Carolina Psychiatric & Wellness
EVERY MIND MATTERS

2800 Village Way | Trent Woods, NC 28562
Phone 252-637-7300 | Fax 252-637-1772

Patient Intake Sheet - Legacy 2020

Historical version recovered from the existing website. The May 2022 intake packet is a separate source.

MR# _____

Patient First Name _____ MI _____ Patient Last Name _____

Date of Birth _____ Age _____ Sex: M / F _____ Patient Social Security # _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address (if other than physical address) _____

City _____ State _____ Zip _____

PLEASE INDICATE BELOW YOUR PRIMARY CONTACT NUMBER. IF THE PRIMARY CONTACT IS A CELLPHONE, AND YOU WOULD LIKE FOR CPandW TO SEND APPOINTMENT REMINDERS VIA TEXT PLEASE INITIAL HERE _____.

Primary Phone # (H) (C) _____ Secondary Phone # (H) (C) (W) / Ext. _____

Email Address _____

Responsible Party (if other than patient) _____ Relationship to Patient _____

Responsible Party SS # _____ Responsible Party Phone # _____

INSURANCE INFORMATION

If patient is NOT the primary card holder, please fill out the following information:

Primary Policy Holder's Name _____ DOB ___/___/___

Primary Policy Holder's Phone # (_____)_____

Tricare sponsor information required (if Tricare insurance)

Tricare Sponsor SSN _____/_____/_____ (all of SS# required)

Signature of Patient or Responsible Party _____ Date _____

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Medical and Social History

Patient Name _____ Occupation _____

Age: _____ Sex: _____ Race: _____

List Surgeries/Hospitalizations

_____

_____

Allergies

_____

_____

Ongoing Medical Problems/Chief Complaint

_____

_____

Family Medical History

_____

_____

Social History

_____ Married _____ Single _____ Divorced _____ Widowed

Tobacco Use ___past Number of years____

___present Packs per days_____

Alcohol Use ___past Amount_____

___present Amount_____

Substance Use ___past Number of years_____

___present How often_____

Nutrient History (current diet ex: low sodium, regular, diabetic, etc.)

_____

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Patient Medication List

(INCLUDING SUPPLIMENTS)

Patient Name _____ DOB _____

Pharmacy Name(s)/Location(s) _____

Phone Number(s) _____

Please List ALL CURRENT Medications and doses if known:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Authorization for Release of Protected Health Information

NAME:_____ DATE OF BIRTH:_____

(Place an X in the appropriate spaces) (Print name, address, phone/fax of person/agency)

_____ Release Records _____

_____

_____ Receive Records _____

_____

_____ Receive and Release Records _____

(includes written or verbal communication) _____

For the following dates of rendered services: _____

THIS DATE SHALL INCLUDE THE FOLLOWING INFORMATION: (Mark all that apply)

___ ALL records (excludes “psychotherapy notes” as defined in 45 CFR 164.501)

___ Psychiatric evaluation/diagnosis

___ Psychological evaluation/diagnosis (excludes “psychotherapy notes” as defined in 45 CFR 164.501)

___ Psychotherapy Notes (at the discretion of the therapist)

___ Current medications

___ Other_____

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Authorization for Release of Protected Health Information

PURPOSE: The purpose of this disclosure is to improve assessment, treatment, planning, and share information relevant to treatment, continuity of care and, when appropriate, coordinate treatment services. This disclosure is at the request of the individual client or his/her legal representative.

Unless revoked in writing, this consent shall be valid for 365 days from the date of signing this contract, not to exceed one year.

FORM OF DISCLOSURE: Unless you have specifically requested, in writing, that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, including, but not limited to, verbal, written, or electronic format. The doctrine of informed consent has been explained to me, and I understand the contents to be released and the need for the information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent in writing at any time, except to the extent that action based on this consent has been taken. I also understand that revocation of this consent will not condition my treatment.

I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosing it. I understand that mental health and development disability information is protected by N.C. State law (G.S. 122-C), and substance abuse treatment information is protected by federal law (42 C.F.R., Part 2), and HIV/AIDS information is protected by N.C. State law (G.S. 130A-143).

