CAROLINA PSYCHOLOGICAL HEALTH SERVICES (CPHS)

NEW PATIENT INFORMATION PACKET (ADULT/INCAPACITATED ADULTS)

Date: _____ Chart # _____

ONLY ONE PERSON IS TO COMPLETE THIS PACKET

Patient Name: _____ Prefer Name: _____
(Last Name First Middle)

Address: _____ _____ _____ _____
(Street Name City State Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

(Only provide us contact numbers where we can contact you and/or we can leave a message in regards to appointments, inquiries and office/medical related issues.)

Preferred Method of Appointment Reminder [ ]None [ ] Call [ ]Text [ ]E-mail Address:_____

DOB: _____ SSN: _____ Sex (circle one): M / F

Patient Current Marital Status:_____

Race: _____ [ ]Do not wish to answer

Ethnic (Nationality): [ ]Hispanic or Latino [ ]Not Hispanic or Latino [ ]Do not wish to answer

Name Employer/School: _____

Referring Facility: _____Referring Doctor: _____ Phone: _____

Primary Care Provider:_____Phone:_____

(Required for billing purposes)

IN CASE OF EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship:

[ ] Spouse [ ]Mom [ ]Dad [ ]Step-[ ] Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other: _____

AUTHORIZE TO TREAT

I affirm that I am the (circle one) patient/ legal guardian and responsible party of the above patient and, I hereby acknowledge that I authorize and give permission to the staff of ***Carolina Psychological Health Services(CPHS)*** to render treatment and/or services to myself/above named minor child, and I hereby acknowledge that staff is responsible for treatment and/or services rendered in the course of treatment (therapeutic time in facility) and cannot be held responsible for my behavior/behavior of minor child outside of the context of the therapeutic treatment session.

_____ _____
Signature of Patient/Legal Guardian Date

Legal Guardian For Incapacitated Adult:_____ Phone:_____

Responsible Party For Incapacitated Adult _____ Phone: _____

Responsible Party DOB: _____ Responsible Party SSN: _____

_____
CPHS Witness Signature

INSURANCE: (If you have more than two insurances please let us know) Please be prepared to show your insurance card at each visit. For TRICARE members: We require a copy of your military ID (which is authorized under DoDI # 1000.13 and Force Protection Advisory (0050-09-FPA (Change 1)).

Check Here For No Secondary Insurance [ ]

Primary Insurance	***Secondary Insurance***
Insurance Company: _____	Secondary Insurance: _____
Policyholder: _____	Policyholder: _____
Policyholder DOB: _____	Policyholder DOB: _____
Policyholder SSN: _____	Policyholder SSN: _____
Policy ID Number: _____	Policy ID Number: _____
Group Number: _____	Group Number: _____
Policyholder Address: _____	Policyholder Address: _____
_____	_____
Relationship to policyholder: [ ] Self [ ] Spouse [ ]Mom [ ]Dad [ ]Daughter/Son [ ]Step Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other:	Relationship to policyholder: [ ] Self [ ] Spouse [ ]Mom [ ]Dad [ ]Daughter/son [ ]Step- Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other:

INSURANCE AUTHORIZATION AND ASSIGNMENT (INITIAL BOX THAT APPLIES)

[____] ***NonMedicare****:* I assign directly to Carolina Psychological Health Services all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions; I authorize any CPHS holder of medical /psychotherapy/psychiatric information about me to be released to the health care finance administration, insurance company and its agents any information needed to determine these benefits or benefits payable to related services. I agree a photocopy of this form may be used in place of the original.

