Carolina Psychiatric & Wellness
EVERY MIND MATTERS

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

New Patient Intake

MR#

IMPORTANT - Please remember to notify CPandW of any changes to your personal information. Example: Insurance information, home address, phone numbers, ect.

Patient First Name | MI | Patient's Last Name | Preferred Name

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

Physical Address: NO PO Box (must be physical address)

City | State | Zip

Mailing Address/PO Box (only if other than physical address)

City | State | Zip

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

Initials

Primary Phone # - Home / Cell | Secondary Phone # - Home / Cell / Work | Ext.

Email Address

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Responsible Party and Insurance

Responsible Party (if other than patient) Relationship to Patient

Responsible Party SS # Responsible Party Phone #

INSURANCE INFORMATION

ONLY if the patient is NOT primary card holder. Please fill out the following information:

Primary Policy Holder's Name DOB

Primary Policy Holder's Phone #

Secondary Policy Holder's Name DOB

Secondary Policy Holder's Phone #

TRICARE SPONSOR INFORMATION REQUIRED

(ONLY for Tricare insurance)

Tricare Sponsor SSN (all of SS# required)

Signature of patient IF 18, if not 18, the responsible party must sign Date

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Clinical History

Name DOB Occupation

Emergency contact name/relation/phone #:

Main purpose of your visit today:

Primary care physician (PCP):

Other health care providers:

Primary pharmacy location/phone #

Medication allergies:

Current Medication

(if not enough space please write on a separate piece of paper)

Name of medication	Dosage	Frequency taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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Medical History

Please check any box pertaining to a DIAGNOSED medical condition.

If not listed please write in empty box in the middle.

Medical condition		Medical condition
[ ] High Cholesterol		[ ] Iron Deficiency
[ ] High Blood Pressure		[ ] Cancer
[ ] Low Blood Pressure		[ ] Fainting/Dizzy
[ ] High Thyroid		[ ] Stroke
[ ] Low Thyroid		[ ] Migraines
[ ] Diabetes		[ ] Hearing Problems
[ ] Asthma		[ ] Stomach problems
[ ] Dementia		[ ] Acid Reflex (GERD)
[ ] Memory Issues		[ ] Vitamin D Deficiency
[ ] Head Injury		[ ] ADD or ADHD
[ ] Bed Wetting		[ ] Mobility Impairment
[ ] Behavioral Disorder		[ ] Bleeding Disorder
[ ] Trauma		[ ] Low libido/ED

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Current Symptoms or Concerns

Please check any box of any RECENT SYMPTOMS OR CONCERNS.

If not listed please write in empty box in the middle.

Symptoms or concerns		Symptoms or concerns
[ ] Focus issues		[ ] Issues at work
[ ] Worrying		[ ] Issues at school
[ ] Anxiety		[ ] Issues at home
[ ] Mood swings		[ ] Nightmares
[ ] Down days		[ ] Sleep issues
[ ] Hopeless feelings		[ ] Hearing voices/things
[ ] Restlessness (not able to be still)		[ ] Thoughts of giving up
[ ] Change in appetite		[ ] PTSD
[ ] Emotional outburst		[ ] Marital issues
[ ] Confusion		[ ] Child management issues
[ ] Helpless Feelings		[ ] Can't remember things
[ ] Don't want to leave the home		[ ] Social issues
[ ] Task have to be done perfectly		[ ] Time management issues

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Surgeries and Family Medical History

Surgeries

(If not enough space please write on a separate piece of paper)

Family Medical History

please place a check mark in appropriate column(s)

Condition	Mother	Father	Sibling(s)	Child(ren)	Mother's Parents	Father's Parents
Anxiety						
Depression						
Bipolar Disorder						
Schizophrenia						
ADHD						
Suicide						
Heart issues						
Thyroid issues						
Memory issues						
Seizures						
Diabetes						
Stroke						
Cancer						
Sleep apnea						
Other/Not Listed:						

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Psychiatric and Social History

Psychiatric History

Please place a check mark next to any true statement

[ ] I have previously seen a psychiatric medication provider.

[ ] I have been in a psychiatric hospital(s):

[ ] I have a history of self-harm.

