



Coastal Carolina Neuropsychiatric Center

NEW PATIENT INFORMATION PACKET

Date: _____ Patient SSN: _____

Patient Name: _____ Preferred Name: _____
Last First Middle

Address: _____
Street Number & 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, inquires, and office/medical related issues.)

Preferred method of appointment reminders: None Call Text Email: _____

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

Marital Status: _____ If under 18, name(s) of legal guardian(s): _____

Name of employer/school: _____

ADDITIONAL INFORMATION (Check one)

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

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Refused

Preferred Language: English Spanish Indian Russian 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 Address _____

Emergency Contact Relationship: Spouse Mother Father Son Daughter Other: _____

CONSENT TO TREAT

I affirm that I am the (circle one) patient/legal guardian and the 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 seek emergency medical care from hospital or physician, render treatment, and/or services to myself/above name minor child. (10A NCAC 27G.0206) I acknowledge receipt of the notice of privacy practices of CCNC.

Signature of Patient/Legal Guardian Date



MEDICAL HISTORY:

All information is strictly confidential- check symptoms you currently have or have had in the past year

GENERAL

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

MUSCLE/JOINT/BONE

Pain, weakness or numbness in:

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

GENITO-URINARY

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

GASTROINTESTINAL

- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach Pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High/low blood pressure
- Irregular/rapid heart beat
- Poor circulation
- Varicose veins
- Swelling of ankles

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double Vision
- Earache/Ear Discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-Flashes/Halos

SKIN

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

MEN ONLY:

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

WOMEN ONLY:

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual cramps
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- 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:

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lump
- Cancer
- Cataracts
- Chemical dependency
- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- HIV positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Rheumatic fever
- Scarlet fever
- Stroke
- Thyroid problems
- Tuberculosis
- Ulcers
- Venereal Disease

MEDICATIONS/ALLERGIES

List medications you are currently taking: _____

Pharmacy Name: _____

Pharmacy Phone: _____

List allergies to medications/substances: _____

HEALTH HABITS

Check which you use and how often:

- Caffeine _____
- Street drugs _____
- Tobacco _____
- Other _____

Check if your work exposes you to:

- Stress
- Heavy lifting
- Hazardous substances
- 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



Coastal Carolina Neuropsychiatric Center
CONSENT TO TREATMENT-RESTRICTED DISCLOSURE

By signing below, I am authorizing Coastal Carolina Neuropsychiatric Center, PA (CCNC) to seek emergency medical care from hospital or physician, render treatment, and/or services to myself/below name minor/child including following person: _____

I understand that:

- 1) The patient has a right to treatment by CCNC regardless of age or disability.
- 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 disclose 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.

Printed 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 Signature

Date

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

Printed 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 Signature

Date



Coastal Carolina Neuropsychiatric Center

ACKNOWLEDGEMENT OF GUARDIAN/CUSTODIAN

I, _____, certify that I am the legal guardian/custodian of:
(Print name)

(Print name of patient)

◆ Mother/Legal guardian name: _____

Contact information: _____

◆ Father/Legal guardian name: _____

Contact information: _____

◆ NOTE: *Please list legal parent unless parental rights have been terminated by court order. If rights have been terminated, CCNC will need a copy of the court order and legal guardianship paperwork.*

IT IS THE POLICY OF CCNC:

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

Printed Patient Name

Date of Birth

Signature of parent/legal guardian

Printed name of parent/legal guardian

Date

Witness Signature

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 or more of the applicable:

- _____ To release all of my individually identifiable health information for all dates of service, including but not limited to: all medical records, mental health records, physician notes, examination records, sexual assault evidence collection information, diagnostic records, clinical lab test results, observations, opinions, treatment records, billing records, and communications 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. (42 CFR Part 2)
- _____ To release any applicable HIV/AIDS information to my PCP or other referring clinician, named below. (NC General Statute 130A-143)

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 today?:

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:
Brother(s)	None/Alive	Present health:	If deceased, cause of death:
Sister(s)	None/Alive	Present health:	If deceased, cause of death:
Children	None/Alive	Present health:	If deceased, cause of death:

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

- Nervous Illness
 Allergy
 Diabetes
 Heart Disease
 Cancer
 Bleeding
 Kidney Disease
 Tuberculosis
 Stroke
 Other: _____



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 and relationship of person(s) authorized access: _____

The person(s) is authorized to (initial next to approved sections):

- _____ 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 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 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 by 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 Orientation Form

As a patient of Coastal Carolina Neuropsychiatric Center, upon admission I have been instructed in or given written materials regarding the information outlines in the grid below. 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.

