Coastal Carolina Neuropsychiatric Center

NEW PATIENT INFORMATION PACKET

Date:_____ Patient SSN:_____

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

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

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

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

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

DOB: _____ SSN: _____ **Sex (circle one): M - F - T**

Marital Status:_____

Name of Employer/School: _____

ADDITIONAL INFORMATION (Check one)

Race: O American-Indian O African-American O Asian O Hispanic O Pacific-Islander O White O Not Listed O Refused

Ethnicity: O Hispanic/Latino O Non-Hispanic/Latino O Refused

Preferred Language: O English O Spanish O Indian O Russian O Not Listed

TEXT/SMS/MMS DISCLOSURE

By providing us with your signature, you are authorizing CCNC to communicate with you through Text/SMS/MMS messaging for appointment reminders using the cell phone number listed above. You acknowledge that you have been provided with/given instructions on obtaining our Text/SMS/MMS disclosure policies and conditions via the patient orientation packet.

_____ _____
Signature of Patient/Legal Guardian Date

IN CASE OF EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship:

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

AUTHORIZE TO TREAT

I affirm that I am the (circle one) patient/ legal guardian and responsible party of the above patient and, I hereby acknowledge that I authorize and give permission to the staff of ***Coastal Carolina Neuropsychiatric Center (CCNC)*** to render treatment and/or services to myself/above named minor child, and I acknowledge receipt of the notice of privacy practices of CCNC.

_____ _____
Signature of Patient/Legal Guardian Date

PATIENT CARE COMMUNICATION

As part of CCNC's pledge to offer quality care for our patients, we would like your permission to communicate with your primary care physician (and/or other clinician who referred you to us) about your mental health care.

AUTHORIZATION

I, _____, hereby authorize *Coastal Carolina Neuropsychiatric Center, PA* to:

Please check one:

____ To release any applicable mental health information to my primary care physician (PCP) or other referring clinician, named below.

____ To release any applicable substance abuse information to my PCP or other referring clinician, named below.

Primary Care Physician/Clinician Name _____ *Phone Number:* _____

Practice Name: _____

Practice Address: _____

Printed Name of Patient/Guardian _____

Signature of Patient/Guardian _____ Date _____

Date of Initial Appointment _____

Patient Background

How many mental health visits have you had in the last 12 months?:

Date of last physical examination:

What is the reason for your visit?:

FAMILY HISTORY

FATHER	If alive, present health:		If deceased, cause of death:
MOTHER	If alive, present health:		If deceased, cause of death:
SPOUSE	If alive, present health:		If deceased, cause of death:
BROTHERS	No. Alive:	Present Health	No. deceased and cause of death:
SISTERS	No. Alive:	Present Health	No. deceased and cause of death:
CHILDREN	No. Alive:	Ages and Present Health	No. deceased and cause of death:

Check any illnesses which have occurred in any of your **BLOOD RELATIVES:**

O Nervous illness O Allergy O Diabetes O Heart Disease O Cancer O Bleeding Tendencies
O Kidney Disease OTuberculosis O Stroke O Other:

MEDICAL HISTORY: All information is strictly confidential- Check symptoms you currently have or have had in past year

GENERAL

- o Chill
- o Depression/Nervousness
- o Dizziness/Fainting
- o Fever
- o Forgetfulness
- o Headache
- o Loss of sleep
- o Loss of weight
- o Numbness
- o Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- o Arms
- o Hips
- o Back
- o Legs
- o Feet
- o Neck
- o Hands
- o Shoulders

GENITO-URINARY

- o Blood in urine
- o Frequent urination
- o Lack of bladder control
- o Painful urination

GASTROINTESTINAL

- o Appetite poor
- o Bloating
- o Bowel changes
- o Constipation
- o Diarrhea
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal bleeding
- o Stomach pain
- o Vomiting
- o Vomiting blood

CARDIOVASCULAR

- o Chest pain
- o High/Low blood pressure
- o Irregular/Rapid Heart beat
- o Poor circulation
- o Varicose veins
- o Swelling of ankles

EYE, EAR, NOSE, THROAT

- o Bleeding Gums
- o Blurred Vision
- o Crossed Eyes
- o Difficulty swallowing
- o Double Vision
- o Earache/Ear discharge
- o Hay fever
- o Hoarseness
- o Loss of hearing
- o Nosebleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision-Flashes/Halos

SKIN

- o Bruise easily
- o Hives
- o Itching/Rash
- o Changes in moles
- o Scars
- o Sore that won't heal

