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

Marital Status: _____

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

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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 TREATMENT-RESTRICTED DISCLOSURE

I affirm that I am the (circle one) patient/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 Statute*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)*

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 is valid for **one year** and 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

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 □ Tendencies

□Kidney Disease □Tuberculosis □Stroke □Other: _____

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: _____

Contact information: _____

_____

_____

♦ Father/Legal guardian: _____

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 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.

_____ _____
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 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_____

***Due to the sensitive nature of mental health and substance use records, CCNC has chosen not to share patient information through automated health information exchanges in which our Electronic Health Record (EHR) vendor participates.**

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 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 ineffective until revoked by the patient.

_____ _____

Signature of Patient/Legal Guardian Date

_____

CCNC Witness Signature

RESTRICTION/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 regardingthe 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: Patients may call 833-900-3926 • 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. NC Health Information Exchange

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, ect) to allow licensed physicians and other licensed mental health processions ("Healthcare Professionals") employed or contracted by Coastal Carolina Neuropsychiatric Center, PA (CCNC) to consult with you regarding your psychiatric care without requiring you to be present at the same location as the CCNC physician or professional.

Potential Benefits and Risks:
The use of telemedicine to provide you with these professional psychiatric services can be expected to improve your access to care without the inconvenience to you of having to travel to the CCNC physician or professional's location and improved efficiency in evaluation and management. Some possible risks associated with the use of telemedicine include: disruption, delay or failure of the electronic communications equipment used; inadequate exchange of information between you and the Healthcare Professional due to absence 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, i any, otherwise payable to me for services rendered. I understand I am financially responsible for all charge whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions; authorize any CCNC holder of medical/psychotherapy/psychiatric information about me to be released to th health care finance administration, insurance company and its agents any information needed to determine thes benefits or benefits payable to related services. I agree a photocopy of thisform may be used in place of th original.

[ ] ***Medicare:*** I request payment of authorized Medicare benefits be made on my behalf to *Coastal Carolir Neuropsychiatric Center for any services furnished to me. To the extent permitted by law, I authorize any hold of medical and other information about me to be released to the Center of Medicare and Medicaid Services, n Medigap insurer, and their agents any information needed to determine these benefits or benefits for relate 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 Carolin Neuropsychiatric Center in full for services that my health insurer will not cover due to non-payment of my healt insurance premiums. I also understand that it is my responsibility to attend all scheduled appointments. If I canno make my scheduled appointment, I must provide CCNC with a 24- hour notice. Should I fail to do so, I may b charged a service fee of ***$25.00*** *at the provider's discretion. Repeated no-shows for appointments may result in th provider declining further services. I have read and understand the above policies.*

_____
Printed Name of Patient/Legal Guardian

_____ _____
Signature of Patient/LegalGuardian 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 come 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 long 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 only 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.

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 his 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 you 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 prove 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 outlines here in. 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 _____

Coastal Carolina Neuropsychiatric Center

Telemedicine Consent Form

This form is intended to provide information about telemedicine visits, which are different from in-person office visits and require separate consent from the patient.

1. Telemedicine uses audio and video technology to enable health care providers to have visits in real time with patients who are not physically present in the office.
2. During a telemedicine visit, the information obtained, such as medical history, examinations, diagnostic imaging, and/or test results will be used for diagnosis, treatment, follow-up, and/or education. I understand tests may be conducted by individuals at my location at the direction of the telemedicine provider. Communication will be through live two-way audio and video, so that the patient can talk with the provider.
3. Consenting to receive telemedicine visits does not mean that all future visits will be via telemedicine.
4. The provider has the right to determine whether or not any given patient visit is appropriate to be conducted via telemedicine. The provider and the patient both have the right to discontinue the visit at any time.
5. The records of telemedicine visits will become part of the patient's medical record. All existing laws regarding your access to medical information and records apply to telemedicine visits. Sharing of any personal health information to other persons or entities outside of ***Coastal Carolina Neuropsychiatric Center's*** providers and staff shall not occur without the patient's written consent unless shared for purposes of treatment, practice operations, or billing.
6. There are technology related risks in using telemedicine, such as problems with transmission (such as low resolution or interruption in the signal) and/or deficiencies or failure of telecommunications equipment. These may interfere with proper evaluation of the patient. In addition, the transmission is encrypted, and other measures have been taken to prevent unauthorized parties from accessing the transmitted information.
7. Please protect your email and patient portal passwords, and notify the practice of changes of email address.
8. This telemedicine visit will follow the same process for billing and payment for an in-person, face-to-face visit and the patient or subscriber may be responsible for all or some of the bill based on insurance coverage.

Consent To The Use of Telemedicine

I have read and understood the information provided above regarding telemedicine, including the risks associated with online communication, and all of my questions about telemedicine have been answered to my satisfaction. I give my consent for the use of telemedicine for my care at ***Coastal Carolina Neuropsychiatric Center, PA.***

Signature: _____ Date of Birth: _____
Patient (or person legally authorized to give consent on patient's behalf)

Printed Name: _____ Date: _____

Relationship to patient: ☐ Self ☐ Parent/Legal Guardian (*for children under age of 18*)

Coastal Carolina Neuropsychiatric Center

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH RECORDS

Patient Name: _____ Patient DOB: _____

I hereby authorize the use and disclosure of protected health information as described below:

(1) Identify those one or more persons/organizations ("Covered Entity," whether one or more) authorized to use or disclose your information: Coastal Carolina Neuropsychiatric Center, P.A.

