Coastal Carolina Neuropsychiatric Center

CONSENT TO TREATMENT-RESTRICTED DISCLOSURE

By signing below, I am authorizing Coastal Carolina Neuropsychiatric Center, PA (CCNC) to evaluate and treat the following person: _____.

I understand that

1. the patient has a right to treatment by CCNC regardless of age or disability, and
2. in emergency situations, treatment or medications may be administered over my refusal or without my opportunity to object.

I have requested to restrict certain uses and disclosures of my medical information and CCNC has approved my request. CCNC will not disclosure or use my medical information as requested unless otherwise required by law or until I revoke this consent.

If I have requested to restrict the disclosure of my medical information to a health plan for payment or healthcare operations, I understand and accept that I must pay for these services out of pocket in full.

I accept full responsibility for payment of services rendered.

I hereby acknowledge that my consent may be revoked at any time by providing written notice to CCNC.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of patient (16 and over) Date

_____ _____
Signature of parent, legal guardian if patient is minor Date

_____ _____
Witness Date

I acknowledge receipt of the notice of privacy practices of CCNC.

_____ _____
Signature of patient, parent, legal guardian Date

_____ _____
Witness Date

Description of Restriction:

NAME	DOB	CHART NO.	INITIALS

___ Initial Release Form
___ Addition to Previous Release(s)
___Replaces Previous Releases

Coastal Carolina Neuropsychiatric Center

Compound Authorization for Release of Verbal Information

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.*

Entity to Receive Information. *Check each person/entity that you approve to receive information.*	**Description of information to be released.** *Check each that can be given to person/entity on the left in the same section.*
☐ Voice Mail	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Text Message (MMS/SMS): ***Signed acknowledgement must be completed (attached)** ☐ Email	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Give information to employer (provide name)_____ ☐ Give information to school (provide name)_____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Patient's Spouse (provide name) _____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Patient's Parent (provide name) _____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Other / Support Group / Group Home (provide name / relationship to patient) _____	☐ Appointment information ☐ Financial information ☐ Medical information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time 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 by 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 or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

NAME	DOB	CHART NO.	INITIALS

Coastal Carolina Neuropsychiatric Center

If the following information is not completed in full, there may be a delay in fulfilling your request while we obtain the necessary information.

Patient _____

Date of Birth _____

Parent/Guardian Name _____

POSITIVE IDENTIFICATION OF RECIPIENT IS REQUIRED

Prescriptions May Be Picked Up On My Behalf By the Following Individuals:

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Correspondence May Be Picked Up On My Behalf By the Following Individuals:

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

A COPY OF THIS SIGNED AND WITNESSED FORM IS AVAILABLE UPON REQUEST.

I hereby request and authorize the above named agency, organization or individual who possesses information relative to the patient named above to release information, as specified, to the individual(s) named on this request.

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be disclosed without my written consent unless otherwise provided for by state and federal law. I understand that any documents or information disclosed pursuant to this authorization, upon receipt by the above named individual(s), may no longer protected by HIPAA Privacy Rule. Proof of authority to act for a patient must be provided.

This consent shall not expire without express written revocation. Consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

_____ Printed Name of Patient

_____ Printed Name of Legal Representative

_____ Patient Signature Date

_____ Legal Representative Signature Date

_____ Witness Signature Date

_____ Relationship to Patient

NOT VALID WITHOUT WITNESS SIGNATURE

200 Tarpon Trail Jacksonville, NC 28546 office 910.938.1114 fax 910.938.1118

NAME	DOB	CHART NO.	INITIALS

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 CARE COMMUNICATION FORM

Patient Name_____ **Date of Birth**_____

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

Print Patient's Name

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_____ Telephone No _____

Practice Name _____

Practice Address _____

Print Name of Patient	Print Name of Guardian	Date

Signature	Signature

DATE OF INITIAL APPOINTMENT _____

NAME	DOB	CHART NO.	INITIALS

PATIENT ORIENTATION FORM

As a patient of Coastal Carolina Neuropsychiatric Center, upon admission I have been instructed in or given written materials regarding:

- Rights and responsibilities of the person served.
- Grievance and appeal procedures.
- Ways in which input is given regarding:
  - (a) The quality of care.
  - (b) Achievement of outcomes.
  - (c) Satisfaction of the person served.
- An explanation of the organization's:
  - (1) Services and activities.
  - (2) Expectations.
  - (3) Hours of operation.
  - (4) Access to after-hour services.
  - (5) Code of ethics.
  - (6) Confidentiality policy.
  - (7) Requirements for follow-up for the mandated 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:
  - (1) The use of seclusion or restraint.
  - (2) Smoking.
  - (3) Illicit or licit drugs brought into the program.
  - (4) Weapons brought into the program.
  - (5) 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
    (1). Any restrictions the program may place on the person served.
    (2). Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.
    (3). Means by which the person served may regain rights of privileges that have been restricted
- Education regarding advanced 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:
    (1). Expectation for consistent court appearances
    (2). Identification of therapeutic interventions, including:
        (a). Sanctions.
        (b). Interventions.
        (c). Incentives.
        (d). Administrative discharge criteria.

