Patient's Name: ________________________ Intake Date: ______________

# PATIENT REGISTRATION INFORMATION

Patient's Full Name: ________________________________________________________________
Last First Middle/Maiden

DOB: ____________ Sex: M ☐ / F ☐ Race: Social Security No.: _________

Age: _______ Mailing Address: ____________________________________________________________
Street City State Zip.Code

Telephone Number: __________________ Alternate Telephone Number: ______________________________

Marital Status: ______________________ Spouse/Partner Name (if applicable): ___________________

Employment Status (Check what applies):

☐ Unemployed ☐ Disability ☐ Employed ☐ Retired ☐ Student ☐ Other ________________

Pharmacy Name: ___________________________________ Phone: ___________________

Emergency Contact Information (or parent/guardian if patient is a minor):

Name: ____________________________________ Telephone Number: _________________________

Referred By: ________________________________ Reason for Referral: _________________________

## Insurance Information

Medicare Number: ___________________________ Is Medicare your primary insurance? Y ☐ / N ☐

Medicaid Number: ____________________________

Primary Insurance Company: _____________________

Address/Phone Number: ___________________________________ / _______________

Policy#: ____________________ Group#: ______________________

Insured's Name: _________________________ Insured's Date of Birth: _________________

Insured's Relationship to Patient: ___________________

Secondary Insurance Company: ___________

Address/Phone Number: ______________________________________________ / _________________________

Policy#: _________________________ Group#: __________________________

Insured's Name: ____________________________ Insured's Date of Birth: _________________

Insured's Relationship to Patient: ______________________

Patient's Name: ______________________

**Psychiatric Services of Carolinas, PC**

## PAST MEDICAL HISTORY

**Do you, now or have you ever had, any of the following:**

| | | |
|---|---|---|
| **Endocrine:** | **Infectious/Inflammatory:** | **Neurological:** |
| ☐ Hypo/Hyperthyroidism | HIV/AIDS | Epilepsy/Seizures |
| ☐ Hypo/Hyperaldosteronism | ☐ Systemic Lupus Erythematosus | ☐ Huntington's Disease |
| ☐ Hypo/Hyperparathyroidism | Tuberculosis | Wilson's Disease |
| ☐ Diabetes | ☐ Mononucleosis | Head Trauma |
| ☐ Vitamin B Deficiency | Fibromyalgia | Parkinson's Disease |
| ☐ Hypoglycemia | Temporal Arteritis | ☐ Stroke/ TIAs |
| ☐ Cushing's Disease | ☐ Chronic Fatigue Syndrome | Dementia |
| ☐ Porphyria | Cancer: | Inner Ear Problems |
| ☐ Folate Deficiency | Group A Strep/Scarlet Fever | Multiple Sclerosis |
| ☐ Addison's Disease | Syphilis | Encephalitis |
| | | |
| **Cardiovascular:** | **Gastrointestinal:** | **Respiratory:** |
| ☐ Heart Attack | IBS | Pulmonary Embolism |
| ☐ Hypertension | ☐ Crohn's Disease | ☐ Asthma |
| ☐ Mitral Valve Prolapse | Ulcerative Colitis | Pneumonia |
| ☐ Coronary Artery Disease | Ulcers | COPD |
| ☐ Congestive Heart Failure | Pancreatitis | Sleep Apnea |
| ☐ Heart Arrhythmia | ☐ Liver Disease | |
| ☐ High Cholesterol | Gallstones | **Eyes/Ears/Nose/Throat:** |
| ☐ Heart Murmur | Jaundice | Seasonal Allergies |
| ☐ Pacemaker/Defibrillator | Hepatitis | Glaucoma |
| | | Vertigo |
| **Reproductive:** | **Kidney/Bladder:** | Ear Infections |
| ☐ Prostate Disease | Uremia | |
| ☐ Polycystic Ovaries | Chronic Kidney Disease | **Other:** |
| ☐ Problems with Menstruation | ☐ Kidney Failure | ☐ Electrolyte Imbalance |
| ☐ Erectile Dysfunction | Dialysis | Pernicious Anemia |
| ☐ **Last Menstrual Period:** | Urinary Tract/Bladder Infections | Pellagra |
| | | |
| | | |
| | | |

Please check as appropriate. If other than what is listed, add to the bottom.