MEN only

- o Erection difficulties
- o Lump in testicles
- o Penis discharge
- o Sore on penis

WOMEN only

- o Abnormal Pap Smear
- o Bleeding between periods
- o Breast lump
- o Extreme menstrual cramps
- o Hot flashes
- o Nipple discharge
- o Painful intercourse
- o Vaginal discharge
- o Other

Date of last menstrual period: _____

Date of last Pap Smear: _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (,/) conditions you have or have had in the past

- o AIDS
- o Appendicitis
- o Arthritis
- o Asthma
- o Bleeding disorders
- o Breast Lump
- o Cancer
- o Cataracts
- o Chemical Dependency
- o Chicken Pox
- o Diabetes
- o Emphysema
- o Epilepsy
- o Glaucoma
- o Heart Disease
- o Hepatitis
- o Herpes
- o Hiqh Cholesterol
- o HIV Positive
- o Kidney Disease
- o Liver Disease
- o Measles
- o Migraine Headaches
- o Multiple Sclerosis
- o Mumps
- o Pacemaker
- o Pneumonia
- o Polio
- o Prostate Problem
- o Rheumatic Fever
- o Scarlet Fever
- o Stroke
- o Thyroid Problems
- o Tuberculosis
- o Ulcers
- o Venereal Disease

MEDICATIONS/ALLERGIES

List medications you are currently taking: _____

Pharmacy Name: _____

Phone: _____

List allergies to medications or substances: _____

HEALTH HABITS

Check which you use and how often:	Check if your work exposes you to:
o Caffeine _____	o Stress
o Street Drugs _____	o Heavy Lifting
o Tobacco _____	o Hazardous Substances
o Other _____	o Other _____

Your occupation: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Please *print* name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

INSURANCE: Please be prepared to show your insurance card at each visit.
TRICARE members: We must have a copy of your military ID (Authorized under DoDI # 1000.13 and Force Protection Advisory (0050-09-FPA (Change 1)).

Check Here For No Secondary Insurance [ ]

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

INSURANCE AUTHORIZATION AND ASSIGNMENT (INITIAL BOX THAT APPLIES)

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

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

Advance Premium Tax Credit/Affordable Care Act Coverage/No Show and Cancellation Policies
By signing below, I understand and acknowledge that I am personally responsible to pay Coastal Carolina Neuropsychiatric Center in full for services that my health insurer will not cover due to non-payment of my health insurance premiums. I also understand that it is my responsibility to attend all scheduled appointments. If I cannot make my scheduled appointment, I must provide CCNC with a 24- hour notice. Should I fail to do so, I may be charged a service fee of ***$25.00*** *at the provider's discretion. Repeated no-shows for appointments may result in the provider declining further services. I have read and understand the above policies.*

_____
Printed Name of Patient/Legal Guardian

_____ _____
Signature of Patient/Legal Guardian Date

Coastal Carolina Neuropsychiatric Center

Patient:_____

DOB: _____

By signing this letter, I am affirming that I have given CCNC all of my current insurances, and acknowledge that it is my responsibility to provide updated insurance information should it change. If the insurance company denies or recoups money for services rendered due to my enrollment in other health insurance, I am aware that I will be held responsible for any denied/outstanding balance if CCNC is not given the necessary information within that insurance's timely filing limitations.

O I do not have other health insurance.

Patient Signature: Date:

Witness Signature: Date:

200 Tarpon Trail Jacksonville, NC 28546 office 910.938.1114 fax 910.938.1118

RELEASE OF INFORMATION/ACCESS PERMISSION FORM

Name of Patient_____ Date of Birth_____

Coastal Carolina Neuropsychiatric Center, PA (CCNC) *is* ***authorized*** *to release protected health information about the* ***above*** *named patient to the entities named below. The* ***purpose*** *is to* ***inform*** *the* ***patient*** *or* ***others*** *in keeping with the patient's instructions.*

I **DO NOT** WISH TO GRANT ACCESS:_____ *Initial and skip to signature section

_____ _____

Printed name of person authorized access Relationship to patient

This person is authorized to (initial next to approved action):

- _____ Have knowledge of appointments
- _____ Make, change or cancel appointments on my behalf
- _____ Have knowledge of medical information
- _____ Pick up prescriptions on my behalf
- _____ Pick up medical records requested by me
- _____ Pick up correspondence on my behalf
- _____ Have knowledge of billing/financial matters
- _____ Make payments/provide financial information on my behalf
- _____ Pick up/attend my minor child's appointments

Rights of the Patient

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to CCNC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient/Legal Guardian Date

_____

CCNC Witness Signature

CANCELLATION OF ACCESS

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

Patient's Name

_____ _____

Signature of Patient/Legal Guardian Date

_____

CCNC Witness Signature

Coastal Carolina Neuropsychiatric Center

Patient Portal Notice and Consent

Note: This notice and consent automatically appears the first time you sign into our patient portal. The patient portal requires you to read and agree to this consent before you are allowed access. This copy is in case you wish to retain the terms of use for your records.