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

Patient Name: _____

_____

Signature of Patient

_____

Signature Parent/Guardian

Date: _____

Coastal Carolina Neuropsychiatric Center

ACKNOWLEDGMENT OF GUARDIAN/CUSTODIAN

I, _____, certify that I am the
(print name)

legal guardian/custodian of:

_____
(print name of patient)

_____ _____
Signature Date

_____
Witness

Mother/Legal Guardian: _____

Contact Information: _____

_____

_____

_____

Father/Legal Guardian: _____

Contact Information: _____

_____

_____

_____

NAME	DOB	CHART NO.	INITIALS

Coastal Carolina Neuropsychiatric Center

IT IS THE POLICY OF CCNC:

That a parent or guardian needs to remain in the building during the appointment for children 16 years of age and younger. This is for 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.

Parent/Guardian Printed Name	Date
Parent/Guardian Signature	Date
Witness	Date

Coastal Carolina Neuropsychiatric Center

Text / SMS / MMS Disclosure

Name of Patient _____ Date of Birth _____

By signing below and providing us with your current mobile number you authorize Coastal Carolina Neuropsychiatric Center to communicate with you via text/SMS/MMS messaging for appointment reminders at our office (the "Service").

Mobile Account Owner: If you are not the mobile account owner, you represent that you have the permission of the mobile account holder to use the Service and to enter into this Agreement.

Age and Permission: You represent that you are of legal age to enter into this Agreement or have your parent's permission to use the Service. If you are a parent or guardian whose child has signed up for the Service without your consent, you can stop the messages at any time by contacting our office at 910.938.1114 or completing a change form in person, at any of our offices.

What We Will Send You: You are expressly consenting to receive text / SMS / MMS message regarding appointment confirmations or other reminders specific to your care (for example, reminders about obtaining lab work).

Stop Messages: You may opt out of the Service at any time by calling us at 910.938.1114; or completing a change form in person, at any of our offices.

Your Carrier May Charge You For These Messages: We do not charge a fee for this Service; however, depending on your messaging plan, your mobile carrier may charge you for each message we send you or that you send us. It is your responsibility to know whether your carrier will charge you per-message costs. We assume no responsibility for charges incurred by your using the Service.

Help: For help regarding the Service, call 910.938.1114

Delivery Not Guaranteed: The Service may not be available in all areas at all times. SMS/MMS messages are distributed via a complex system of service providers and we cannot guarantee their availability or performance. This means we may not be able to successfully transmit SMS/MMS messages to you, and we have no liability for any such transmission delay or message failure. The Service may not work in the event of product, software, coverage, or other changes made by your wireless carrier or changes you make to your mobile device.

Number Changes: In the event you change your mobile phone number, you should notify us immediately by calling 910.938.1114 or coming into any office location to complete a change form.

Message Privacy: You understand the text message we send may be seen by anyone with access to your mobile phone. Accordingly, you should take steps to safeguard your phone and your text messages if you want them to remain private.

NAME	DOB	CHART NO.	INITIALS

Coastal Carolina Neuropsychiatric Center

Your Wireless Service: You must provide your own wireless device, subscribe to a wireless service on a participating mobile carrier, and be able to receive text messages using that wireless device and your carrier's service.

Preferred Contact Method: If you prefer not to use the Service, please contact us immediately to discuss your preferred contact method. Coastal Carolina Neuropsychiatric Center will accommodate reasonable requests for alterative contact methods.

Other Terms and Conditions: The Service may be changed or discontinued without notice to you. Coastal Carolina Neuropsychiatric Center and its suppliers and affiliates are not responsible for any damages arising from your use of the Service.

_____ _____

Signature of Patient or Personal Representative Date

_____

Current Mobile Number

Description of Personal Representative's Authority (attach necessary documentation)

_____

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 on 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. This form is intended to inform you of those risks and to evidence your acknowledgement and acceptance of these

Pt acct#: _____ CCNC Staff_____ Photo ID verified: Y N
Scanned into chart _____ Acct Activated for PP: _____ Info Printed for Pt? Y N

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 8a 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.** 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

Pt acct#: _____ CCNC Staff_____ Photo ID verified: Y N
Scanned into chart _____ Acct Activated for PP: _____ Info Printed for Pt? Y N

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#: _____ CCNC Staff_____ Photo ID verified: Y N
Scanned into chart _____ Acct Activated for PP: _____ 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

Health Net FEDERAL SERVICES | TRICARE

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.

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

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

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**

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.

☐ do not have other health insurance.

Signature: _____ Date: _____

Witness: _____ Date: _____

200 Tarpon Trail Jacksonville, NC 28546 office 910.938.1114 fax 910.938.1118