Drug Allergies: ____________________________________________

____________________________________________

Surgeries: ____________________________________________

____________________________________________

Chart # ________

Reviewed by Provider: ______

## Psychiatric Services of Carolinas, PC

| Social History | | | |
|---|---|---|---|
| Do you use tobacco products? | Past: | Current: | Never ☐ |
| Do you drink/use coffee/caffeine products? | Past: | Current: | Never ☐ |
| Do you drink alcohol? | Past: | Current: | Never ☐ |
| Do you abuse medications/street drugs? | Past: | Current: | Never ☐ |
| Do you exercise? | Yes: How often? | | No ☐ |
| Do you use any form of birth control? | Yes: | | No ☐ |

**Health Maintenance Screening Tests**

| Test | Date | Office That Ordered Test | Result |
|---|---|---|---|
| Cholesterol/Lipids | | | |
| Fasting Blood Sugar | | | |
| Eye Exam | | | |
| Physical Exam | | | |
| Mammogram | | | |
| Colonoscopy | | | |
| Prostate Exam | | | |
| Bone Density Test | | | |
| | | | |
| | | | |

**Family Medical/Psychiatric History** (grandparents, parents, siblings, children)

| | Family Member(s) | | Family Member(s) |
|---|---|---|---|
| Heart Disease | | Depression | |
| High Blood Pressure | | Bipolar | |
| Sudden Cardiac Death | | Anxiety/Panic Attacks | |
| Stroke/TIA | | Schizophrenia/Psychosis | |
| Epilepsy | | ADHD | |
| COPD/Emphysema | | Obsessive-Compulsive | |
| Cancer | | Dementia | |
| Parkinson's Disease | | Mental Retardation | |
| Diabetes | | Autism | |
| Thyroid Disease | | Alcoholism | |
| Kidney Disease | | Substance Abuse | |
| High Cholesterol | | Fibromyalgia | |
| Anemia/Blood Disorders | | Other: | |

| Current Doctors/Providers | Office Name | Last Appt. | Reason for Seeing |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Chart # ________

Reviewed by Provider: ______

Patient's Name:________________________

Psychiatric Services of Carolinas, PC

## REVIEW OF SYSTEMS

In the past month, have you bad any of the following problems?

GENERAL
- ☐ Recent weight gain; how much __
- ☐ Recent weight loss: how much __
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

Where?

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain injaw

HEART AND LUNGS
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands/feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

PSYCffIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulties with sexual arousal
- ☐ Poor appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide/ attempt!
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Amciety
- ☐ Risky behavior

OTHER PROBLEMS:

Chart# ----

Reviewed by Provider: --

**Psychiatric Services of Carolinas, PC**

**MEDICATIONS**

**Current Medications**

(Includim! orescribed, over the counter, and herbal medications, vitamins, and sunnlements)

| Name | Dose/Freouencv | Prescribed Bv |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
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| | | |

**Past Psychiatric Medications**

(Medications taken in the past for depression, bipolar, anxiety, etc.)

| Name | Dose/Frequency | Response (Did it help? Did you have side effects? etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Chart# ----

Reviewed by Provider: __ _

**Psychiatric Services of Carolinas, PC**

## CONSENT AND AUTHORIZATION FORMS AND POLICIES

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information to be true and correct to the best of my knowledge. I agree to notify the office of any changes in my health or health insurance status or any of the above information. I also grant permission to Psychiatric Services of Carolinas office to remind me of my scheduled appointments with the provider.

______________________________ ______________________
Patient/ Guardian Signature Date/Time

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**(To your insurance company for payment)**

I authorize Psychiatric Services of Carolinas, PC to release my medical records and information needed for the purpose of insurance payments and authorizations.

______________________________ ______________________
Patient/ Guardian Signature Date/Time

## AUTHORIZATION TO PAY

Patient's Full Name: ______________________________________________
Last First Middle/Maiden

Relationship to Patient: ____________________ Responsible Party: ____________________

Insurance Company: ________________________

All professional services rendered are charged to the patient. As a courtesy, we will file with your insurance company regardless of whether or not we participate with your insurance plan to help expedite the payment. However, the patient (Guarantor) is responsible for all costs regardless of the insurance coverage. It is also expected that copayment be made at the time the services are rendered.

I hereby authorize Psychiatric Services of Carolinas, PC to furnish my information to my insurance carriers concerning my or my dependant's examinations and treatments and I hereby assign to the physician all payments for medical services rendered. I understand that I am ultimately responsible for all the charges as well as any and all amounts not covered by my insurance company.

______________________________ ______________________
Patient/ Guardian Signature Date/Time

______________________________ ______________________
Witness Signature Date/Time

Chart # ________ Reviewed by Provider: ______

Psychiatric Services of Carolinas, PC

## ATTENDANCE POLICY

### CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of our patients, please be courteous and call **Psychiatric Services of Carolinas, PC** promptly, if you are unable to attend an appointment. In order to best serve the needs of our patients, this time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **within 24 hours of your scheduled appointment time.** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Late cancellations will be considered as a "No Show". Failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "No Show". After 3 **"No Shows", you may be discharged from the practice** and referred to the local mental health facility. A copy of the letter to this effect will be placed in the patient's file.