Coastal Carolina Neuropsychiatric Center, PA ("CCNC") provides this patient portal ("Portal") for the exclusive use of established patients, in order to enhance patient - physician communications. All users must be established by a previous office visit. *(New patients can pre-register, however, an account must be set up for use in our office on such patient's initial visit prior to use of the Portal.)*

CCNC offers secure viewing and communication as a service to patients who wish to view limited parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions oh the access and use of the Portal by patients. By signing this Patient Portal Notice and Consent ("Consent') you acknowledge and accept the risks and agree to the conditions of access and use of the Portal.

The information on the Portal is maintained by CCNC. For questions about this site you may contact us at 910.938.1114.

All of the doctors in our group are licensed in the State of North Carolina.

We provide limited internet based medical services, primarily related to:

- Medication re-fill request
- Review of patient's medication list, treatment history and visitation dates
- Schedule requests, patient directed scheduling, and waiting list requests
- Limited communication regarding on-going treatment of patients.

This Portal is not intended to provide internet based diagnostic medical services. Also, the following limitations apply:

- No internet based triage will be provided and treatment requests will not be accepted. Diagnosis can only be made, and treatment rendered, after the patient schedules and is SEEN by the doctor.
- No emergent communications or services shall be provided via the Portal. Any patient with an emergent condition should seek treatment from Urgent Care, Emergency Department, or 911.
- No request for narcotic pain medication will be accepted.
- Requests for prescription refills for patients not currently being treated by a CCNC physician will not be accepted.

There are no fees for access or use of the Portal at this time, however CCNC reserves the right to impose such fees in its sole discretion upon prior notice to users. The patient portal is currently provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate access to the Portal, suspend user access, or modify the services offered through the Portal.

CCNC offers secure access to limited parts of your medical record and communication with our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose certain conditions of access and use of the Portal.

Ptacct#: _____ CCNC Staff_____ Photo ID verified: Y N

Scanned into chart_____ Acct Activated for PP:_____ Info Printed for Pt? Y N

Coastal Carolina Neuropsychiatric Center

This form is intended to inform you of those risks and to evidence your acknowledgement and acceptance of these risks and the conditions of participation. Use of the Portal is optional and not necessary to interact and communicate with CCNC or its staff.

How the secure patient portal works:
A secure Web portal is a kind of webpage that uses encryption to keep unauthorized persons from accessing communications, information, or attachments. Secure messages and information can only be accessed by someone who knows the right password to log into the Portal site.

CCNC is also informing you that:
1) All internet communication with CCNC staff is recorded in your medical record.
2) Staff members other than your physician will be involved in receiving your messages, and routing them to the doctor, nurse, or front desk as necessary.
3) CCNC's hours of operation are *Ba* to 6p, Monday-Friday. We encourage you to use the web site at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 24hrs, but no later than 3 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office. If you do not get a response within 3 business days, please call our office as necessary.
4) If we are unable to access email for any reason we will attempt to have an automatic response inform you of this as soon as possible
4) The types of transactions available online are:
   a) Secure messaging to medical office staff for non-urgent needs
   b) Requests for appointments
   c) Review of existing appointments
   d) Review of medication list
   e) Requests for current medication refills (please make sure we have your correct pharmacy information).
   f) Update of medical history and contact information
   g) Review of patient statements

CCNC's Policies and Procedures are subject to change without notice

All communication via Patient Portal will be included in your permanent patient record
Privacy:

- All messages sent to you will be encrypted, see Patient Portal Information for explanation
- Emails from you to any staff should be through this portal or they are not secure
- We will keep all email lists confidential and will not share this with other parties
- Any of our staff may read your messages or reply in order to help the Clinician that has been emailed. **(Similar to how phone communication is handled)*
- Our system will check when messages are viewed, so you do not need to reply that you have read it.