[____] ***Medicare:*** I request payment of authorized Medicare benefits be made on my behalf to *Carolina Psychological Health Services for any services furnished to me. To the extent permitted by law, I authorize any holder of medical and other information about me to be released to the Center of Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services.*

_____ _____

Signature of Patient/ Legal Guardian Date

_____

CPHS Witness Signature

PATIENT QUESTIONNAIRE

Name of patient:_____ Age:_____

Reason for Visit:_____

_____

Have you sought treatment for this problem before?: [ ]YES [ ]NO If yes, when?_____

Where?_____

Have you, or the person who is being seen, been a patient in this clinic before?_____

If so, whom were they seen by?_____

Who referred you to this clinic?_____

_____

Have you sought treatment for any mental health/emotional problems before?_____

If so, please explain:_____

_____

_____

Please list and describe any significant medical history (illnesses, diseases, surgeries, allergies, etc.)

_____

_____

_____

Please list all medications you are taking:

_____

_____

_____

ACCESS PERMISSION FORM

Patient Name: _____ Chart # _____

I DO NOT WISH TO GRANT ACCESS: _____ SKIP TO SIGNATURE SECTION TO CONTINUE

I, _____ (Patient, Legal Guardian), authorize ***Carolina Psychological Health Services*** (CPHS) staff to allow the following person access to the above patient:

_____ _____
Printed name of one person authorized access Relationship to patient

to: (check appropriate choices **(If all boxes are checked we are not liable for error in communication to others)**):

- _____ have knowledge of appointments
- _____ make, change or cancel appointments
- _____ pick up prescriptions
- _____ pick up medical record requested by me
- _____ verbal/open communication regarding case discussion information with CPHS Providers
- _____ verbal/open communication regarding billing (do diagnosis info will be given out)
- _____ bring and attend my minor child's appointments

This <u>DOES NOT</u> give authorization for this individual to request release of records. This authorization shall remain in effect for one year from the date of signature, unless cancelled by me in writing.

_____ _____
Signature of Patient/Legal Guardian Date

_____
Witness Signature

CANCELLATION OF ACCESS

I, _____, hereby revoke the above access to my information.

_____ _____
Signature of Patient/Legal Guardian Date

_____
Witness Signature

CAROLINA PSYCHOLOGICAL HEALTH SERVICES

1703 Country Club Rd, Suite 204
Jacksonville NC 28546
Telephone: 910-347-3010
Fax: 910-347-6137

AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____

Patient Name:_____

Date of Birth:_____

Referring Facility/Provider: _____
(Name)

_____
(Contact Information i.e. phone number or address)

Active Duty Service Members: Evaluations will be released to your military treatment facility with or without your consent.

[ ]The above patient was referred to Carolina Psychological Health Services. To ensure my referring facility is fully informed of my treatment here, I authorize the release of my Psychological/Psychiatric Evaluations to the above listed facility.

[ ] I do not wish to have my information to be released to my above listed referring facility.

Name (print):_____ Date:_____

Name (signature) _____

Witness:_____ Date:_____

CAROLINA PSYCHOLOGICAL HEALTH SERVICES
1703 Country Club Road, Suite 204
Jacksonville, NC 28546
Telephone 910-347-3010 Fax 910-347-6137

CONSENT FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT:_____

DATE OF BIRTH:_____

SOC. SEC. NO._____

ALLOW 15 TO 30 DAYS FOR PROCESSING OF RECORDS. FORMS FILLED OUT INCORRECTLY ARE INVALID AND WILL NOT BE PROCESSED.

RELEASE RECORDS FROM:

Carolina Psychological Health Services
Medical Records
1703 Country Club Road, Suite 204
Jacksonville, NC 28546

RELEASE RECORDS TO:
(PRINT NAME & ADDRESS FOR MAILING OR TELEPHONE # FOR PICKUP)

_____Patient/ Parent/Legal Guardian_____
_____(See Relationship Below)_____
_____
_____
_____

Information Requested (Check data or specify under "Other".)

_____ Verbal Case Discussion. Specify below, person(s) to be involved in verbal discussion:

_____
(Name)

_____ Medical History (MD notes)
__XX__ Psychological / Neurological Eval
_____ Discharge / Summary Report
_____ Other:_____
_____
Specify dates requested: _____to _____

Purpose or need for which information is to be used:

____ Transferring to another therapist/doctor
____ School
____ Extended Care (Specialists)
____ Primary Care Manager
____ Case Management with DSS/OCBHS
_XX_ Other: _Courtesy Copy For Communication_____

NOTICE: Under HIPAA Privacy laws and NC State Laws, Psychotherapy Notes are exempt from disclosure. This clinic reserves the right to refuse to release records directly to the patient or guardian and instead, only to another medical/mental health professional of the patients or guardians choice.