### LATE ARRIVALS TO APPOINTMENTS:

***Due to the busy schedules of our providers in the office, for anyone who checks in late for his/her scheduled appointment, we will make every effort to accommodate you with the first available appointment. Be aware though, that you may not be seen by the provider that day and may be rescheduled. Late arrivals affect everyone involved, and are an inconvenience to the patients who arrive promptly and the providers who are delayed in seeing them.***

______________________________ ______________________
Patient/ Guardian Signature Date/Time

## MEDICATION(S) CONSENT FORM

By becoming a patient of a provider at Psychiatric Services of Carolinas, PC, I understand that medication(s) can be prescribed to me, myself, or ______________________________ a person for whom I am the legal guardian and I consent to be prescribed medication.

It is recommended that women who are pregnant, who are breastfeeding, or who are trying to become pregnant discuss this with their doctor before taking any medications.

It is recommended that patients become educated on reporting all side effects they experience, including but not limited to which side effects to report immediately to a health care provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include, but may not be limited to:

1. What medications (prescribed and over the counter) the patient is or has been taking.
2. What food/drug allergies the patient has.
3. What medical conditions the patient has.

Those patients who are prescribed controlled substances, including but not limited to benzodiazepines, stimulants, and/or Suboxone may be required to complete a drug screening on a routine or random basis. These patients may also be required to see the provider more frequently as these medications have a high potential for dependence and abuse and must be closely monitored.

______________________________ ______________________
Patient/ Guardian Signature Date/Time

______________________________ ______________________
Provider Signature Date/Time

Chart # ________

Reviewed by Provider: ______

**Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)**

## MEDICATION(S) CONSENT FORM

By becoming a patient of a provider at Psychiatric Services of Carolinas, PC, I understand that medication(s) can be prescribed to me, myself, or________________________________________a person for whom I am the legal guardian and I consent to be prescribed medication.

It is recommended that women who are pregnant, who are breastfeeding, or who are trying to become pregnant discuss this with their doctor before taking any medications.

It is recommended that patients become educated on reporting all side effects they experience, including but not limited to which side effects to report immediately to a health care provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include, but may not be limited to:

1. What medications (prescribed and over the counter) the patient is or has been taking.
2. What food/drug allergies the patient has.
3. What medical conditions the patient has.

Those patients who are prescribed controlled substances, including but not limited to benzodiazepines, stimulants, and/or Suboxone may be required to complete a drug screening on a routine or random basis. These patients may also be required to see the provider more frequently as these medications have a high potential for dependence and abuse and must be closely monitored.

______________________________ ______________________

Patient/ Guardian Signature Date/Time

______________________________ ______________________

Provider Signature Date/Time

## CONSENT FOR TREATMENT INCLUDING EMERGENCY MEDICAL TREATMENT

I hereby, voluntarily grant authorization for such treatment, procedures and other therapies that may be deemed necessary and recommended by my attending physician. I also grant permission to seek emergency medical care from a hospital or physician as well as the Mobile Crisis Units which may be deemed necessary and appropriate by my attending physician.

I consent for myself or on behalf of the patient named above the selection and assignment of a physician and/or clinician and agree to make arrangements with the physician and/or clinician for obtaining a complete diagnosis and continuation of treatment as needed.

I certify that I have read the above consent for patient treatment and fully understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from this treatment.

Patient/Guardian signature______________________________________________Date ________________________

Chart # __________

Reviewed by Provider: ______

**Psychiatric Services of Carolinas, PC**

## CONSENT FOR TREATMENT

I hereby, voluntarily grant authorization for such treatment, procedures and other therapies that may be deemed necessary and recommended by my attending physician.

I consent for myself or on behalf of the patient named above the selection and assignment of a physician and/or clinician and agree to make arrangements with the physician and/or clinician for obtaining a complete diagnosis and continuation of treatment as needed.

I certify that I have read the above consent for patient treatment and fully understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from this treatment.

Patient/Guardian signature__________________________________________ Date ______________________

## PATIENT'S RIGHT TO REFUSE TREATMENT

Patients must be notified the right to refuse treatment per 10A NCAC 27D .0303 (INFORMED CONSENT). Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with General Statute 122C-57 (RIGHT TO TREATMENT AND CONSENT TO TREATMENT). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility. Per G.S. 122C-57 each voluntarily admitted client or the client's legally responsible person (including a health care agent named pursuant to a valid health care power of attorney) has the right to consent to or refuse any treatment offered by the facility. Consent may be withdrawn at any time by the person who gave the consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the voluntarily admitted client may be discharged.