Protecting Your Private Health Information and Risks
The method of communication and access utilized by the Portal prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: (1) the patient must provide the correct email address to which such confidential communications are to be sent, and (2) only individuals authorized by the patient to receive his or her confidential health information have access to such email address. Only you can make sure these two factors are satisfied. It Is your sole responsibility to provide CCNC with the correct email address and to inform CCNC in the event your desired email address changes.

Pt acct#:_____ CCNC Staff._____ — — — — Photo ID verified: Y N
Scanned into chart_____ Acct Activated for PP:_____ Info Printed for Pt? Y N

You also need to control who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. It is your sole responsibility to protect your password from unauthorized individuals. If you think someone has learned your password, you should promptly go to the Portal and change it. In no event shall CCNC be liable for any costs or damages resulting from access to the Portal by a person to whom you have provided your password or who has obtained your password due to your failure to adequately protect it's secrecy. CCNC understands the importance of privacy in regards to your health care and will continue to take all practical measures to maintain the privacy of your information. We will never sell or give away any private information, including email addresses, without your written consent.

Conditions of Participating in the Patient Portal

Access to this secure Patient Portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service we will notify you as promptly as we reasonably can. You agree not to hold Coastal Carolina Neuropsychiatric Center, PA or any of its staff liable for network infractions beyond its control. Before you were given this form, we provided you with our policies and procedures page or you agreed to view them via our website (www.coastalcarolinapsych.com) for using this web portal. We need you to understand and comply with the policies and procedures contained in this Consent, and by signing this Consent, you acknowledge that understand, and agree to comply with, such policies and procedures. If you do not understand, or do not agree to comply with our policies and procedures, please contact us to terminate your use of Portal.

How to Use Patient Portal

1. Request access
2. Review and sign this Consent which is automatically provided the first time you sign in to the Portal.
3. Provide valid, government issued photo ID to CCNC at your first visit to our office.
4. After we have received your request for access, your signed Consent and have been provided with your valid identification, you can expect to see a welcome email. On this email you will click on the URL link (web page) and use the assigned login and password.
5. Once logged into the portal, you should go to "My Account" on the top right of the page. Here you can change your user name and password to something only you will know. *This is essential to make sure your information remains secure and private!* After the above is complete you should be able to use the Portal!

Available Components:

1. *Messages:* This allows you to send and receive secure email to/from our staff. This may include attachments, pictures, or other information. Use of this is very similar to standard email. Here you can also request a referral, ask billing questions, or even make suggestions on how we can improve the site.
2. *Medications:* Here you can see current and past medications written by our office or entered by our staff. You can also request REFILLS of medications (other than controlled substances) prescribed by CCNC physicians or other authorized providers here. It is your sole responsibility to provide accurate pharmacy information.
3. *Appointments:* In this section you can view upcoming appointments or see requested appointments.
4. *Billing Account Inquiries*

Pt acct#: _____
Scanned into chart_____

CCNC Staff_____
Acct Activated for PP:_____

Photo ID verified: Y N
Info Printed for Pt? Y N

Coastal Carolina Neuropsychiatric Center

Patient Acknowledgement and Consent

The Portal is a secure web portal that allows you, as a patient, to access list of your medications, appointments, billing inquiries and limited medical history via the internet. It also allows you communicate with our office via secure messaging. You may request refills, with the exception of controlled substances, and request to schedule/change/cancel appointments online.

Please read the following policies carefully:

- We are offering the Portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the Portal at any time and for any reason.

- We will make every attempt to return Portal messages within one business day, however no later than three business days. You must call our office at 910.938.1114 if you have an urgent matter to discuss. THE PORTAL IS NOT TO BE USED FOR EMERGENCIES.

- We do NOT refill controlled substances over the Portal.

- If you are not receiving emails from us, please check your JUNK email folder before contacting us.

- By using this Portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should you suspect that your password has be stolen. You agree to release CCNC from responsibility for any unauthorized access which was beyond our control.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this Consent. I have been advised of the risks and benefits of use of the Portal and acknowledge that I understand the potential risks associated with online communications between my physician and myself, and consent to the conditions outlined herein. I acknowledge that using the Portal is entirely voluntary and the quality of care I receive from CCNC will not be impacted should I decide against using the Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that CCNC may impose for online communications. I have been given an opportunity to ask questions related to this Consent. All of my questions have been answered to my satisfaction.

