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

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

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**

INSTRUCTIONS FOR:

TRICARE® Other Health Insurance Questionnaire

Privacy Act Statement

This statement serves to inform you of the purpose for collecting your personal information through a *TRICARE Other Health Insurance Questionnaire* and how that information will be used.

Authority: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

Purpose: To collect information from you in order to process your TRICARE medical claims under your TRICARE insurance and coordinate payment activities with other health insurance that may be available to you or members of your family.

Routine uses: Your records may be disclosed to the federal and state agencies and to other health insurers in order to coordinate your benefits and payments for health care received.

Use and disclosure of your records outside of the Department of Defense (DoD) may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and health care operations.

Disclosure: Voluntary. If you choose not to provide this information, no penalty may be imposed, but failure to provide the requested information may result in the delay or denial of payments and claims.

Reporting Your Other Health Insurance

You can report and update your other health insurance (OHI) to minimize any delay in processing claims through the following methods:

- **By phone:** Call Health Net Federal Services, LLC at 1-877-TRICARE (1-877-874-2273)
- **In person:** Visit your military hospital or clinic or a uniformed services identification card-issuing facility
- **By computer:** Go to www.myTRICARE.com
- **By mail:** Please mail this questionnaire to our claims-processing subcontractor at the address below:

  TRICARE North - OHI Questionnaires
  P.O. Box 870159
  Surfside Beach, SC 29587-9759

- **By fax:** Please fax this questionnaire to our claims-processing subcontractor at 1-888-237-6262

Visit www.hnfs.com and www.tricare.mil/ohi for more information on OHI.

If you have received this correspondence in error, please notify 1-877-TRICARE (1-877-874-2273), then destroy completed documents and any copies you have made.

FM5501BEN1154W

November 2015

TRICARE Other Health Insurance Questionnaire

Do you or any of your family members have other health insurance (OHI) coverage or have you had OHI in the last 12 months? (TRICARE supplements are not OHI) ☐ **YES** ☐ **NO**

If **YES**, report your OHI information online at www.myTRICARE.com to minimize any delay in processing claims. You may also complete the questionnaire for each insurance policy and mail to the address provided on page 1. **This questionnaire may be copied.**

Important - If there was a break in OHI coverage, please include information about the previous OHI coverage.

Type of coverage: ☐ HMO/PPO ☐ Group ☐ Individual ☐ Medicare ☐ Supplemental ☐ Medicaid ☐ Other

Policyholder's name: _____

Social Security number (SSN) or Department of Defense Benefits Number (DBN): _____

Name of insurance company: _____

Insurance company's address/phone number: _____

_____

Policy/Group/Plan number: _____

Effective date: _____ Expiration date: _____

This policy provides the following benefits (check all that apply):
☐ Pharmacy ☐ Dental ☐ Vision ☐ Mental health ☐ Durable medical equipment

Please list who is covered by this policy:

Name	Gender	Relationship to policyholder	Date of birth	SSN or DBN
			___/___/___	
			___/___/___	
			___/___/___	
			___/___/___	
			___/___/___	

(If additional people are covered, please attach a separate list.)

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 or making false, fictitious, or fraudulent statements or claims in any matter within jurisdiction of any department or 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 Beneficiary Counseling and Assistance Coordinators.

Sponsor's name	Sponsor's SSN or DBN	Sponsor's phone number

Your signature	Your relationship to the sponsor	Date