Coastal Carolina Neuropsychiatric Center

EXISITING PATIENT UPDATE 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

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

I affirm that I am the (circle one) patient or 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 **Mental Health/Substance Abuse/Intellectual disability**.
2) Patient has the right to **refuse treatment without threat of termination** of services, except as outlined by NC Administrative Code *10A NCAC 26B .0202*
3) A **minor** may seek and receive periodic services from a physician without parental consent per *NC General Statutes Section 90-21.5*

Emergency situations

4) I hereby 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.

I accept full responsibility for payment of services rendered. 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 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 _____ Date _____

Signature of Parent/Legal Guardian _____ Printed name of Parent/Legal Guardian _____ Date _____

Witness Signature _____ Date _____

Advance Instruction for Mental Health Treatment

I understand that it is my responsibility to notify CCNC of a change or revocation of my Mental Health Advance Directive and to provide a new Mental Health Advance Directive as applicable

Please check which applies of the following statements:

- ☐ I have executed a Mental Health Advance Directive and provided it to CCNC
- ☐ I have executed a Mental Health Directive, but do not wish to provide it to CCNC
- ☐ I have NOT executed a Mental Health Directive.

Patient/Legal Guardian (Printed Name) _____ Patient/Legal Guardian Signature _____

Date _____

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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 use (by CCNC) and release any applicable **substance use disorder** records for payment, treatment and healthcare operations to my PCP or other referring clinician, named below or to any treating providers, health plans, and third-party payers.(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.**

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 under 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 remain in effect until revoked by the patient.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

CCNC Witness Signature Date

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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: 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 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 identifie 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: 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 _____

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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:

_____

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*)