CAROLINA COMPLETE PSYCHIATRY

New Patient Packet

Date ____/___/____

PATIENT INFORMATION:

Name: Last _____

Legal First _____Middle _____ Preferred Name:_____

Date of Birth ____/___/___Age: _____ SSN#: _____-_____-_____

Street Address: _____

City: _____

State _____ Zip Code: _____

Cell Phone: _____ Email address: _____

Home Phone: _____ Work Phone: _____

Employer/School & Grade: _____

Highest Level of Education: _____

Employed/School Schedule: ◉ Full Time ○ Part Time ○ Disabled ○ Retired ○ N/A

Gender: _____ Sexual Orientation: _____

Race: _____

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

Emergency Contact: _____

Phone Number: _____ Relationship: _____

How did you hear about our practice/Referred by? _____

Preferred Pharmacy: _____ Phone: _____

Address:_____

Insurance provider for prescriptions only: _____

ID No:_____Group No: _____ BIN:_____ PCN:_____

What is your greatest concern currently? (For example sadness, worry, attention issues, mood swings) 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).

_____

_____

_____

What is your biggest goal in seeking psychiatric care?

_____

_____

_____

Medical History:

Primary Care Physician: _____

Phone: _____ Fax: _____

Primary Care Physician's Address: _____

City: _____ State _____ Zip Code: _____

Date of most recent physical exam: _____

Results: _____

Did you have any blood work done? Yes☐ No☐

Are you now receiving treatment for any medical issues?

_____

List below any serious illnesses (IE: hypertension, seizures, thyroid disease, diabetes, heart disease, liver or kidney problems), accidents (IE: head trauma, concussions), or surgeries which you have had. Please use back of paper to continue list if needed:

_____

_____

_____

_____

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/Taken For:	**Dose and Frequency:**	**Prescribed by:**	**How long have you been taking this?**

Allergies? (Medications, Food or Environmental)

_____

_____

For Females:

Date of Last Menstrual Cycle: _____

Currently Pregnant: Yes ☐ No ☐ Due Date: _____

Number of Prior Pregnancies: _____ Currently Breastfeeding: Yes ☐ No ☐

Form of Birth Control: _____

Family History:

Describe any medical, **psychiatric conditions** of your parents, siblings, children or other family members:

_____

_____

_____

_____

Family History of Substance Abuse: Yes ☐ No ☐ Who? _____

Family history of Completed Suicide: Yes ☐ No ☐ Who? _____

Family history of Suicide Attempts: Yes ☐ No ☐ Who? _____

List below all people residing in your home:

Name:	**Relationship:**	**Birthday and Age**	**Occupation/Grade**

Psychiatric History:

Have you previously been given a psychiatric diagnosis? By whom?

_____

_____

_____

_____

Who have you previously seen as a psychiatric provider (that prescribes medication)?

_____

_____

_____

What medications have you previously been prescribed? List prescriber, dose, length of time, and response to treatment if you can recall.

_____

_____

_____

_____

_____

_

Are you currently seeing a therapist? Yes ☐ No ☐ Who? _____
Have you ever seen a therapist? Yes ☐ No ☐ Who? _____

Have you ever had a psychiatric hospitalization? Yes ☐ No ☐
Hospital: _____ Length of Stay: _____ When: _____
Hospital: _____ Length of Stay: _____ When: _____
Hospital: _____ Length of Stay: _____ When: _____

Have you ever had treatment for eating disorder? Yes ☐ No ☐
Facility: _____ Length of Program: _____ When: _____
Facility: _____ Length of Program: _____ When: _____
Facility: _____ Length of Program: _____ When: _____

Personal History of Suicide Attempts? Yes ☐ No ☐

_____

_____

Personal History of Self Injury? Yes ☐ No ☐

_____

_____

Substance Use:

Substance	Average Amount:	Age of First Use:	Most Used:	Last Used:
Cigarettes:				
E-Cig/Juul:				
Alcohol:				
Cannabis:				
Other:				
Other:				
Other:				

Do you have a history of blackouts, seizures or withdrawal symptoms?

Are you or family/friends concerned about your use of substances now? Yes ☐ No ☐
Have you ever received substance abuse treatment of any kind? Yes ☐ No ☐

Social History:

Do you exercise on a regular basis: Yes ☐ No ☐
Type of Exercise: _____
Days per week:_____ Length of Time Per Workout: _____

Having difficulty with sleep? Yes ☐ No ☐ Average hours of sleep per night: ____
Have you been diagnosed with Sleep Apnea? Yes ☑ No ☐ Use CPAP: Yes ☐ No ☐
Describe sleep issues/habits:

Change in appetite recently? No ☐ Increase ☐ Decrease ☐
Change in weight recently? _____
How many meals a day do you eat? _____
Special diet? (ie: vegan, gluten free) _____

Do you have access to firearms? Yes ☐ No ☐

Do you have any pending legal issues? Yes ☐ No ☐

Do you have any history of abuse or trauma? Yes ☐ No ☐

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

REVIEW OF SYSTEMS: Check "No Problems" or circle applicable issues or explain any that may not be listed.

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, difficulty swallowing, 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, 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, urinary urgency, prostate problems, bladder problems.

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, nipple discharge.

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, sexual dysfunction.

