Child 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? (*please circle one*) Yes No
Parent/Guardian Name: _____ Phone Number: _____

Employment Information

Patient's Employer: _____ Occupation: _____
Employer's Address: _____
Employer's Phone: _____
If Military Affiliated (*please circle one*): Beneficiary/Dependent Active Retired

Insurance Information

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

Secondary Insurance: _____ Policy Number: _____
Group Number: _____ Subscriber Number: _____
Phone Number: _____
Medicare Number: _____ Medicaid Number: _____

Emergency Contact Information

Name: _____ Relationship: _____
Phone Number: _____

Pharmacy Information

Name: _____ Phone Number: _____
Address: _____

PRIMARY REASON(S) FOR SEEKING TREATMENT

Please circle the primary reason(s) you are seeking services for your child:

Anger	Anxiety	Depression
Violent Outburst	Eating Disorder	Fear/Phobias
Addictive Behaviors	Abuse Victim	Grief/Loss
Sexual Concerns	Sleeping Problems	Traumatic Events
Behavioral Concerns	Alcohol/Drug Use	Other:_____

How long have the behaviors you are concerned with been present?_____

List any additional outside stressors or challenges that are influencing your Childs's behavior:

_____

_____

_____

Describe the onset of your child's current situation:

_____

_____

_____

Has the issue been treated by other means before now? ___ Yes ___ No If yes, describe what was done and your child's response to the intervention?

_____

_____

_____

_____

Does your child get along with all members of your household?_____ If no, describe why:_____

_____

_____

_____

_____

Does your family regularly attend church or participate in other spiritual support systems? ☐Yes ☐ No

If yes, describe: _____

_____

Any historical or current legal involvement? ☐Yes ☐ No If yes, describe: _____

_____

_____

Other relevant information _____

_____

_____

CHILDCARE AND SCHOOL HISTORY

List ages and types of childcare provided for your child: Home w/parent/relative _____

Daycare _____ School _____

Home w/other caregiver _____ Other _____

What grade is your child currently in? _____ Does your child maintain good grades? ☐Yes ☐ No

If no, describe: _____

Does your child have IEP or Special Education services? ☐Yes ☐ No

Describe your child's strengths and challenges as they relate to childcare or school:

Strengths _____

Challenges _____

Describe your child's relationships as they apply to

Peers _____

Teachers _____

Childcare providers _____

Does your child have any issues with school attendance? ☐Yes ☐ No ☐ NA

If yes, describe why: _____

Does your child maintain a group of friends? ☐Yes ☐ No

Has your child been a victim of bullying? ☐Yes ☐ No

Other relevant information _____

_____

_____

_____

SOCIAL AND BEHAVIORAL HISTORY AND CURRENT STATUS OF CHILD

Describe your child's current temperament _____

_____

Does your child react well to frustrating or difficult tasks? ☐Yes ☐ No

If no, describe: _____

Has your child experienced significant losses (i.e., separation from parents, illness, death)? ☐Yes ☐ No

If yes, describe: _____

Has your child been exposed to any of the following types of abuse?

Physical abuse ☐Yes ☐ No Sexual abuse ☐Yes ☐ No

Emotional abuse ☐Yes ☐ No Exposure to violence ☐Yes ☐ No

If yes, describe: _____

_____

Has your child experienced any of the following traumatic events?

Accidents ☐Yes ☐ No Family member/pet loss ☐Yes ☐ No

Witness to domestic violence ☐Yes ☐ No Police/CPS involvement ☐Yes ☐ No

If yes, describe: _____

_____

In your child's life, have they ever had any experience that was so frightening, horrible, or upsetting that in the past month they

had nightmares about it or thought about it when they did not want to? ☐Yes ☐ No

tried hard not to think about it or went out of their way to avoid situations that reminded them of it? ☐Yes ☐ No

were constantly on guard, watchful, or easily startled? ☐Yes ☐ No

felt numb or detached from others, activities, or their surroundings? ☐Yes ☐ No

Does your child regularly use social media? ☐Yes ☐ No

Other relevant information _____

_____

_____

DEVELOPMENTAL HISTORY TO AGE 5:

Indicate all factors that influenced your child's developmental growth to age five (5)