A COPY OF THIS SIGNED AND WITNESSED FORM IS AVAILABLE UPON REQUEST.

I hereby request and authorize the above named agency, organization or individual who possesses information relative to the patient named above to release information, as specified, to the agency, organization or individual named on this request. I understand that the information to be released ***may include*** information regarding ***drug abuse***, ***alcohol abuse***, ***psychological or psychiatric impairments***, ***or HIV diagnostic information***.

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be disclosed without my written consent unless otherwise provided for by state and federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by HIPAA Privacy Rule. Proof of authority to act for a patient must be provided.

This consent shall expire without *express written revocation* one hundred eighty (180) days after the date of signing. Consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Printed Name of Patient **Printed Name of Legal Representative**

_____ _____
Patient Signature **Date** **Legal Representative Signature** **Date**

_____ _____
Witness Signature **Date** **Relationship to Patient**

NOT VALID WITHOUT WITNESS SIGNATURE

CAROLINA PSYCHOLOGICAL HEALTH SERVICES

1703 Country Club Rd, Suite 204
Jacksonville NC 28546
Telephone: 910-347-3010
Fax: 910-347-6137

ACKNOWLEDGEMENT/RECEIPT OF *Patient/Client Bill Of Rights, Responsibilities, and The Limits Of Confidentiality; Carolina Psychological Health Services (CPHS) Patient Policies and Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information*

I acknowledge that I have been given copies of the ***Patient/Client Bill Of Rights, Responsibilities, And The Limits Of Confidentiality; Our Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information and our Carolina Psychological Health Services (CPHS) Patient Policy*** to have and read. If I have any questions, it is my responsibility to ask them.

I understand I must read the "***Patient/Client Bill Of Rights, Responsibilities, And The Limits Of Confidentiality.***" It describes how my psychological and medical information may be used and disclosed and how I can get access to the information. I have read and understood the Bill of Rights, Responsibilities, and Limits of Confidentiality above.

I also understand I have been offered "***Carolina Psychological Health Services (CPHS) Patient Policies***" handout describes CPHS patient policies regarding treatment rendered, state and local law required reporting, no show and cancellation fees, Co-Pays/Deductible and Co-Insurance Payments, policy on electronics/cell phones, patient bringing minor children to appointments, bringing under aged guests to appointments and insurance.

I understand I have been offered CPHS "***Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information***" handout describes how psychological and psychiatric information about you may be used and disclosed and how you can get access to this information.

By signing, I have read and understand all of the above listed handouts/forms and I accept a copy of these handouts. I also understand, it is my responsibility to read them and ask any questions I may have.

_____ _____

Patient Name: Chart#

_____ _____

SIGNATURE of Patient / Legal Guardian Date

_____

Witness Signature

PATIENT/CLIENT BILL OF RIGHTS, RESPONSIBILITIES, AND THE LIMITS OF CONFIDENTIALITY

Carolina Psychological Health Services (CPHS) has a written policy identifying their commitment to delivery of client services in a manner that respects the individual's right and clearly states the patient's responsibilities.

RIGHTS:

- Clients have a right to receive information in a clear and concise manner stating the services provided, the practitioners rendering services, and knowledge of the treatment plan and options available to them.
- Clients have a right to expect treatment being rendered with respect, recognition of their dignity and a right to privacy.
- Clients have a right to participate with the practitioners in determining the most appropriate treatment plan and services regarding their healthcare.
- Clients have a right to candid discussions and explanations in decisions related to their treatment and selection/rejection of the most appropriate options regardless of the cost of benefit coverage.
- Clients have the right to voice complaints or request appeals about the services or personnel delivering the services.

