NORTH RALEIGH PSYCHIATRY, P.A. – PATIENT REGISTRATION SHEET

Today's Date: _____ **Please print all information. Thank you.**

Patient Name: _____ _____ _____ Nickname: _____
LAST *FIRST* *MI*

Patient Address: _____

City: _____ State:_____ Zip:_____ Patient Sex: M F (circle)

Date of Birth: _____(mm) _____ (dd) _____ (yyyy) Age: _____ Social Security #: _____
(not required unless used as insurance ID)

Primary Contact #: (_____)_____ Alternate Contact #: (_____)_____
Please note—any or all phone numbers listed above may be used to leave voice mail and/or answering machine messages.

Patient's Employer: _____ Phone#: (_____)_____

Address: _____City:_____ State:_____Zip:_____

Marital Status: ☐ Single ☐ Married* ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

*Spouse name: _____ Spouse Contact #: (_____)_____

If patient is under 18 years of age, please complete the following:

Mother's Name: _____ Primary Contact #: (_____)_____

Employer name: _____ Phone#: (_____)_____

Father's Name: _____ Primary Contact #: (_____)_____

Employer name: _____ Phone#: (_____)_____

Patient's School: _____ ☐ Private ☐ Public

If the person initiating treatment for this patient is NOT the mother or father, please check here: ☐
What is your relationship to the patient? ☐ Legal guardian ☐ Grandparent with custody ☐ Other (with custody/guardianship

Primary Insurance Coverage: _____

Policyholder/Subscriber Name: _____ Date of Birth:____(mm)____(dd)_____(yyyy)

Social Security #: _____ Policy ID# (if different from SSN):_____

Group number: _____ Group Name: _____ Relationship: ☐self ☐spouse ☐ child ☐other

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Secondary Insurance Coverage:

Please note that we only file secondary coverage to plans in which we participate and only if we participate with the primary coverage. If you have any questions about this, please let us know upon arrival. Thank you.

PRIVACY PRACTICES ACKNOWLEDGEMENT

A copy of our privacy practices (HIPAA notice) can be obtained by visiting our website at www.nrpsych.com or by requesting it from the reception desk upon arrival at our office.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact the Office Manager by phone or in writing at 5530 Munford Road, Suite 119, Raleigh, NC 27612. All complaints must be filed within 180 days of the alleged violation. You will not be penalized for filing a complaint.

If you have questions regarding this notice or our health information privacy policies, please contact the Office Manager at the address noted above. By signing below, I (the patient, guarantor or legal guardian) hereby acknowledge that North Raleigh Psychiatry, P.A. has notified me of their Privacy Practices.

ASSIGNMENT OF MEDICAL BENEFITS

I hereby authorize payment of medical benefits to be made directly to North Raleigh Psychiatry, P. A. I agree to be fully responsible for any and all charges incurred. In accordance with HIPAA/Privacy guidelines, I authorize North Raleigh Psychiatry, P.A. to release any medical information necessary to process my insurance claims, whether filed by North Raleigh Psychiatry or by the patient/guarantor.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize North Raleigh Psychiatry, P.A. to release any pertinent medical information to any physician or provider for the continuation of my medical care.* I also authorize any current or previous physicians, providers or other clinical care entities to release to North Raleigh Psychiatry any pertinent medical information to assist in the continuation of my medical care at North Raleigh Psychiatry. I understand that patient medical records are the sole property of North Raleigh Psychiatry, P.A., and in order to obtain a copy of the patients' medical record or any information contained therein, a signed medical release form is required. I understand there will be a charge for the copying of said records. I understand that if I want to transfer my records to another physician, a signed medical release form will be required. There is no fee charged to transfer records to another physician, medical office or hospital. I understand that this release is valid until revoked in writing by the patient, parent or legal guardian. **NOTE*: Unless authorized in writing, only the patient, parent or legal guardian will be accepted as the authorized agent to schedule appointments, discuss care with the physician and/or discuss billing information regarding the patient.**

****EXCEPTIONS: You must indicate to us in writing any exceptions to this policy.***

I have read and understand the above office policies concerning the PRIVACY PRACTICES ACKNOWLEDGEMENT, ASSIGNMENT OF MEDICAL BENEFITS and AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION. I agree to the terms and conditions as set forth in this document as noted above.