(2) Provide a specific description of your information to be used and disclosed (check applicable box):

☐ All of my individually identifiable health information for all dates of service, including but not limited to all medical records, mental health records, records of communicable diseases (including HIV/AIDS), physician notes, examination records, sexual assault evidence collection information, diagnostic records, clinical lab test results, observations, opinions, treatment records, billing records, and communications

✓ Other (specify below):

Letter (Released to authorized person)

(3) The purpose of this HIPAA Authorization is at my request.

(4) I understand that I may revoke this HIPAA Authorization at any time by delivering a written, signed revocation to Coastal Carolina Neuropsychiatric Center, P.A., Attention: Privacy Officer, 200 Tarpon Trail, Jacksonville, NC 28546; however, such revocation does not affect any actions taken by Covered Entity before my written revocation is received by Covered Entity.

(5) I understand that the information used or disclosed pursuant to this HIPAA Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

(6) I understand I am entitled to receive a copy of this HIPAA Authorization form after I sign it.

(7) Unless revoked earlier, I understand that this HIPAA Authorization will expire one year following the date I sign it.

(8) I understand that this HIPAA Authorization is voluntary, that I have the right to refuse to sign it, and that Covered Entity may not refuse to treat me if I do not sign it.

Dated: _____

_____
Signature of Patient

_____
Print Name of person signing form if not patient

_____
Signature of person signing form if not patient

Describe authority to sign on behalf of patient:

_____

NC HealthConnex
Powering Health Care Outcomes

North Carolina Health Information Exchange Authority
Patient Opt-Out Information

Updated 10/2/2019

The North Carolina Health Information Exchange Authority (NC HIEA) is operating North Carolina's Health Information Exchange, now called NC HealthConnex. NC HealthConnex is a secure, electronic network that allows participating medical providers to share your health information with one another. This enables participating physicians, hospitals, laboratories, pharmacies, and other health care providers to have access to important medical information about you that can assist them in making critical medical decisions for you.

Your Patient Record

Your patient record in NC HealthConnex will include information about your medications, allergies, laboratory results, and other information gathered during your encounters from your health care provider. Your record will also include your demographic data to help identify you when you visit different health care providers across the state. It will not include any information about you that federal law prohibits sharing without your express authorization, like psychotherapy notes and substance abuse treatment records.

Benefits of NC HealthConnex

What does it mean to be a part of NC HealthConnex network? As a patient, it means having peace of mind in visiting a new health care provider's office if they are participating in the NC HealthConnex. If your information has been uploaded before, your new provider will be able to access that data. This means they can spend less time taking down your history and spend more time treating you.

Participating in the NC HealthConnex is even more important if you visit an emergency department at a participating hospital and you are unable to provide critical information about your current health status to hospital staff, including your diagnoses, medications, and allergies.

Who Can See My Record?

Only participating health care providers and other HIPAA covered entities that have signed contracts with the NC HIEA will be able to access your medical information through the NC HealthConnex. Your NC HealthConnex data may also be provided to third parties who have entered into contracts with the NC HIEA for limited purposes (i.e. the NC Department of Public Health for immunizations). These contracts ensure that all relevant privacy statutes and regulations are followed in how your health information is viewed, used, and shared. The NC HIEA also has the power to audit the use of patient information by each participating practice and each third party to ensure the law is being followed.

Right to Opt Out of NC HealthConnex

You have the right to opt out of having your information shared between providers through NC HealthConnex. If you choose to opt out, please fill out the form on the following page and mail it to the NC HIEA. Opting out of NC HealthConnex will not adversely affect your treatment by your physician and you cannot be discriminated against if you to decide to opt out. You can also use the form to rescind a previous opt-out if you change your mind. However, your information may also be shared as required or permitted by law, for instance, for public health purposes.

Please note that the NC HIEA will only process opt out forms that are signed by adults over the age of 18. If you are under the age of 18 and have not gone through the legal process to become emancipated, you must have a parent or legal guardian sign the opt-out form.

The information presented is not legal advice and is not to be acted on as such, may not be current, and is subject to change without notice.

NC HealthConnex
Powering Health Care Outcomes

North Carolina Health Information Exchange Authority
Patient Opt-Out Form

Please complete one box and the information requested below, and mail to:
NC HIEA, Attn: Opt-Out Processing, 4101 Mail Service Center, Raleigh, NC 27699-4101 Please include a return address on the mailing envelope.

☐ **Opt-Out: The NC HIEA may not share any of my health information.**

By completing and signing this form, I certify that I have been notified of the benefits of NC HealthConnex and of my right to opt out of having my data shared between participating health care providers through NC HealthConnex. I also understand that my personal health information may be accessed and used in certain circumstances pursuant to HIPAA and NC law, such as reporting public health threats. **I understand that the information provided to me is not legal advice and I will hold the North Carolina Health Information Exchange Authority harmless for the direct or indirect consequences of my decision to opt out.**

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Print Name

☐ **Rescind Opt-Out: I request to terminate my previous decision to opt out.**

By completing and signing this form, I am allowing my health information to be accessible to my health care providers through NC HealthConnex as permitted or required by North Carolina or federal law.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Print Name

Please complete all of the following fields for the patient who is requesting the opt-out or the opt-out rescission. Incomplete forms will not be processed.

_____
First Name of Patient Middle Name Last Name

_____ _____
Street Address Mailing Address

_____ _____
City State Zip City State Zip

_____/_____/_____ _____ _____
Date of Birth Sex Email

(_____)_____ (_____)_____
Primary Phone Number Secondary Phone Number

NC HealthConnex
Powering Health Care Outcomes

Please use the following fields to list previous addresses which may be required in order to positively identify your patient record in NC HealthConnex.

Street Address

City State Zip Code

Street Address

City State Zip Code

Street Address

City State Zip Code

Street Address

City State Zip Code

Street Address

City State Zip Code