RESPONSIBILITIES:

- Clients have a responsibility to provide, to the extent possible, information needed in order to deliver care with full knowledge of the client's history, current status and other relevant details.
- Clients have a responsibility to comply with the treatment plans and instructions for the care they have agreed to with their healthcare provider.
- Clients have a responsibility to understand their allowances, requirements, and limitations of their selected health insurance plans.
- Clients, their families, and visitors are responsible for following the policies, rules and regulations.
- Clients are responsible to promptly meet any financial obligations, which include but are not limited to co-pays, coinsurance, deductibles and other charges deemed patient responsibility.
- Clients are responsible to provide accurate and current information to the practice representative and healthcare providers to permit timely and just coverage for services rendered.

LIMITS OF CONFIDENTIALITY:

- You direct the clinician to tell someone else.
- The clinician determines that the patient is a danger to themselves or others.
- The clinician receives information regarding child/elder abuse or neglect.
- The clinician is ordered by a court to disclose information.
- If required for insurance billing purposes.

CAROLINA PSYCHOLOGICAL HEALTH SERVICES (CPHS) PATIENT POLICY

TREATMENT RENDERED

I understand I can withdraw consent to treatment at any time, a withdrawal of consent must be done in writing and will include the reason for the withdrawal. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and no guarantees have been made to me concerning care. Because psychotherapy (counseling) is a cooperative effort between patient and therapist, you must work with the therapist, if refused, the treatment that is suggested will be discontinued. CPHS or any individual will not be held responsible for any consequences resulting from decision beyond that time.

NO SHOW/CANCELLATION FEE

I understand that if I cannot keep an appointment, I must cancel 24 hours prior to the appointment or that I may be charged a "No Show" charge of $70.00

Co-Pays/Deductible and Co-Insurance Payments

Per your insurance policy, we must collect any co-pays, deductible or co-insurance payments at time of service. If issues arise regarding this part of our policy, talk to your therapist so financial arrangements can be made.

POLICY ON ELECTRONICS/CELL PHONES

Government regulations do not allow the use of cell phones or other electronic devices when conducting business at the check-in/check-out windows or when in an appointment with a therapist or medical doctor.

Taking photographs or videos of staff members, another patient or any aspects of the Carolina Psychological Health Services office space is also prohibited.

Please power off cell phones and other electronic devices in the lobby and during appointment times.

PATIENT BRINGING MINOR CHILDREN TO APPOINTMENTS

A patient who brings minor children with them at time of their appointments must not leave children unattended; the children must remain with the patient. This is for safety purpose of the children. CPHS will not be responsible for the well-being of a child left unattended.

Failure to comply with this office policy could result in additional fees your insurance company will not reimburse.

BRINGING UNDER AGED GUESTS TO APPOINTMENTS

For the safety of underage guest, they must remain with the patient. In order to bring a guest under the age of 18 to attend an appointment your guest must have a signed consent letter from their parent and you must have consent from your therapist. If your guest is unable to remain with you, we will be happy to reschedule your appointment.

INSURANCE

Carolina Psychological Health Services (CPHS) requires all patients to make financial arrangements with us before we provide treatment. CPHS will file insurance on your behalf as a courtesy. CPHS cannot accept patients that have Medicaid, even if it is not the primary insurance.

Please be aware that your MENTAL HEALTH COVERAGE AND BENEFITS may differ from your medical benefits. You are responsible for knowing your coverage. Some may need PRE-AUTHORIZATION. Please check with your insurance company. For more than one insurance, make sure to contact all the insurances and complete the COORDINATION OF BENEFITS.

For TRICARE members: We require a copy of your military ID (which is authorized under DoDI # 1000.13 and Force Protection Advisory (0050-09-FPA (Change 1))).

You will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to CPHS for payment.

You must inform CPHS, in writing, of any concerns, questions, or disputes you may have concerning treatment or charges in a timely manner but not more than 30 days from either the completion of the procedure or awareness of dispute.