Patient Signature_____ Print Name_____

Date_____ EMAIL ADDRESS:_____

Witness Signature (CCNC staff)_____

Pt acct#-:_____ CCNC Staff_____ Photo ID verified: Y N

Scanned into chart_____ Acct Activated for PP:_____ Info Printed for Pt? Y N

Coastal Carolina Neuropsychiatric Center

CONSENT TO TREATMENT - TELEMEDICINE SERVICES

Introduction

Telemedicine involves the use of electronic communication (telephone, video conferencing, web camera, etc) to allow licensed physicians and other licensed mental health professionals ("Healthcare Professionals") employed or contracted by Coastal Carolina Neuropsychiatric Center, PA (CCNC) to consult with you regarding your psychiatric care without requiring you to be present at the same location as the CCNC physician or professional.

Potential Benefits and Risks

The use of telemedicine to provide you with these professional psychiatric services can be expected to improve your access to care without the inconvenience to you of having to travel to the CCNC physician or professional's location and improved efficiency in evaluation and management. Some possible risks associated with the use of telemedicine include: disruption, delay or failure of the electronic communications equipment used; inadequate exchange of information between you and the Healthcare Professional due to absence of face-to-face interaction; potential failure of security protocols and the intentional acts of others to access the communications between you and the Healthcare Professional which may result in a breach of privacy of your personal medical information; and the potential that you may be overheard if you are not in a private place during the telemedicine services. Further, there are potential risks and benefits with any type of psychiatric care, and despite your efforts and the efforts of the Healthcare Professionals, your condition may not improve.

Confidentiality

All laws and regulations applicable to the protection of the confidentiality of your personal information in a traditional medical office setting also apply to telemedicine services, including, without limitation, HIPAA. The information that you disclose during the course of your telemedicine services is generally confidential. However, there are mandatory and permissive exceptions to such confidentiality including, without limitation, child, elder and dependent adult abuse and expressed threats of violence against an identifiable victim.

Acknowledgements, Consents and Agreements

By signing below:

- I acknowledge that I have read and understand the potential benefits and risks associated with my receipt of telemedicine services from CCNC's Healthcare Professionals.
- I understand that all laws and regulations applicable to the protection of the confidentiality of my personal information in a medical office setting also apply to telemedicine services provided by CCNC, and such laws and regulations include certain exceptions to the confidentiality of such information.
- I acknowledge that this Consent to Treatment shall become part of my medical record.
- I agree to be fully responsible for payment of services rendered and authorize my insurance benefits to be paid directly to CCNC or the Hospital as applicable, realizing that I am responsible for paying non-covered services.
- I consent to the release of pertinent medical information for treatment, payment, and health care operations.
- I authorize CCNC's Healthcare Professional to evaluate and treat me through the use of telemedicine.
- I acknowledge that I have received CCNC's Notice of Privacy Practices.

Print Patient Name	Date of Birth
Signature of patient (over 16 *years* old)	Date
Signature of parent/legal guardian / Printed name of parent/legal guardian	Date
Witness	Date

NAME	DOB	CHART NO.	INITIALS

Coastal Carolina Neuropsychiatric Center

Patient Orientation Form

As a patient of Coastal Carolina Neuropsychiatric Center, upon admission I have been instructed in or given written materials regarding, in addition I have been made aware that a parent or guardian needs to remain in the building during the appointment for children 16 years of age or younger. This is for the safety purposes of the child (ren). We are unable to be responsible for the well-being of a child left unattended.

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

Rights and responsibilities of the person served. Grievance and appeal procedures. Ways in which input is given regarding: - The quality of care. - Achievement of outcomes. - Satisfaction of the person served. An explanation of the organization's: - Services and activities. - Expectations. - Hours of operation. - Access to after-hour services. - Code of ethics. - Confidentiality policy. - Requirements for follow-up for them and dated person served, regardless of his or her discharge outcome. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits. The program's policies regarding: - The use of seclusion or restraint. - Smoking. - Illicit or licit drugs brought into the program. - Weapons brought into the program. - Abuse and Neglect - Identification of the person responsible for service coordination.	A copy of the program rules to the person served that identifies the following: -Any restrictions the program may place on the person served. -Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served. -Means by which the person served may regain rights or privileges that have been restricted. -Education regarding advance directives, if appropriate. -Identification of the purpose and process of the assessment. -A description of how the individual plan will be developed and the person's participation in it. -Information regarding transition criteria and procedures. When applicable, an explanation of the organization's services and activities include: -Services and activities. -Expectations for consistent court appearances. -Identification of therapeutic interventions, including: • Sanctions. • Interventions. • Incentives. • Administrative discharge criteria.