- ☐ Unwanted Pregnancy
- ☐ Alcohol or drug exposure under age 5
- ☐ Toilet training/bathing issues
- ☐ Irregular sleep schedule
- ☐ Walk/crawl/speech delays
- ☐ Difficulties with weight loss/gain
- ☐ Parent incarceration
- ☐ Separation anxiety
- ☐ Parent divorce
- ☐ Night terrors
- ☐ Parent with physical illness
- ☐ Marital discord in home
- ☐ Limited socialization
- ☐ Attention span difficulties
- ☐ Complicated pregnancy/delivery
- ☐ Colic
- ☐ Frequent childhood illness
- ☐ Inadequate nutrition
- ☐ Extended isolation
- ☐ Childhood eating disorders
- ☐ Suicidal thoughts/attempts in family
- ☐ Frequent temper tantrums
- ☐ Multiple moves/relocations
- ☐ Constant family stress
- ☐ Food allergies
- ☐ Appetite/feeding difficulties
- ☐ Substance use during pregnancy

List all members in the home during this time (ages 0-5) and their relation to your child

name _____ relation _____

name _____ relation _____

name _____ relation _____

name _____ relation _____

Were there any issues or concerns with your child's pre-school readiness screening? ☐ Yes ☐ No

If yes, describe: _____

Other relevant information _____

_____

_____

MEDICAL HISTORY AND CURRENT MEDICAL STATUS

Describe your child's general health ☐ Excellent ☐ Good ☐ Average ☐ Poor

When was your child's last checkup? _____

Does your child have any acute or chronic health problems? ☐Yes ☐ No If yes, describe: _____

_____

Has your child ever been hospitalized? ☐Yes ☐ No For how long _____

Reason for hospitalization _____

Does your child maintain a healthy appetite? ☐Yes ☐ No If no, describe: _____

_____

Does your child maintain a healthy sleep pattern? ☐Yes ☐ No If no, describe: _____

_____

Has your child ever been on or currently taking any medications? ☐Yes ☐ No

Medication _____ Currently taking? ☐Yes ☐ No

Medication _____ Currently taking? ☐Yes ☐ No

Medication _____ Currently taking? ☐Yes ☐ No

Medication _____ Currently taking? ☐Yes ☐ No

Does anyone in your family have current or historical mental illness? ☐Yes ☐ No

Family member _____ Mental Illness _____

Family member _____ Mental Illness _____

CHEMICAL USE HISTORY

Does your child have any current/historical substance or alcohol use? ☐Yes ☐ No If Yes:

Have you ever felt your child ought to cut down on their alcohol or substance use? ☐Yes ☐ No

Has your child ever been annoyed by being criticized for alcohol or substance use? ☐Yes ☐ No

Has your child felt bad or guilty about alcohol or substance use? ☐Yes ☐ No

Has your child ever felt the need to use alcohol or substances right away in the morning? ☐Yes ☐ No

Does your child smoke, vape, or chew? ☐Yes ☐ No

Does your child use pain medication? ☐Yes ☐ No

Please indicate below which substances you have used (if any): ☐ Never used any substance

☐Alcohol	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Marijuana	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Cocaine/crack	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Meth/Amphetamine	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Heroin	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Other opiates	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used

☐ Synthetics	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Inhalants	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Benzos	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Hallucinogens	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Over the counter	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Other:_____	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Nicotine	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used

Does anyone in the family have current/historical substance or alcohol use? ☐Yes ☐ No

Family member _____ Substance or Alcohol Use _____

Family member _____ Substance or Alcohol Use _____

Other relevant information _____

_____

_____

_____

_____

_____

_____

_____

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 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 history and current life. Therefore, in the initial stages of treatment, psychotherapy may lead to uncomfortable 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 initial evaluation, we will offer you some initial impressions and 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 condition; and any long

Patient Initials:----------

term effects which may occur after taking the medication for 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 08-16-16

Once you 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 accumulates 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 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 during that office visit.

Patient Initials:----------

Carolina Psychiatry, P.C

24 Hour Crisis Information

In the event you are experiencing a crisis during office 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 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 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 consultant 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 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)----------

Signature of patient: ----------

Date: ----------

Name of Parent/Guardian (print)----------

Signature of Parent/Guardian:----------

Date:----------

Name of Witness (print)----------

Signature of witness:----------

Date:----------

Patient Initials:----------

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 withdraw 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 () 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	Telephone #
Name	Relationship	Telephone #

Patient Initials:----------

Carolina Psychiatry, P.C

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

I choose the following hospital, medical doctor, and dentist to provide services to me:

Hospital Preference	Address	Telephone #
Medical Doctor	Address	Telephone #
Dentist	Address	Telephone #

If the above medical doctor or dentist cannot be 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

Relationship to Consumer Date

Witness Signature Date

Patient Initials:----------

Carolina Psychiatry, P.C

Consent to Receive of Controlled Substances

The purpose of this contact 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 Substances(s). I understand that if I break this agreement, the medication(s) being prescribed for the diagnoses 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 MEDICATIONS 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 mediations misplaced, lost, stolen, or if I use them up sooner than prescribed, I understand that it will NOT be replaced, or refilled 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 Substances(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 that 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 Initials:----------

Carolina Psychiatry, P.C

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 immediate discharge from Carolina Psychiatry P.C.

