ Date_____

My Signature below indicates that I understand that I may revoke this consent, verbally or in writing at any time, except to the extent that action has been taken in reliance on the consent. If you revoke this consent, you may contact the employee working with you or privacy officer as outlined in the notice of privacy practices.

Only sign below if you are REVOKING this consent:

Signature of client/legally responsible person _____ Date _____

Carolina Psychiatry P.C.

TREATMENT CONSENT FORM

PSYCHOTHERAPY

Psychotherapy may have benefits such as significant reduction in distress, improved social relationships, resolution of specific problems, and clearer understanding of yourself, your values, and your goals. However, there are no guarantees about what will happen in therapy. For therapy to be most successful, you will need to be able to talk openly and honestly, address any difficulties that arise, and put forth an active effort outside of our sessions.

Psychotherapy may also require revealing unpleasant aspects of your history and current life. Therefore, in the initial stages of treatment, psychotherapy may lead to uncomfortable levels of feelings levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness and could impact your relationship with others. While unpleasant experiences are usually temporary, please let us know if they occur.

By the end of your initial evaluation, we will offer you some initial impressions and a treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy that only you can fully commit to. If you have questions regarding procedures, we should discuss them as they arise. If your doubts persist, we will be happy to offer referrals for you to secure an appropriate consultation with another mental health provider.

MEDICATIONS

If a medication is necessary, we will discuss with you the nature of your illness, the reason for the medication, the likelihood of improving with and without the medication. We will also explain any reasonable alternative treatment other than medication which have not been tried and an explanation of why they should not be tried first. Further, you will understand the type(s) of medication being recommended; dosage and frequency of administration including a discussion of the initial dose, the maintenance dose and the dose range; probable side effect known to occur and any side effects likely to occur in particular cases, as determined by your medical and psychiatric history or known medical conditions; and any long term effects which may occur after taking the medication for long periods or terminating the medication, including tardive dyskinesia or withdrawal. Finally, we will discuss the effect of sudden withdrawal of the drug against medical advice. Side effects of such medications like Antabuse and Depo-Provera when used for non-FDA approved uses should be thoroughly explained when such medications are necessary.

As many psychiatric conditions have an underlying biological basis, medications can be an important component of treating certain illnesses. It is our belief that a bio-psycho-social model to treatment – incorporating biological aspects, psychological factors and social components – provides most patients the best chances of improving. We will examine all areas through the course of our treatment and together we can decide which interventions are specifically best for you.

SESSIONS

Our normal practice is to conduct a thorough evaluation in the initial interview. This comprehensive assessment is necessary whether we will provide you with therapy, medication management, or both, as it will allow us to better understand your history, your symptoms, and your reasons for seeking treatment. Before the end of your first visit, your provider will determine whether or not you will benefit from further evaluation or begin treatment. If we feel that you would benefit from psychotherapy, we will usually schedule a one hour session as needed at a mutually agreed time. We may agree to vary session length and frequency.

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to keep your agreed appointment date and time unless you provide us with at least 24 business hours advance notice of cancellation. Business hours are considered the weekdays between Monday and Friday, during the hours of 9 am and 5:30 pm to avoid being charged. If you do not provide at least a 24 hour notice, or fail to show for a scheduled appointment, you will be responsible for a "No Call-No Show fee". This fee is $25.00 fee for a missed appointment with the doctor, and $50.00 fee for a missed appointment with the therapist. Please note, insurance companies will **NOT** reimburse for the fee of a missed appointment.

BILLING AND PAYMENTS

You will be expected to pay for each visit, at the time of the visit. Credit cards, personal checks, and cash are accepted. Please note, there is a $25.00 fee for any returned check. Once a check is returned to us for insufficient funds, we will no longer accept personal checks from you as a method of payment. We will bill your insurance for all services provided during that office visit.

CONTACTING US

Our staff is available to help during normal business hours at (910) 484-3400. If our staff is busy when you call, or it is after hours, our voicemail will answer so you can leave a message. We monitor our voicemail frequently and will return your call as soon as possible. We will make every effort to return your call on the same day you leave a message with the exception of after hours, weekends and holidays as calls made on those days will be returned on the next business day. When you call, please leave your name, date of birth and a phone number where you can be reached. If it is regarding a true medical emergency, go straight to the closest emergency room or dial 911.

CONFIDENTIALITY

Confidentiality is the cornerstone of mental health treatment and is protected by the law. We can only release information about our work to others with your written permission. Some basic information about your diagnosis and treatment may be required as a condition of your insurance coverage. There are certain exceptions to confidentiality where disclosure is required by law:

- If there is threat of serious bodily harm to others, we are required to take proactive actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.

- If there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection.
- If there is any indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency.
- If you are involved in judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony.
- If due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs.

These situations have rarely arisen in our clinical practice, but should such situations occur, we will make every effort to fully discuss it with you before taking any action. We may occasionally find it helpful to consult with any other professionals. In these circumstances, we will make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential.

TREATMENT CONSENT FORM

Your signature below indicates that you have read the treatment consent form, which contains information on psychiatric services, sessions, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, and practice status, and you agree to abide by its terms during our professional relationship.

Name of patient (print): _____ Date: _____

Signature of patient: _____

Name of clinician (print): _____ Date: _____

Signature of clinician: _____