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: _____

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 of Patient or Parent/Legal Guardian (and relationship if patient is a minor)

CAROLINA COMPLETE PSYCHIATRY

PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and your access to it. Protected health information about you is obtained as a record of your visits or contacts with Carolina Complete Psychiatry, PLLC for healthcare services. Specifically, PROTECTED HEALTH INFORMATION is information about you, including demographic information (name, address, age, etc.) that may identify you and may relate to your past, present and/or future physical or mental health condition(s) and related healthcare services. Carolina Complete Psychiatry, PLLC is required to follow specific rules for maintaining the confidentiality of your protected health information, the use of your information and how providers disclose or share this information to/with other healthcare professionals involved in your care and treatment. This Policy describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE:

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions/concerns with the staff.

YOUR RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that Carolina Complete Psychiatry, PLCC has taken an action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO YOUR PROTECTED HEALTH INFORMATION

This means that you may inspect and obtain a copy of protected health information about you that is contained in your patient record. Under certain circumstances, we may deny your request. Any requests for copies of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means that you may request, in writing, that we not disclose any part of your protected health information for the purposes of treatment, payment for service you have received, or healthcare operations. You may also request that any part of your protected health information be restricted from disclosure to others who may be involved in your care or for notification purposes as described in this Notice of Privacy Policies. Under certain circumstances, we may deny your request for restriction. All requests for restriction of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means that you may request an amendment of your protected health information for as long as we maintain the information. Under certain circumstances, we may deny your request for an amendment. All requests for amendment to your protected health information must be made in writing.

CAROLINA COMPLETE PSYCHIATRY

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

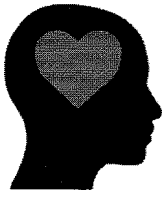
_____
Signature of Patient or Parent/Legal Guardian (and relationship if patient is a minor)

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 of Patient or Parent/Legal Guardian (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 HIPAA 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 <u>no</u> communication by email, please check here ☐

Lastly, you are invited to use Patient Fusion, an electronic communication portal that is encrypted and HIPAA 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.

CAROLINA COMPLETE PSYCHIATRY

Payment Method

Patient Name:_____ DOB:_____

Cardholder Name:_____ Relationship:_____

WE DO NOT CARRY PATIENT BALANCES.
ALL FEES ARE DUE AT THE TIME OF SERVICE.
A VALID CREDIT CARD OR DEBIT CARD IS REQUIRED BY ALL PATIENTS.

- ★ In the event of a missed appointment without proper 24 hour cancellation, the following card will be charged for the full fee of the appointment
- ★ In the event of a late arrival greater than 10 minutes or a cancellation less than 24 hours, the following card will be charged $100

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name (as it appears on your credit card)_____
Card Number: _____ Exp Date:_____
3 Digit security code on the back of card (CVV)_____
Billing address_____
Billing Zip Code_____
Cardholder Signature_____

Please note: You must inform the office if there have been **ANY** changes to your credit card information. Failure to inform the office of such changes or a declined credit card transaction will result in a $25.00 charge to your account.

By signing below, you agree to, approve, and understand all of the following:

- Carolina Complete Psychiatry, PLLC, reserves the right to charge the credit card on file, at any time for service provided by the company.
- If your account at Carolina Complete Psychiatry, PLLC carries an outstanding balance for more than 30 days, we may charge the card for the outstanding amount without giving prior notice.
- You have the right to request an invoice/statement at any time.
- Carolina Complete Psychiatry, LLPC. will not be held liable for any fraudulent charges made to the credit card account.
- If you are not the cardholder of the credit card, you agree to take full responsibility for any charges made by Carolina Complete Psychiatry to the card you have provided.

Patient Signature_____ Date_____

CAROLINA COMPLETE PSYCHIATRY

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. You may not wait on premise for an available appointment. **If an appointment is for a person under the age of 18, a parent or legal guardian must accompany the patient to every appointment. No exceptions will be made and the appointment will need to be rescheduled if a parent/guardian is not present.**

_____CANCELLATIONS or LATE ARRIVALS: Cancellations must be made 24 hours in advance. In the event that you need to cancel an appointment on Monday, cancellation must be done on Friday by 5 PM in order to avoid being charged. Cancellations made less than 24 hours in advance will be **charged a $100 fee**. You will also incur this fee if you arrive **more than 10 minutes** past your scheduled appointment time. If you have incurred this fee, it will be taken automatically from a credit card on file as all patients are expected to keep a zero balance. Refill requests or scheduling follow up appointments will also not be given if there is a balance on your account.

_____MISSED APPOINTMENTS: In the event that you need to miss your appointment, we ask that you notify the office so that we may late cancel your appointment. If you miss your appointment without notification to the office, you will be automatically charged to your credit card the full fee of your appointment. This is $160 for follow up appointments and $320 for initial appointments. Excessive missed appointments may result in discharge from the practice.

_____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/superbill 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. Payment may be made in the form of cash, check (to Carolina Complete Psychiatry -returned checks due to insufficient funds will incur a $25 fee), or credit card. 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. This is not optional to have a credit card authorization form on file with the office. It is the patient's responsibility to notify the office if the card on file needs to be updated.

_____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 by the patient or those accompanying the patient that is directed towards any provider, staff or other people within the suite 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. For transparency, our fees are also listed on our website. 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 $25 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. No forms for medical leave or school withdrawal will be completed at a new patient appointment.

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 if scheduling allows. If there is not time for the extension, an additional follow up appointment may be needed.

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. This line is also not for crisis or emergency needs. If you are in crisis, please call 911 or go to the nearest emergency department.

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 of Patient or Parent/Legal Guardian (and relationship if patient is a minor)