CAROLINA COMPLETE
PSYCHIATRY

New Patient Packet

Date _____/____/_____ Chart # _______________

PATIENT INFORMATION:

Name: Last ____

First _________________________ Middle ________________ Preferred Name:____________

Street Address: ____

City: ____

State __________________________ Zip Code: ________________

Cell Phone: ______________________________ Email address: _________________________

Home Phone: _____________________________ Work Phone: __________________________

Date of Birth _____/____/____ Age: ________ SSN#: ________-_______-________

Employer/School & Grade: ____

Employed: **Full Time** **Part Time** **Disabled** **Retired** **N/A**

Gender: **Male** **Female** **Transgender**

Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

Student**: Full Time** **Part Time**

Emergency Contact:____

Phone Number: _________________________ Relationship: __________________

Primary Care Physician: ____

Phone: ___________________________ Fax: _________________________

Primary Care Physician's Address: _________________________________

City: ___________________State _____________ Zip Code: __________

Who referred you: _________________________________

Phone: ___________________________

Preferred Pharmacy: ___________________________________ Phone: ___________________

Address: ____

List below all people residing in your home:

Name:	Relationship:	Birthday and Age	Occupation/Grade

What, if any, events or circumstances prompted you to call at this time?

____

____

Describe what you believe has caused the difficulties you are having?

____

____

____

What have you done to help these problems?

____

____

____

Describe any family difficulties or events which were upsetting (such as: illness or death of a family member or close relative, moves, financial problems, marital stress, sexual or physical abuse).

____

____

____

Medical History

Date of most recent physical exam: ___________________________

Results: _________________________________ Did you have any blood work done? **Y/N**

Are you now receiving treatment for any medical issues?

____

List below serious illnesses (hypertension, diabetes, heart disease, etc), accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

____

____

____

____

____

List all current medications. Please include over the counter, vitamins and herbal medications. Continue on back if needed. Please bring medication bottles with you to your appointment.

Medication:	**Dose:**	**Prescribed by:**	**Duration:**

Allergies? (Medications or Environmental)

____

____

Family History:

Describe any medical or psychiatric conditions of your parents, siblings and children:

____

____

____

____

Habits:	Amount currently using	Most ever used
Caffeine (cups/day)	____________________	________________
Cigarettes (packs/day)	____________________	________________
Alcohol	____________________	________________

Exercise habits:

____

____

Sleep habits:

____

____

Psychiatric History:

Have you ever received psychiatric or psychological treatment of any kind before?

Yes ( ) No ( )

If you checked yes to the above question please complete the following:

Name/Service/Hospital:	**Provider:**	**Reason:**	**Date/Treatment Length**

Did your doctor prescribe medicine at that time? Yes ( ) No ( ) Not applicable ( )
If yes, what was prescribed (include dosage if known)? List all previous psychiatric medication trials please.

____
____
____
____

Personal OR family history of Suicide Attempts?

____
____

Substance Use History
Have you ever abused drugs or alcohol? Yes ( ) No ( )
If yes please describe:

Substance:	Amount:	Frequency:	When (First & Last Use):

If yes, have you ever received substance abuse treatment of any kind? Yes ( ) No ( )
Do you have a history of blackouts, seizures or withdrawal symptoms?

____
____

Please describe anything else you would like your clinician to know.

____
____
____
____
____

REVIEW OF SYSTEMS: In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask at your appointment.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other: ____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nose bleeds, sore throat, facial pain or numbness.
Other: ____

Cardiac: ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking, structural abnormalities, history of abnormal EKG.
Other: ____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: ____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other: ____

Kidney & Bladder: ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other: ____

Muscles, Bones, Joints: ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: ____

Skin, Hair & Breast: ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.
Other: ____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: ____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: ____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: ____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other: ____

Please feel free to list other medical concerns that you do not think were addressed:

____
____
____
____
____

CAROLINA COMPLETE PSYCHIATRY

PATIENT RIGHTS AND RESPONSIBILITIES/CONSENT FOR TREATMENT

This is to help you understand your rights and responsibilities and the level of cooperation that we need from you in order to help you realize the highest level of mental and emotional health of which you are uniquely capable. Our desire is to form a partnership with you regarding your mental health. Your assistance is crucial and the interest and commitment that you bring to this partnership are essential to attaining significant resolution to your mental health concerns.

YOUR RIGHTS

You are assured the following rights:

- The right to be treated with dignity and respect
- The right to treatment including access to medical care and habilitation, regardless of your race, religion, gender, ethnicity, age, or sexual orientation.
- The right to have your treatment and other patient information kept private.
- The right to know about all treatment choices, regardless of the cost of those treatment choices, and to participate in the choice of treatment.
- The right to consent or to refuse treatment. Refusal cannot be sole grounds for termination and consent can be withdrawn at any time.
- The right to obtain a copy of your treatment plan by completing a release form.
- The right to contact Disability Rights of North Carolina at 919-856-2195.