_____ _____

Signature of patient *(if under age 18, parent/guardian must sign)* Date

_____ _____

Signature of parent/guardian/responsible party Date

NORTH RALEIGH PSYCHIATRY, P.A.
Medical History and Information Form

Today's Date: ____/____/_____ New Patient? ___ Yes ___ No Sex: ☐ Male ☐ Female

Patient Name: _____ _____ ____ Date of birth: ____/____/_____
Last First MI

Primary Care Physician's Name: _____ Phone: (_____) _____ - _____

Were you referred to our practice? ___Yes ___ No If yes, please indicate below how you were referred:

___ PCP/Pediatrician ___ OB/GYN ___ Other specialist ___ Relative/Friend/Coworker ___ Insurance

If no, how did you hear about us? _____

Are you currently receiving treatment from a psychologist, therapist or clinical social worker? ___Yes ___No

If yes, please provide their name and phone number: _____

If female, a) is there a possibility that you may be pregnant? ___ Yes ___ No
b) have you ever had any miscarriages? ___ Yes ___ No

Briefly state the reason for your visit: _____

Are you allergic to any medications? ___ Yes ___ No If yes, please indicate below:

___ Acetaminophen ___ Aspirin ___ Codeine ___ Ibuprofen ___ Naproxen ___ Penicillin ___ Sulfa

Other (please specify): _____

Do you drink alcoholic beverages? ___ Yes ___ No Do you smoke marijuana? ___ Yes ___ No

Do you use non-prescribed drugs (eg: amphetamines, tranquilizers, hallucinogens, etc.)? ___ Yes ___ No

If yes to any of the above, how often? Rarely Occasionally Daily Other _____

Please list the names of any prescription medications, over-the-counter (OTC) medications, vitamins or supplements you are currently taking, and include the strength and frequency if known (if a list is provided, please state 'see list'):

_____

_____

_____

Please provide the name, address and phone number of the local pharmacy that you use most often:

Pharmacy Name: _____ Phone # (_____)_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Below is a list of problems or symptoms people sometimes have. Using the scale below, indicate how each of these problems or symptoms has distressed, worried or bothered you during the last week, including today.
NOTE: Please select only one number per item.

	NOT AT ALL		MODERATELY		EXTREMELY
1) Headaches	1	2	3	4	5
2) Upset stomach	1	2	3	4	5
3) Difficulty sleeping	1	2	3	4	5
4) Loss of appetite	1	2	3	4	5
5) Blaming, criticizing or condemning yourself	1	2	3	4	5
6) Feeling depressed or dejected	1	2	3	4	5
7) Suicidal thoughts	1	2	3	4	5
8) Being easily embarrassed	1	2	3	4	5
9) Being ill at ease with others	1	2	3	4	5
10) Trouble in keeping conversations going	1	2	3	4	5
11) Feeling shy with the opposite sex	1	2	3	4	5
12) Relationship problems	1	2	3	4	5
13) Sexual concerns	1	2	3	4	5
14) A lack of real friends	1	2	3	4	5
15) Problems with your parents	1	2	3	4	5
16) Financial problems	1	2	3	4	5
17) Feeling things around you seem unnatural or unreal	1	2	3	4	5
18) Staying by yourself a lot	1	2	3	4	5

PATIENT CONSENT (parent/guardian must sign if patient is under age 18):

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize the physician to provide any medical care that may be deemed necessary in order to diagnosis and treat the patient.

Patient Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature:_____ Date:_____/_____/_____

revised 04/09/15

NORTH RALEIGH PSYCHIATRY, P. A. PATIENT FINANCIAL POLICY

Thank you for choosing our practice! It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients. If you have any questions regarding any of the policies mentioned below, please feel free to speak with any of our office staff.

1) PAYMENT OF SERVICES

Payment in full is expected at the time services are rendered. Patients with insurance coverage in which we participate will be asked to pay all applicable copays, coinsurance and/or deductibles. There will be an additional fee assessed for non-payment. If the patient is a minor, the parent/legal guardian will be responsible for making or arranging for payment of services. Prior balances on your account must be paid in full within 60 days unless other arrangements are made **in advance** with the billing supervisor or office manager. In the case of services provided to patients under the age of 18, the parent, legal guardian or other court appointed representative who initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment. We accept cash, check, money orders, Mastercard, VISA and Discover.