Per G.S. 122C-51 (CLIENTS' RIGHTS AND ADVANCE INSTRUCTION), it is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

Patient/Guardian Signature:____________________________________________ Date:__________________

Chart # _________ Reviewed by Provider: ______

**Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)**

## AUTHORIZATION FOR RELEASE OF INFORMATION FROM FACILITY

Psychiatric Services of Carolinas, PC is committed to the protection of substance abuse information per the confidentiality and disclosure requirements of 45 CFR Part 164 and a statement regarding the protection of HIV/AIDS information under G.S. 130A-143 (CONFIDENTIALITY OF RECORDS).

Additionally, the HIV/AIDS related conditions statue for protection mandates that the information will only be released in accordance with G.S. 130A-143 and the statues for Substance Abuse include "Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45 CFR Part 164) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it". Other laws, however, may prohibit re-disclosure. When information is released from this agency protected by state law (NC G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR, Part 2), the recipient of the information is informed of that consent voluntarily. Re-disclosure is prohibited except as permitted or required by these two laws.

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations. Yes ☐ No ☐

**PURPOSE OF RELEASE**: ***MARK AREA WITH A CHECK FOR EXPLANATION OF THIS RELEASE***

☐ Coordination of Care ☐ Ongoing Communication ☐ Copy of Record to specified Representative(s) Request

OTHER ________________________________________

**RELEASE FROM**: The facility/practice/individual listed below is authorized to release the requested health information.

Facility/Practice Name: ________________________________________

Address: ________________________________________

Phone#: ____________________ Fax: ____________________

The facility/practice individual listed above is authorized to release the requested health information for the following date(s) of service, range of time. From: (mm/dd/yy)________________To:(mm/dd/yy) ________________

**INFORMATION TO BE RELEASED**: ***MARK AREA WITH A CHECK FOR EXPLANATION OF THIS RELEASE***

☐ Psychiatric Evaluation ☐ All records/details ☐ Billing information ☐ Physician's Notes ☐ Labs
☐ Urine ☐ Substance Abuse Information ☐ HIV Information

***NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:***

**Patient's Name:** ____________________________ **DoB:** ________________

**Address:** ________________________________________

________________________________________

Chart # ________

Reviewed by Provider: ______

**Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)**

**RELEASE TO:** This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/ organization listed below.

Name:______________________________ Relationship ______________

Address: ______________________________

Phone: ______________________ Fax: ______________________

**PATIENT RIGHTS AND SIGNATURE:**

- **I understand that I have the right to revoke this authorization at any time notifying Psychiatric Services of Carolinas, PC in writing, and I understand that such revocation will not apply to information that has already been released in response to this authorization. I understand that such revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
- **I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.**
- **I understand that I may request to obtain a copy of the information to be used or disclosed per Psychiatric Services of Carolinas, PC Notice of Privacy Practice/Policy.**
- **This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.**
- **I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. If the patient is a minor or is clinically unable to sign an authorized representative may sign this authorization.**
- **I understand that I may request a copy of this signed authorization.**

**Printed Name:** ______________________________

**Patient/Guardian Signature:** ______________________________

**Date:** ______________________

Chart # ________ Reviewed by Provider: _____

**Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)**

**REVOCATION SECTION**

I do hereby request that this authorization to disclose health information for patient ______________________ __________________________ be rescinded, effective________________(Date). I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

| | | | |
|---|---|---|---|
| *(Signature of Patient)* | *(Date)* | *(Signature of Witness)* | *(Date)* |
| *(Signature of Personal Representative)* | *(Date)* | *(Personal Representative Relationship/Authority)* | |

**VERBAL REVOCATION SECTION**

I do hereby attest to the verbal request for revocation of this authorization by __________________________ __________________________________________________________ Date __________________________
*(Name of Client or Personal Representative)*

The client or his personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

| | | | |
|---|---|---|---|
| *(Signature of Staff)* | *(Date)* | *(Signature of Witness)* | *(Date)* |

Chart # ________

Reviewed by Provider: ______

# Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)

## NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

Chart # ________ Reviewed by Provider: ______

**Psychiatric Services of Carolinas, PC**

## PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for all, Psychiatric Services of Carolinas expects **patients, family members, and visitors** to refrain from behaviors that are disruptive, threatening or violent to the rights and safety of **other patients and staff.**

**Disruptive behavior** is inappropriate behavior that interferes with the functioning and flow of the workplace. It hinders or prevents providers and staff members from carrying out their professional responsibilities. It is important that providers, managers, and supervisors address disruptive behavior promptly. If left unaddressed, disruptive behavior typically continues to escalate, resulting in negative consequences for the individual as well as others. Examples include yelling, using profanity, waving arms or fists, verbally abusing others, attempting to intimidate or harass other individuals by making offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication and refusing reasonable requests for identification. As well as Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or gender.