YOUR RESPONSIBILITIES

In order to provide you with the best care, your commitment to your treatment and recovery is essential. We require that patients understand their role and responsibilities in their care:

- You have the responsibility to give your provider the information needed so that we can deliver the best possible care.
- You have the responsibility to let your treating provider know if or when the treatment plan no longer works for you.
- You have the responsibility to follow your medication plan. You must tell your treating provider about any medication changes, including medications prescribed for you by other healthcare professionals.
- You have the responsibility to keep your scheduled appointments.
- You have the responsibility to ask your treating provider any questions you may have about your care, so that you can better understand your care and the role you play in your care.
- You have the responsibility to follow your treatment plan and instructions for your care, once that care has been agreed upon by you and your treating provider.

CAROLINA COMPLETE PSYCHIATRY

I have read and fully understand my rights and responsibilities in my partnership with Carolina Complete Psychiatry, PLLC in providing for my care, and agree to adhere to them, and acknowledge that I have received a copy of this statement. Further, I hereby consent to outpatient treatment and give permission for the clinician to provide the services deemed necessary or advisable in the diagnosis and treatment of the patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment received by Carolina Complete Psychiatry, PLLC. I understand that the patient has the right to withhold consent to any medical service that is deemed necessary or advisable by the clinician. My signature below indicates my understanding and approval of the above.

____ Date: ____________

Printed Name of Patient

____

Signature (and relationship if patient is a minor)

Notice of Privacy Practices for

Carolina Complete Psychiatry, PLLC

Date:__________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Carolina Complete Psychiatry, PLLC. A copy of this signed, dated document shall be as effective as the original. A current copy of the privacy policy may be found at www.ccpsychiatry.com.

____ Date of Birth: ____________
Printed Name of Patient

____
Signature (and relationship if patient is a minor)

Carolina Complete Psychiatry, PLLC may contact me at the following phone numbers or email address regarding my appointments, treatment, and information about my health. Messages may be left unless otherwise noted.

Email address: ____________________________________
Cell Phone: ____________________________________ NO messages: [ ]
Home Phone: ____________________________________ NO messages: [ ]
Work Phone: ____________________________________ NO messages: [ ]

____
Printed Name of Patient

____
Signature (and relationship if patient is a minor)

CAROLINA COMPLETE
PSYCHIATRY

Waiver of Electronic Mail Confidentiality Release

By providing my email address below and signing, I understand that I give Carolina Complete Psychiatry permission to e-mail me on the account given. Furthermore, I understand that e-mail is not a HIPPA compliant form of communication, nor is information protected in any way other than basic passwords. I waive any and all liability for Carolina Complete Psychiatry, PLLC in the event of information disclosure that resulted from the use of e-mail.

Patient Name: ____

Date of Birth: ____

Home Address: ____

____

E-mail Address: ____

Signature:____

If you would prefer no communication by email, please check here [ ]

Lastly, you are invited to use Patient Fusion, an electronic communication portal that is encrypted and HIPPA complaint. This will allow you to communicate with your provider, as well as see upcoming appointments, medications, and recent lab work results. Please ask the office for an invitation code if you do not want an invitation to be sent to you via email.

OFFICE POLICIES (Please initial next to each policy)

______APPOINTMENTS: Services are by appointment only. This time slot has been reserved just for you. In the event of an emergency, every effort will be made to work you into the schedule. It is recommended that you plan to arrive early and anticipate possible delays such as traffic. In the event that you run late, you will not be given additional time as this may interfere with another patient's reserved time. If an appointment is missed, you will be billed according to the scheduled fee.

______CANCELLATIONS: Cancellations must be made 24 hours in advance. Cancellations made less than 24 hours in advance, or no-show appointments, will be **charged a $100 fee**. If you have incurred this fee, it will be taken automatically from a credit card on file and all patients are expected to keep a zero balance. Refills on medication will also not be given if you miss an appointment or if there is a balance on your account. In the event that you need to cancel an appointment on Monday, cancellation must be done on Friday in order to avoid being charged.

______REQUESTS FOR RECORDS: If you have an appointment with another provider or request medical information for any reason, you must notify Carolina Complete Psychiatry, PLLC at least five days before your appointment. This will allow your provider sufficient time to prepare documentation for you. In the event that you need records sooner, a fee may be charged.