Name of patient (print)----------

Date:----------

Signature of Patient:----------

Name of witness (print):----------

Date:----------

Signature of witness:----------

Patient Initials:----------

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 services, to the extent permitted by law.
- Every patient has a right to privacy and confidentiality of all information pertaining to his/her healthcare.
- Every patient has the 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, ethic 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 concern 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 patient's pregnancy status in order to provide the safest care.
- Every patient should keep their scheduled appointment time. In an 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 cancelation fee. This fee is nonnegotiable and at the doctors 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 schedule. Patient should understand they or 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 that you will be seen early! Patients are seen according to schedule.
- Every patient is responsible for keeping up with their appointment day and time. Appointment cards are given upon check-out and patients should bring these appointments cards with them next scheduled appointment. Patient should bring ALL PRESCRIPTION BOTTLES for medications that were prescribed from Carolina Psychiatry to each and every visit. Failure to bring medication bottles may result in result needing the appointment rescheduled.
- 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 must communicate in a direct and honest manner with provider's and staff regarding their physical and emotional health.
- 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 are 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 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.

Patient Signature(s): _____ Date:

Witness: _____ Date:

Carolina Psychiatry, P.C

Carolina Psychiatry, P.C. Medical Records Process

The HIPPAA Privacy Rule

The Health Insurance Portability and Accountability Act of 1996(HIPAA; 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 HIPAA Privacy Rule establishes national standards to protect individuals' 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 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 patient authorization.

1. Patient/Guardians must fill out a release form for medical records to be release.:
   (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 patient/guardian to sit in 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 papers or a release signed by guardian/parent.
     - 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
   (HIPAA 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 fee imposed also cannot exceed the labor and supply cost of responding to the request.)
   - a. Please keep in mind that if you are a patient/guardian paying for medical records, you will need to pay first. Thereafter, medical records will be completed and provided to you.
   - b. Patients with Alliances 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 Statutes 90-411
     - i. The maximum fee shall be 75C per page for the first 25 pages, 50C per page for pages 26 to 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 record. 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.

Signature: _____ Print: _____

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. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have advised to develop this payment policy. Please read it, ask us any question 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 will do our business with, payment in full is expected at each visit is required until we can verify your coverage. Knowing your insurance benefits is responsibility. Please contact your insurance company with any question 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-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. : Please be aware that some ____and perhaps all____of the services you receive may be no 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 insurance to provide proof of insurance. If you fail to provide us with the correct 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 of 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 to in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment : If your is over 90 days past due, you will receive a letter stating that you have 20 days to pay to pay you be r 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 this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 days period, our physician will only be able to treat you on an emergency basis.
8. Missed appointment. : Our policy is to charge for missed appointment not canceled within a reasonable 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 representative of the usual and customary charges for our area. Thanks 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 guideline:

Signature of patient or responsible party: _____

Printed name: _____

CAROLINA PSYCHIATRY P.C.

548 Sandhurst Dr. Fayetteville, NC 28304 TEL: 910-484-3400 Fax:910-484-3404

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize Carolina Psychiatry, PC to use or disclose my
Consumer Name *Date of Birth*
protected health information to:

Name of agency/person/program to who requested use/disclosure will be made — Client Initials

_____ _____
_____ _____
_____ _____

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 beside each applicable document*)

_____Medications
_____Psychiatric Evaluations
_____Discharge Summaries
_____Alcohol/Drug Treatment
_____Other: _____
_____ Treatment Plans
_____ Psychological Evaluations
_____Aftercare Plans/Orders
_____Acquired Immunodeficiency Syndrome (HIV)
_____ Admission Assessments
_____Treatment Recommendations
_____ Progress/Psychotherapy Notes
_____ Lab Results

I understand the purpose of the disclosure/redisclosure will be used for:_____

Information to be redisclosed from:_____

Dates/Timelines 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 recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental 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 redisclosure 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 *Relationship* *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 choose to revoke this consent, you may contact the employee working with you or the Privacy Officer as outlined in the Notice of Privacy Practices.

_____ _____
Signature of client/legally responsible person *Date*

If revoked verbally, put name, job title and date verbal request was made: _____