2) MISSED OR LATE CANCELLED APPOINTMENTS

Please call our office during regular business hours to schedule, cancel or change appointments. You will be charged a fee for any appointments missed or not cancelled/rescheduled with one business days' (or more) notice. If you miss more than one-half of your scheduled appointment time, it may be considered a missed appointment. This fee is due and payable before your next appointment, unless other arrangements have been made with our office. It is not filed with insurance as it is a non-covered service. Reminder calls are generally made three business days prior to the appointment; however, *this is done as a courtesy only.* It is **your responsibility** to remember your appointments.

3) INSURANCE & CLAIMS FILING

We participate with only a few insurance plans. **We do not file claims to any insurance in which we do not participate.** Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. PLEASE REMEMBER: The agreement of the insurance carrier to pay for health care is a contract between you and the insurance company. Any questions or complaints regarding coverage should be directed to your insurance company.

If we participate with your insurance plan(s), we will file your claims for covered services to said insurance(s) with the understanding that: 1) You authorize payment of benefits to be made to North Raleigh Psychiatry; 2) If your insurance denies your claim(s), you will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent to you by North Raleigh Psychiatry following the receipt of the denial(s). **NOTE: North Raleigh Psychiatry will not file any claims for non-covered services, which may include phone consultations.** Supplemental insurances will not be filed unless we participate with both the primary AND supplemental coverage.

4) PRESCRIPTION REFILLS

Please note that it may take up to three (3) business days to process your prescription request(s). **PLEASE DO NOT WAIT UNTIL YOUR MEDICINE RUNS OUT.** We reserve the right to charge a fee for any prescription request(s) resulting from missed or cancelled appointments. *There is a $20 fee for any prescription request taken AFTER HOURS on the emergency line or if requested to be filled same day by the on-call doctor during regular business hours.* This fee will be the patient/guarantor's responsibility and is not billed to insurance. NOTE: If you wish to have a prescription mailed to you, you will need to provide a postage paid envelope to us for this purpose.

5) AFTER HOURS PHONE CALLS

There may be a **minimum** $20 fee for NON-EMERGENT after hours phone calls placed with the physician on call. The physician on call will make a determination as to whether the situation is an emergency and whether a fee should be charged. This fee is the patient/guarantor's responsibility and is NOT billed to insurance.

6) PRIVACY/HIPAA

Our office complies with the Health Insurance Portability and Accountability Act (HIPAA). We respect the privacy of our patients and will not release any information to any party without the written consent of the patient or responsible party, except in any case where required by law or for continuity of care, which is described on the patient registration form. **Any exceptions to this policy must be provided to us in writing.** We encourage you to read the privacy notice so that you may understand your rights under HIPAA law. All signed releases provided to us are valid until revoked in writing. Our privacy notice is available on our website or you may request a copy from our office.

7) OTHER FEES

a) There will be a fee charged for the completion of forms such as disability, Family Medical Leave Act (FMLA), attending physician statements (APS) or any other miscellaneous forms or correspondence not associated with the reimbursement of a claim. The fee is based on the length of time required to complete the form(s) and payment is expected when the form is picked up.
b) A service fee will be assessed for all returned checks. The service fee and the unpaid balance must be paid by cash, debit/credit card, money order or cashier's check.
c) A service fee will be assessed for the refiling of insurance claims due to incomplete or incorrect information given at the time of the appointment.
d) Our physicians reserve the right to charge for any phone calls resulting from or relating to: cancelled or missed appointments, preparation of forms, request for medication changes or medical advice without an appointment, or other services provided during any call lasting longer than 5 minutes.

8) COLLECTION OF ACCOUNT

In order for us to service your account and/or to collect any amounts you may owe, you or the responsible party for the account may be contacted by telephone at any number associated with the account, including any wireless phone numbers provided, which may result in charges to you. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. You understand that you will be legally responsible for all costs associated with the collection of any unpaid balance on your account, which may include (but is not limited to), collection agency fees, court costs and/or reasonable attorney fees. NOTE: Collection agency fees will not exceed 33% of the original debt owed and you will be notified in writing prior to the assessment of this fee.

I have read, and agree to abide by, the above policies and disclosures as stated. I accept full financial responsibility for any and all incurred charges for this account, and agree to the terms of telephone contact as described in section (8) above.

_____ _____

Patient name (please print) Parent/Legal Guardian/POA (please print)

_____ _____

Signature of Patient* Signature of Parent/Legal Guardian/POA*

Date Signed: _____ ***NOTE: Only one signature is required***