CAROLINA PSYCHOLOGICAL HEALTH SERVICES (CPHS)

Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND PSYCHIATRIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Revised October 2015

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

CPHS may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operation purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when CPHS provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when CPHS consults with other health care providers, such as your family physician or another psychologist.
  - Payment is when CPHS obtains reimbursement for care or to determine eligibility or coverage.
  - Health care operations are activities that relate to the performance and operations of CPHS. Examples are quality assessment and improvement activities, business related matters such as audits, administrative services, case management and care coordination.
- "Use" applies only to activities within CPHS, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside CPHS, such as releasing, transferring, or providing access to information about you to other parties.
- Fund-raising: CPHS does not use PHI for fund-raising opportunities.
- Appointment reminders: CPHS may use your information to send reminders about appointments.

II. Uses and Disclosures for Requiring Authorization

CPHS may use or disclose PHI for purposed of outside treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when CPHS is asked for information for purposed outside treatment, payment, and health care operations, CPHS will obtain an authorization from you before releasing this information. CPHS will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversations during a private, group, joint, or family counseling session. By law, these notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that CPHS has relied on that authorization, or if the authorization was obtained as a condition of insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

CPHS may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If you give CPHS information which leads your therapist to suspect child abuse, neglect, or death due to maltreatment, s/he must report such information to the County Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a Child Protective Services investigation, CPHS must do so.
- Adult and Domestic Abuse: If information you give, gives your therapist reasonable cause to believe that a disabled adult is in need of protective services, CPHS must report this to the Director of Social Services.
- Health Oversight: Your MD/therapist's NC professional review board has the power, when necessary, to subpoena records should s/he be the focus of an inquiry.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services CPHS has provided to you and/or the records thereof, such information is privileged under state law, and may not be released without your written authorization or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: CPHS may disclose your confidential information to protect you or others from serious threat or harm by you.
- Worker's Compensation: If you file a worker's compensation claim, CPHS is required by law to provide your mental health information, if relevant to the claim, to your employer and the NC Industrial Commission.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of PHI about you. However, CPHS is not required to agree to a restriction you request.
- Right to Receive Confidential Communication by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are being seen at CPHS. Upon your request, CPHS will send your bills to another address.
- Right to Inspect and Copy: Right to inspect and/or obtain a copy of PHI in CPHS mental and billing records used to make decisions about you for as long as the PHI is maintained in the record. CPHS may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, CPHS will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as PHI is maintained in the record. CPHS may deny your request. On your request, CPHS will discuss with you the details of the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you neither provided consent nor authorization (as described in Section III of this Notice). On your request, CPHS will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice form upon request.

THERAPIST'S DUTIES: CPHS is required by law to maintain privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

V. Breach Notification

CPHS will fully comply with all requirements for reporting a breach of PHI, following completion of risk analysis. Based on the results of the risk analysis, CPS will take any and all steps to review and mitigate the harm and reduce the likelihood of future breaches. Factors to be considered in the risk analysis include: the nature and extent of the PHI involved; who obtained the unauthorized access; whether the PHI was actually acquired or accessed; and the extent to which the risk has been mitigated.

VI. Complaints

If you are concerned that CPHS has violated your privacy rights, or if you disagree with a decision CPHS has made about access to your records, you may contact the HIPAA Privacy/Security Officer at (910) 347-3010. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Privacy/Security Officer listed above can provide you with the appropriate form and address upon request.

VII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice was revised October 2015. You have the right to a paper copy of this Notice. HIPAA requires CPHS to make every effort to provide you with a copy and to have you acknowledge receipt with your signature.

CPHS reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that CPHS maintains. CPHS will post notice of any revision to this notice in the clinic lobby and will provide you a copy upon request.

STATE AND LOCAL LAW

Under the state and local laws my psychiatrist/psychologist/therapist is required to report all cases in which there exists a specific potential harm to others in cases of reported or suspected physical, sexual and/or neglect of children which are required by law.