SIGNATURE OF CLIENT:_____DATE:_____

SIGNATURE OF LEGALLY RESPONSIBLE PERSON:_____

Printed Name of Legally Responsible Person:_____

_____ Parent ____ Guardian ____ Other _____

WITNESS:_____DATE:_____

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Patient Consent for Treatment

Carolina Psychiatric and Wellness, PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

{As required by HIPAA Regulation}

With my consent, Carolina Psychiatric and Wellness, PLLC may use and disclose protected health information about me or my child(ren) to carry out treatment, payment and healthcare transactions. Please refer to Carolina Psychiatric and Wellness, PLLC's Notice of Privacy Policies for a more complete description of such uses and disclosures.

The Notice of Privacy Practices has been made available to me and I have the right to a copy if I so desire. CPandW reserves the right to revise its Notice of Privacy Polices Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carolina Psychiatric and Wellness, PLLC, Privacy Officer, 2800 Village Way, Trent Woods, NC 28562.

With my consent, CPandW may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the office to carry out treatment, payment and healthcare transactions, such as appointment reminders, insurance items and any call pertaining to me or my child(ren) clinical care.

With my consent, CPandW may mail my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare transactions, such as appointment reminder cards, prescriptions and patient statements.

With my consent, CPandW may email my appointment reminder. I have the right to request that CPandW restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare transactions. However, CPandW is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I hereby assign to CPandW all payments for medical services rendered to myself or to my dependents. I have read and understand the Financial Policy. I understand I am responsible for any amount not paid by my insurance company(ies). I am responsible for all services performed by CPandW providers deemed not covered or denied by my insurance company. Any copayment or deductible is due at the time of the visit. I authorize the use of a photocopy of this assignment in lieu of original by my signature below. If for any reason it becomes necessary to send the financial balance on the account to collections, the expense incurred will be charged to the patient's account.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, CPandW may decline to provide treatment to me or my child(ren).

Signature of Patient/Parent/Legal Guardian/Other _____ Relationship to Patient _____

Printed name of patient/parent/legal guardian/other _____

Date _____

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Patient's Rights and Responsibilities

Carolina Psychiatric and Wellness, PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

As a patient you have certain rights and responsibilities. We recognize that a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care.

Patients have the right to:

Receive dignified, private, humane care and treatment while being cared for with respect and consideration

While receiving treatment, gain access to medical care and habilitation, regardless of age or degree of mental illness or developmental disabilities

Privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations

Confidentiality of your health records

Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health related condition

Ask about reasonable alternatives to care

Consent to/or refuse mental health treatment

Participate actively in decisions regarding one's health care and treatment

Accessible information regarding the scope and availability of services

Be informed about any legal reporting requirements regarding any aspect of screening or care

Patients have the responsibility to:

Provide complete information about one's illness/problem, to enable proper evaluation and treatment

Ask questions so that an understanding of the condition or problems is ensured

Show respect to health personnel and other patients

Reschedule/cancel an appointment in a timely manner (24 hours prior to appointment)

Update the office with any insurance changes. If you do not provide your new insurance information, the date of service will be your responsibility.

Pay outstanding balances in a timely manner

Provide accurate/up to date medication list

Inform the provider(s) if one's condition worsens or an unexpected reaction occurs from a medication

Update office when contact information changes. Which may include and/all of the following: home/cell/work phone numbers, home and email address

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Individual Rights:

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information. The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed to

The right to receive a printed copy of this notice

Carolina Psychiatric and Wellness, PLLC Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. The release and/or disclosure of your protected health information may only occur with a signed consent unless it is an emergency. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Right of Minors to Consent to Treatment

Under North Carolina law, minors, with or without the consent of a parent or guardian, have the ability to consent to services for the prevention, diagnosis and treatment of certain illnesses including: venereal disease and other diseases that must be reported to the State; pregnancy, abuse of controlled substances or alcohol; and emotional disturbance.

Financial Responsibilities

You will be expected to show your insurance card at each visit. You are required to update the office of any insurance changes. You are responsible for knowing your co-pay amount and whether you need to meet your deductible. If you have not met your deductible, we will expect payment in full. Insurance companies do not cover some services; you will be responsible for these charges. Insurance is a contractual agreement between you and your insurance company. If we are contracted with your insurance company, we will be glad to file your claim.

Requests to Inspect Protected Health Information

You may generally inspect of copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

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Duty to Warn

CPandW reserves the right to breach confidentiality to notify authorities, persons who know the client and/or persons who are at risk of harm in situations where the individual presents a significant and imminent risk of harm to themselves or others. This right is known as “duty to warn”. Employees are not under a duty to voluntarily inform authorities regarding a client’s past or intended criminal act, except where there is a risk of imminent physical harm. Involving authorities may lead to the determination that the client needs to be detained for an involuntary assessment.