______BILLING: Carolina Complete Psychiatry, PLLC is not contracted with any insurance companies and we do not file claims for the services you receive. You will be provided with a receipt containing a diagnosis code that you may submit to your insurance carrier for reimbursement. It is your responsibility to know what your insurance carrier will or will not reimburse. Any reimbursement must be sent directly to you. In the event that any insurance reimbursement is sent to the office, it will be returned to sender as we will not be responsible for handling any insurance reimbursements.

_____PAYMENT POLICY: Carolina Complete Psychiatry, PLLC requires payment in full at the time of service. Please discuss service fees with provider. Payment may be made in the form of cash, check (to Carolina Complete Psychiatry), or credit card. If you have any questions regarding payment and services, please voice them to your provider. It is expected that all patients maintain a zero balance. You are required to keep a credit card on file with this office in the event of a no-show appointment/late cancellation. Your initials provide consent for this payment. **This is not optional.**

Debit/Credit Card to be kept on File: ____

Expiration Date:____/____ CVV: __________ Billing Zip Code: ___________

_____CONFIDENTIALITY: What is shared between you and your provider will be held in strict confidence. Please see the Patient Privacy Notice for more specific details about your Private Health Information. Information will only be shared if the patient has signed a release of information. Please be aware that the following circumstances are exceptions to confidentiality: a) Patient is a physical danger to self. b) Patient is a physical danger to others. c) Child or elder abuse/neglect is suspected.

_____MESSAGES: All messages will be returned as promptly as possible. No messages will be checked on weekends or standard holidays. If you need urgent assistance, you may call the provider on call at 704-750-8083. This will not be charged if the phone call is truly needed, but you may incur a cost for phone conversations over 10 minutes in length. In the event of an emergency, call 911 or go to the nearest emergency department for treatment. Please be aware that providers of Carolina Complete Psychiatry do not provide inpatient treatment for patients.

_____REFILLS: Refills will typically be handled during your office visit. **No routine prescriptions will be refilled after 5PM during the week, on weekends, or holidays. Check your medications regularly to be sure that you have enough. We are closed Fridays**. Please allow 72 hours for prescription refill requests to be processed. If you have any medication questions, please contact the office. If you miss an appointment and need a refill, you will need to be seen prior to a refill being sent to your pharmacy. You are strongly encouraged to bring your pill bottles with you to each appointment to ensure that you have enough medication.

_____COURTESY: Please put your mobile device on silent when you visit Carolina Complete Psychiatry, PLLC. If you must be on your phone, we ask that you step outside of the suite to avoid disturbing others within the area. Rude or disruptive behavior could result in termination of the provider-patient relationship.

_____TERMINATION: At times, termination between a patient and provider is necessary. Termination of treatment may occur at any time and may be initiated by either the patient or the provider. Reasons for termination by the provider are generally due to non-compliance with treatment, missed appointments, or violation of office policies. If you have any questions about this, please discuss with provider. In the event that your care needs to be transferred to another psychiatric provider, Carolina Complete Psychiatry, PLLC will provide assistance as able.

FEES: Fee structures are subject to change based on the severity of presenting concerns, appointment length, and services provided. The providers at Carolina Complete Psychiatry have your best interest in mind and alter their scheduling to accommodate meeting your needs. Fees may be added to your account for both direct and indirect patient care for the following purposes as listed below. We value you as a patient of the practice and should you have any questions or concerns, please feel free to discuss any pricing or financial issues with the practice manager or owner. Please initial each line:

1. ______ Carolina Complete Psychiatry will complete applicable forms or paperwork for any patient that has been seen within the last four weeks. There is a $20 fee for paperwork to be completed outside of your scheduled office visit. We will make every attempt to complete forms during your office visit if time allows for this, but may not always guarantee this can be completed. In the event these forms require more time and resources, additional fees may occur; however, you will be notified prior to being charged. In the event that you need a form completed with less than 72 hours notice, you may be charged an additional fee.

2. ______ We value our time with our patients and want to make sure that you are able to discuss what you need to during your appointment. Your initial evaluation is generally 60 minutes long and your follow-ups are typically 20-30 minutes. In the event that you need additional time, there is a $40 extended service fee for each 20 minutes past your appointment end time.

3. ______ A provider is available to you 24 hours a day, 7 days a week by phone for urgent matters. Please note that any issues that require longer than a 10 minute phone call will be charged at a rate of $20 per ten minute intervals. We ask that you be mindful on your purpose for calling as this line is not for appointment scheduling or refill requests.

Please feel free to request a copy of this document for your own records if needed. Thank you. The undersigned acknowledges reading and understanding the policies for Carolina Complete Psychiatry, PLLC.

____ Date of Birth: ____________
Printed Name of Patient

____ Date:__________________
Signature (and relationship if patient is a minor)