<p>Rights and responsibilities of the person served. Grievance and appeal procedures.</p> <p>Ways in which input is given regarding:</p> <ul style="list-style-type: none"> • The quality of care. • Achievement of outcomes • Satisfaction of the person served <p>An explanation of the organization's:</p> <ul style="list-style-type: none"> • 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. <p>An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization.</p> <p>Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.</p> <p>The program's policies regarding:</p> <ul style="list-style-type: none"> • The use of seclusion and 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. 	<p>A copy of the program rules to the person served that identifies following:</p> <ul style="list-style-type: none"> • 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. <p>When applicable, an explanation of the organization's service and activities include:</p> <ul style="list-style-type: none"> • Services and activities • Expectations for consistent court appearances. • Identification of therapeutic interventions, including: <ul style="list-style-type: none"> ○ Sanctions ○ Interventions ○ Incentives ○ Administrative discharge criteria <p>Process for obtaining a copy of persons served treatment plan.</p> <p>Right to contact Disability Rights North Carolina.</p>
---	---

My signature below indicates that I have been made aware of the electronic version of this document found at: <http://coastalcarolinapsych.com/for-patients/forms/> 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

CCNC Witness Signature

Date



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 improve 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 to 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 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, HIPPA. 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, or dependent adult abuse and expressed threats of violence against 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 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.

Printed 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



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))).

<p><u>Primary Insurance</u> Insurance Company: _____ Policyholder: _____ Policyholder DOB: _____ Policyholder SSN: _____ Policy ID Number: _____ Group Number: _____ Policyholder Address: _____ _____ Relationship to policyholder: <input type="checkbox"/>Self <input type="checkbox"/>Spouse <input type="checkbox"/>Mom <input type="checkbox"/>Dad <input type="checkbox"/>Daughter/Son <input type="checkbox"/>Step-daughter/son <input type="checkbox"/>Step-mom <input type="checkbox"/>Step-dad <input type="checkbox"/>Other: _____</p>	<p><u>Secondary Insurance</u> Check here for no secondary insurance [] Secondary Insurance: _____ Policyholder: _____ Policyholder DOB: _____ Policyholder SSN: _____ Policy ID Number: _____ Group Number: _____ Policyholder Address: _____ _____ Relationship to policyholder: <input type="checkbox"/>Self <input type="checkbox"/>Spouse <input type="checkbox"/>Mom <input type="checkbox"/>Dad <input type="checkbox"/>Daughter/Son <input type="checkbox"/>Step-daughter/son <input type="checkbox"/>Step-mom <input type="checkbox"/>Step-dad <input type="checkbox"/>Other: _____</p>
--	--

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

Printed Patient Name: _____

Date of Birth: _____

By signing this letter, I am affirming that I have given CCNC all my current insurances, and acknowledge that it is my responsibility to provide updated insurance information should it change. If the insurance company, whether it is in or out of network with CCNC, 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.

I do not have other health insurance.

Signature of Patient/Legal Guardian

Date

Witness Signature

Date



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 refill requests
- Review of patient’s medication list, treatment history, and visitation dates
- Schedule requests, patient directed scheduling, and waiting list requests.
- Limited communication regarding ongoing 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 risks and the conditions of participation. Use of the Portal is optional and not necessary to interact and communicate with CCNC or its staff.



Coastal Carolina Neuropsychiatric Center

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 8am to 6pm, Monday-Thursday, and 8am-1pm Friday. We encourage you to use the website at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 2 hours, 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 that will inform you of this as soon as possible.
- 5) 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. Request 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

Note: 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.



Coastal Carolina Neuropsychiatric Center

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 its secrecy. CCNC understands the importance of 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 the 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 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 you 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 the Portal.

How to use the patient portal:

- 1) Request access
- 2) Review and sign this consent which is automatically provided the first time you sign into 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 username 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: In this section you can view current and past statements including current account balance.



Coastal Carolina Neuropsychiatric Center
Patient Acknowledgement and Consent to Patient Portal

The Portal is a secure web portal that allows you, as a patient, to access list of your medications, appointments, and billing inquiries, and limited medical history via the internet. It also allows you to 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 been 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 my questions have been answered to my satisfaction.

 Printed 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

 EMAIL ADDRESS

 Witness Signature

 Date