Complaints

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to:

CPandW HIPAA

2800 Village Way

Trent Woods, NC 28562

You will not be penalized or otherwise retaliated against for filing a complaint. Carolina Psychiatric and Wellness, PLLC is committed to protecting the confidentiality of your health information.

Effective Date of this Notice of Privacy Practices August 31, 2017

Signature _____ Date _____

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Privacy Notice Acknowledgement Form

Carolina Psychiatric and Wellness, PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

The Federal Privacy Regulations require that CPandW have a written acknowledgement that you have received our Notice of Privacy Practices.

Your Signature indicates that you have been offered or received the Notice of Privacy Practices.

Name of Patient (print)_____ (DOB)_____

Signature of Patient/Parent or Legal Guardian/Custodian

Signature_____ Date_____

Printed Name_____

ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AN ATTEMPT WAS MADE TO OBTAIN AN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES ON _____. THE ACKNOWLEDGEMENT WAS NOT OBTAINED FOR THE FOLLOWING REASON:

_____ PATIENT WAS UNDERGOING EMERGENCY TREATMENT

_____ PATIENT/GUARDIAN DECLINED TO SIGN THE ACKNOWLEDGEMENT

_____ OTHER

Office Staff Member Signature:_____ Date:_____

The following Policies and Patient Information and HIPPA Notice of Privacy Practices sections are for you to keep. They do not have to be returned to our office.

2800 Village Way | Trent Woods, NC 28562
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Policies and Patient Information

General Office Policy

Please be advised that no children under the age of 12 years of age are to be left unattended in the waiting room.

New Patients

New Patients are required to arrive at least 20 minutes prior to your scheduled appointment time to fill out new patient paperwork. You are required to bring any/all insurance cards with you to your first appointment and any subsequent office visits. Patients are responsible for any and all services not paid by their insurance company. We collect benefit information, request authorization and bill your insurance company as a courtesy. If for any reason there is a problem with coverage, you will be responsible for payment. If you are responsible to meet a deductible with your particular insurance plan, you will be required to pay for your visit in full at the time of service. If you are uninsured, it is also required that you pay for your visit in full at the time services are rendered. We accept Visa, MasterCard and Discover Card as well as cash, money orders and will accept personal checks after your initial visit to our office.

A $25 returned check fee will be charged for checks returned for lack of funds. A returned check will also result in Carolina Psychiatric and Wellness, PLLC refusing to accept future personal checks.

New Patient-Reschedule/Cancellation Policy

We ask that if you find the need to cancel or reschedule your new patient appointment, please give the practice 24-hour notice by calling our office. Carolina Psychiatric and Wellness, PLLC holds a policy that states failure to give 24-hour notice to reschedule or the cancellation of a new patient appointment could result in the inability to make any appointments with our practice in the future.

Late Policy - Established Patients

Our office allows a 10-minute grace period arrival time to your appointment. Anything later 10 minutes however, you will need to reschedule. A $25 fee might also be added to your account, which would need to be paid before your next appointment.

Appointments - Established Patients

All appointments that are not cancelled at least 24 hours in advance are subject to $25.00 late cancel fee. Also, if you do not show up for your appointment there will be a $25.00 charge to your account. This $25.00 charge must be paid prior to your next visit.

If you are going to be 10 minutes or later for your appointment, you will be rescheduled.

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Prescriptions

There is a 72-business hour turn around time for ALL prescriptions. Please request your prescriptions one week in advance. Please wait for a call back and/or check with your pharmacy. Please allow 72 business hours if you are expecting a return call or are checking with your pharmacy. Please know that we are doing our best to complete your request as soon as possible. Pick-up times for prescriptions, paperwork, etc. are Mon-Thur 8:30 AM - 4:30PM and Fri 8:30 AM - 4 PM.

Medical Records

There is at least a 14 to 21 business day turn-around time now for all medical record requests. Please allow at least 14 business days before following up on your request. Please note: *Our office DOES NOT fill out disability forms/paperwork.*

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HIPPA Notice of Privacy Practices

_____

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you ‘to pay your health care bills’ to support the operation of the physician’s practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required By Law, Public Health issues as required by law, communicable Diseases: Health oversight: Abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights - Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications for us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 252-637-7300.