My signature below indicates that I have been made aware of the electronic version of this document found at: http://coastalcarolinapsych.com/wp-content/uploads/2016/05/CCNC-Patient-Orientation-Packet.doc and that I agree to abide by the contents. My signature also confirms that if I requested a hard copy I was provided one.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Witness Date

TRICARE Other Health Insurance (OHI) Questionnaire

Update your Other Health Information at www.myTRICARE.com **to minimize any delay in processing claims.**
If you prefer you can fax a completed form to: 1-888-237-6262 or mail a completed form to: TRICARE North, PO Box 870159, Surfside Beach, SC 29587-9759.

Section I: Personal Information

TRICARE Sponsor's Name: _____ **TRICARE Sponsor's SSN:** _____

Section II: OHI Information

Policy Holder's Name and SSN (if different from above): _____

OHI Company Name: _____ **State:** _____

OHI Phone Number: _____ **OHI Policy, Group or Plan#:** _____

OHI Coverage Effective Date: ____/____/____ **OHI Coverage Termination Date:** ____/____/____

Is the Coverage an HMO/PPO plan? ❑Yes ❑No

Type of Coverage: ❑ Group ❑ Individual ❑ Medicare ❑ Supplemental ❑ Medicaid

Indicate if the policy covers the following: ❑ Pharmacy ❑ Dental ❑ Mental Health ❑ Vision

Please list all individuals covered by this policy, indicating effective or termination dates if different from the date(s) above.

Name	Date of Birth	Effective Date	Termination Date
_____	____/____/____	____/____/____	____/____/____
_____	____/____/____	____/____/____	____/____/____
_____	____/____/____	____/____/____	____/____/____

Section III: Authorization

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department of agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ _____ _____
Signature **Date** **Phone Number**

PRIVACY ACT 1) Authority: 5 USC 552a; 10 USC 1079, 1086; 58 FR 45318; 32 CFR 199.7. 2) Purpose: To evaluate for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE program. 3) Uses: Information from claim forms and related documents may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE program. 4) Disclosure: Voluntary, however, failure to provide information may result in a delay or denial of claims for medical services, or may result in the TRICARE beneficiary not receiving maximum benefits from their health coverage.

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the PGBA, LLC (PGBA) and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care: 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; 32 CFR 199.17, TRICARE Program; and E.O. 9397 (SSN), as amended.
PURPOSE:	To provide eligibility, enrollment, deductibles, catastrophic caps, claims processing, and customer service to individuals eligible for TRICARE benefits.
ROUTINE USES:	In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Department of Veterans Affairs, the Department of Health and Human Services, the Department of Homeland Security, and to other federal, state, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.
DISCLOSURE:	Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays.

Coordination of Benefits Questionnaire

BlueCross BlueShield of North Carolina

Your Blue Cross Blue Shield contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's Blue Cross Blue Shield plan immediately.

Please send this completed form to the BCBS Plan that you are a member of.
You can call the customer service phone number on your membership ID card to get the address.

BCBS Policyholder Name

BCBS Group Number | BCBS Member ID Number

Section A | Other Insurance *If this does not apply, skip to Section B.*

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

☐ **No** If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ **Yes** If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name

Address

City | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth (/ /) | ID Number

Effective Date of Other Insurance (/ /) | If Cancelled, Cancellation Date (/ /)

Is the policyholder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date: ____/____/____ ☐ On COBRA, which began: ____/____/____

Policyholder's Employer

Address

City | State | Zip | Phone Number

S115

Section B | Medicare Information *If this does not apply, skip to Section C.*

Do the policyholder and/or dependent(s) have Medicare? ☐ **Yes** ☐ **No**

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A: ___/___/___ Effective date of Medicare Part B: ___/___/___

Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:

1st Date of Dialysis for ESRD:

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of the transplant. ___/___/___

Section C | Court Order Information *If this does not apply, skip to Section D.*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ **Yes** ☐ **No**

List the name(s) of the dependent(s) that this applies to.

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the child(ren)? | Who has custody of the child(ren) more than 50% of the time?

Documentation of the court order may be requested from your Blue Cross Blue Shield plan.

Section D | Name(s) of Dependent(s) on BCBS Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
		/ /		– –
		/ /		– –
		/ /		– –

Policyholder Signature **Date**