[ ] I have a history hurting others.

[ ] I have a history of a suicide attempt.

[ ] I have an outpatient therapist currently.

[ ] I have a history that I consider as trauma.

Social history

Please check all that apply

	Choices
Relationship Status	[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Significant Other [ ] Prefer not to answer
Highest Education	[ ] Grade _____ [ ] High school [ ] Some college [ ] Associate degree [ ] Bachelor degree [ ] Master or higher
Alcohol use	[ ] None [ ] rare [ ] occasional [ ] weekend [ ] daily [ ] Past use
Nicotine	[ ] None [ ] rare [ ] occasional [ ] weekend [ ] daily [ ] Past use
Illegal drugs	[ ] None [ ] rare [ ] occasional [ ] weekend [ ] daily [ ] Past use

Intake sheet 5 2022

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Authorization for Release of Protected Health Information

NAME: _____ DATE OF BIRTH: _____

(Place an X in the appropriate spaces)

(Name, Address, Phone/Fax of Doctor's Office, Person, etc.)

[ ] Release Records

[ ] Receive Records

[ ] Receive and Release Records

(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: _____

(OFFICE PERSONNEL ONLY)

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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.

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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.

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

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

Patient Consent for Treatment

For Use and Disclosure of Protected Health Information

{as required by HIPAA Regulation}

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.

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 Policies 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.

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Patient Consent for Treatment - Continued

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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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/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 acknowledgment 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

Name of Staff Member: Date

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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 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 you 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 could 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.

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Policies and Patient Information - Continued

Late Policy For Established Patients

Our office allows a 10-minute grace period arrival time to your appointment. Anything later than 10 minutes 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. Also-failure to cancel in a timely manner will result in no call backs from the provider until the next face to face appointment.

Appointments for Established Patients

All appointments that are not cancelled at least 24 hours in advanced are subject to $25.00 late cancel fee. The $25.00 charge must be paid prior to your next visit.

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-Thurs 8:30 AM - 4:30 PM 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.

WE LOOK FORWARD TO PROVIDING THE BEST POSSIBLE CARE FOR YOU.

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NC HIE Memorandum

Source packet appendix - May 2022 new patient paperwork. Original memorandum attribution retained.

Charles D. Godwin, M.D., Psychiatrist

MEMORANDUM

Providing you with the highest quality of care is our number one goal. Your health is very important to your doctors and our staff. That is why we have signed up to participate in the NC Health Information Exchange (NC HIE) program with area hospitals, other physicians and health care providers in our community.

Participating in the NC HIE allows doctors at the hospital and in the community get medical information about you to provide better care for you. NC HealthConnex is a secure computer system for doctors, hospitals and other health care providers to share information. The system links your key medical information from all of your health care providers to create a more complete electronic health record. Not only does this help us care for your health, it saves you time and lessens your out-of-pocket costs.

Our practice makes every effort to protect your health information. Only those who treat you will be allowed to view your medical information. The NC HIE complies with our Notice of Privacy Practices. You received a copy of this notice in the new patient paperwork you received on your first date of service. You can request another copy of this notice at any time.

All participants in the NC HIE take their obligation to protect your information very seriously.
- Federal laws and regulations prevent the NC HIEA from receiving and/or managing certain types of mental health or substance use treatment data without patient consent related to disclosures of such data.
- Pursuant to the HIPAA Privacy Rule, HIPAA covered entities are prohibited from sharing a patient's psychotherapy notes unless the covered entity receives explicit authorization from the patient to do so (See 42 C.F.R. 164.508).

You have the right to opt out of having your information shared between providers through NC HealthConnex. If you choose to opt out, please complete the "Opt Out" form accessible via the NC HIEA website: hiea.nc.gov/patients/your-choices. We also have copies of this form in our office. Complete the form and mail it to:

NC Health Information Exchange Authority
Mail Service Center 4101
Raleigh, NC 27699-4101

If you choose to opt out of the NC HIE program, it will not adversely affect your treatment and you cannot be discriminated against if you decide to opt out. Additionally, if you change your mind about participating, you can opt back in at any time by completing a new form.