Coastal Carolina Neuropsychiatric Center

NEW PATIENT INFORMATION PACKET

Date: _____

Patient Name: _____ Preferred Name: _____
Last First Middle

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____
(Only provide us contact numbers where we can contact you and/or we can leave a message in regards to appointments, inquires, and office/medical related issues.)

Preferred method of reminders: □ None □ Call □Text □Email address: _____

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

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

EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____
Emergency Contact Address _____
Emergency Contact Relationship: □ Spouse □ Mother □ Father □ Son □ Daughter □ Other:_____

Acknowledgement/Receipt of:

___Privacy practice of CCNC,
___Patient Portal Notice,
___ I have notified CCNC of all of my current insurances
___Acknowledge my responsibility to provide updated insurance information should it change.

Acknowledgment of no changes to:

_____Guardian/Custodian _____Consent to Treatment-Telemedicine services, _____Patient portal consent.

Acknowledgment of change or revoke to access: _____

My consent is valid for **one** year and may be revoked at any time by providing written notice to CCNC.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
CCNC Witness Signature Date

Coastal Carolina Neuropsychiatric Center

CONSENT TO TREATMENT-RESTRICTED DISCLOSURE

I affirm that I am the (**circle one**) parent/legal guardian and the responsible party of the above patient.

I understand that:

1) The patient has a right to treatment by CCNC including access to medical care and habilitation regardless of age or degree of **MH/SA/ID disability**.
2) Patient has the right to **refuse treatment without threat of termination** of services, except as outlined by North Carolina General Statue *10A NCAC 26B .0202*
3) A **minor** may seek and receive periodic services from a physician without parental consent per *GS 90-21.5*

Emergency situations

4) 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 hereby acknowledge that my consent is valid for one year, or may be revoked at any time (by providing written notice to CCNC.) CCNC will not disclose or use my medical information as requested unless otherwise required by law or until I revoke this consent by providing written notice to CCNC.

I accept full responsibility for payment of services rendered. In particular, 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.

_____	_____
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
_____	_____
Witness Signature	Date

Coastal Carolina Neuropsychiatric Center

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)

OR

____ **I do not grant permission to release information to my primary care provider/I do not have a primary care provider**

*Primary Care Physician/Clinician Name*_____

*Phone Number:*_____

*Practice Name:*_____

*Practice Address:*_____

Printed Name of Patient/Guardian:_____

Signature of Patient/Guardian_____Date_____

Coastal Carolina Neuropsychiatric Center

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) listed above 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 anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to CCNC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward except to the extent that action has been taken **with** reliance on the consent.

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 Date

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 outlined 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 organizatior
 	
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 the following:
	• Any restrictions the program may place on the person served.
	• Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.
	• Means by which the person served may regain rights or privileges that have been restricted.
	• Education regarding advance directives, if appropriate.
	• Identification of the purpose and process of the assessment.
	• A description of how the individual plan will be developed and the person's participation in it.
	• Information regarding transition criteria and procedures.
	
	When applicable, an explanation of the organization's service and activities include:
	• Services and activities
	• Expectations for consistent court appearances.
	• Identification of therapeutic interventions, including:
	  ○ Sanctions
	  ○ Interventions
	  ○ Incentives
	  ○ 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 _____