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

GASTROINTESTIONAL
- ☐ 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:	Check if your work exposes you to:
☐ Caffeine _____	☐ Stress
☐ Street drugs _____	☐ Heavy lifting
☐ Tobacco_____	☐ Hazardous substances
☐ Other _____	☐ 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 rest 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.

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 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.	A copy of the program rules to the person served that identifies 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 service and activities include: • Services and activities • Expectations for consistent court appearances. • Identification of therapeutic interventions, including: o Sanctions o Interventions o Incentives o Administrative discharge criteria Process for obtaining a copy of persons served treatment plan. Right to contact Disability Rights North Carolina.

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)).

Primary Insurance

Insurance Company:_____

Policyholder:_____

Policyholder DOB:_____

Policyholder SSN:_____

Policy ID Number:_____

Group Number:_____

Policyholder Address:_____

_____

Relationship to policyholder: □Self □Spouse
□Mom □Dad □Daughter/Son □Step-daughter/son
□Step-mom □Step-dad □Other: _____

Secondary Insurance Check here for no secondary insurance [ ]

Secondary Insurance:_____

Policyholder:_____

Policyholder DOB:_____

Policyholder SSN:_____

Policy ID Number:_____

Group Number:_____

Policyholder Address:_____

_____

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 benefitsorbenefitsforrelatedservices.

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

200 Tarpon Trail Jacksonville, NC 28546 office 910.938.1114 fax 910.938.1118