**Threatening behavior** includes physical actions short of actual contact/injury (e.g., moving closer aggressively), general oral or written threats to people or property ("You better watch your back" or "I'll get you") as well as implicit threats ("You'll be sorry" or "This isn't over"), possession of firearms or any weapons, making verbal threats to harm another individual or destroy property and using gestures or profane language.

**Violent Behavior** includes any physical assault, with or without weapons; behavior that a reasonable person would interpret as being potentially violent (e.g., throwing things, pounding on a desk or door, or destroying property), or specific threats to inflict physical harm (e.g., a threat to shoot a named individual), climbing on furniture or property, and inflicting bodily harm.

This is to include behaviors that are witnessed in the office as well as telephone calls placed either to or from the office, and email correspondence. This kind of behavior will not be tolerated and will result in immediate action up to and including discharge from the practice.

**Print Name:**______________________________

**Signature:**______________________________ **Date:** ____________

**Witness Signature:** ______________________________

## CONTINUANCE OF CARE

In the event that your doctor leaves the practice, goes on medical leave, or cannot see you, one of the following will take place:

1. Your appointment will be rescheduled to see another provider at this office
2. You will be worked in to see another provider at this office
3. You will need to contact your primary care provider to have them refer you to another mental health care facility

Medications will still be managed by this office until we can get you in with another provider or until you get an appointment at a different office (within a reasonable time frame).

**Signature:** ______________________________ **Date:** ____________

Chart # ________ Reviewed by Provider: ______

Psychiatric Services of Carolinas, PC

# NOTICE OF PRIVACY PRACTICES

**This notice describes how medical of health information about you may be used and disclosed and how you can get access to this information. Please review it carefully**

**Protecting your privacy**
Protecting your privacy and your medical and Health information at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Foothills Consulting Services, LLC, privacy is one of our highest priorities.

**Keeping your information**
Keeping the medical and health information we have about you, secure, is one of our most important responsibilities. We value your trust and will handle your information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise to meet your needs. We may also access information about you when considering a request from you or when exercising your rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these principles.

**Working to meet your needs through information**
In the course of doing business, we collect and use various types of information, like names and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

**Keeping your information accurate**
Keeping your health information accurate and up to date is very important. IF you believe the health we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

**How and why information is shared**
We limit who receives information and what types of information is shared (Except as required by law or as described about. We do not share information with other parties, including government agencies. FCA does not share any consumer information with third party marketers who offer their products and services to our patients. As information is shared or disclosed, we will attempt to explain the disclosure to you as permitted by law as soon as possible).

- Sharing information within FCA, we share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- Sharing information with companies that work with us. To help us offer you our services, we may share information with companies that work with us, such as claims processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them, confidential.
- Patient specific personal identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data is released with the
- If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so).
- FCA may disclose that fact of your admission or discharge to your next of kin whenever it is determined that the disclosure is in your best interest.
- In addition, you may have access to confidential information in your patient record, except information that would be injurious to your physical or mental well being as determined by the attending physician or if there is none, the Clinical Director.
- We also may disclose information to certain consumer advocates, attorney and in certain court proceedings in accordance with applicable state statues.
- We are also required to share information when, in our opinion, there is imminent danger to your health or safety of another individual or there is a likelihood of the commission of a felony or violent misdemeanor.
- We may exchange confidential information with a physician or other health care provider who is providing emergency medical services to you to the extent necessary to meet the emergency need.
- We may share information for certain statistical reporting and research such as non-identifying, aggregated information.
- NC TOPPS (North Carolina Treatment Outcomes and Program Performance System) will now be the chief method for collecting information necessary for accountability, quality improvement and local outcomes management for the states substance abuse and mental health consumers.

## PAYMENT AND FEE FOR SERVICES

You have the right to know the cost for services and billing practices. At the of admission, or as you request, FCA will discuss the fee for service and information related to the use of your insurance, Medicaid, State and other funding benefits. We will ask for information related to your insurance and benefits. At any time you may request information to your account.

Patient/Guardian Signature Date

Medical Records #:

Insurance ID:

Chart # ________

Reviewed by Provider: _____