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 #: (_____)_____
☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work

Please note—any or all phone numbers listed above may be used to leave voice mail, text and/or answering machine messages.

Primary Email Address: _____

Please note—by providing your email address, you authorize us to contact you via email for any office purpose if needed or requested, with the understanding that email is NOT protected by HIPAA and is not considered a secure method of communication.

Employer: _____ Phone#: (_____)_____

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

*Spouse/Significant Other name: _____ Phone#: (_____)_____

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

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

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

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 (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

Secondary/Tertiary Insurance Coverage:

Please note that we only file secondary/tertiary coverage(s) to plans in which we participate, and ONLY if we participate with the primary coverage. If you have any questions about this, please speak with the check-in receptionist upon arrival for your appointment. 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 any/all insurance claims, whether filed by North Raleigh Psychiatry or 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 may 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.**

****You must indicate to us IN WRITING any exceptions to this policy.***

I have read and understand the above information 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 ☐ Male ☐ Female Age: _____

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

Primary Care Physician: _____ 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/Other

Please check if you currently receive treatment from: ☐ Psychologist ☐ Therapist ☐ Clinical Social Worker
→ *If you checked any of the above, please provide their name and phone number below:*

Name: _____ Phone: (_____)_____

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

Are you using any type of contraception? ___ Yes ___ No If yes, what type: _____

Briefly state the reason for your visit: _____

Do you have any allergies? ___ Yes ___ No If yes, what type? ___Medication ___Food ___Seasonal ___Other
If yes, please describe below:

_____

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 medications (prescription or over-the-counter), vitamins or supplements that you are currently taking, including the strength and frequency (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: _____

NORTH RALEIGH PSYCHIATRY, P. A. FINANCIAL & OFFICE POLICY

Welcome to North Raleigh Psychiatry! We look forward to providing you with the highest quality care and trust. We hope you will find our staff friendly and helpful. It is our belief that establishing a written financial and office 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 information below, please feel free to speak with any of our office staff.

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. Self-pay patients will be asked for payment in full; there will be an additional $10 billing fee assessed for less than full payment. Prior balances on your account must be paid in full within 60 days unless other arrangements have been made **in advance** with our office. In the case of services provided to patients under the age of 18, the parent, legal guardian or other court appointed representative who signs the registration paperwork for the minor will be responsible for payment. **We do not bill another individual for payment unless legal documentation is provided.** We accept cash, checks, money orders, Mastercard, VISA and Discover. At this time, we do not accept American Express or travelers checks.

MISSED / LATE CANCELLED APPOINTMENTS

Please call our office during regular business hours to schedule, cancel or change appointments. You may be charged a fee for any appointments missed or any appointment that is cancelled and/or rescheduled with less than one business days' notice. Patients who arrive late for their scheduled appointment may be asked to reschedule and may be assessed a fee. This fee is due and payable before your next appointment, unless other arrangements have been made with our office. These charges are not filed with insurance, as it is a non-covered service. Although our office uses automated appointment reminders when possible, ***they are not guaranteed, and are done as a courtesy only.*** It is expected that the patient or guarantor will be responsible for remembering their appointments regardless of the reminder call.

INSURANCE & CLAIMS FILING

We have physicians that 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 NOTE:** 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 or benefit payments 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 or other services provided after regular office hours by the on-call physician.** Supplemental insurances will not be filed unless we participate with both the primary AND supplemental coverage.

PRESCRIPTION REFILLS

All prescriptions can now be sent to your pharmacy electronically, including any controlled substances. **PLEASE DO NOT WAIT UNTIL YOUR MEDICINE RUNS OUT TO REQUEST A REFILL,** as it may take up to three (3) business days to process your prescription request(s). We reserve the right to charge a fee for any prescription request(s) resulting from non-compliance with follow-up and/or missed or cancelled appointments. ***There is a $20 fee for prescriptions requested to be filled within twenty-four (24) hours.*** Please ask to speak with a staff member for same-day fill requests.

AFTER HOURS PHONE CALLS

There may be a **minimum** $20 fee for NON-EMERGENT after-hours phone calls placed with the physician on call, which includes any requests for medication refills. The physician on call will make the 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.

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 as allowed by HIPAA. **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. NOTE: The transmission of messages or other information via email is NOT secured or protected by HIPAA. **To ensure the privacy of our patients and/or clients, the use of any recording devices within our office is strictly prohibited.**

OTHER FEES

a) There may be a fee charged for the completion of forms or letters, 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 prior to the release of the completed form.
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 or money order.
c) A service fee will be assessed for the refiling of insurance claims due to incomplete/incorrect information given.
d) Our physicians reserve the right to charge for any phone calls resulting from or relating to: non-compliance with follow-up, missed or cancelled 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.

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 or email 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, text messages, email messages and/or the use of automatic dialing devices where 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 and email contact, both as described in section (6) and section (8) above.

_____ _____

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

_____ _____

Signature of Patient Signature of Parent/Legal Guardian/POA

Date Signed: _____

NORTH RALEIGH PSYCHIATRY, PA
General Psychiatry – Child & Adolescent Psychiatry

Child's full name: _____ Date: _____

□ Male □ Female Birthdate _____ Age _____ Race _____

Address _____

This child is in legal custody of _____

Child is:

□ Natural child of parents □ Adopted child of parents □ Foster child

Parents are:

□ Married and together □ Father remarried □ Father deceased

□ Married and separated □ Mother remarried □ Mother deceased

□ Divorced □ Never married

Mother's full name _____

Age _____ Education _____ Occupation _____

Address _____ □ Same

Home phone _____ Work phone _____ Fax number _____

General relationship between mother and child _____

_____

Father's full name _____

Age _____ Education _____ Occupation _____

Address _____ □ Same

Home phone _____ Work phone _____ Fax number _____

General relationship between father and child _____

_____

Other significant contact _____ Phone _____

CURRENT PERSONAL AND FAMILY CIRCUMSTANCES

Describe your child's problems: Length of time

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

What do you think may have caused your child's problem(s)? _____

_____

What specific event(s) caused you to seek help at this time? _____

_____

What have you tried so far to correct these problem(s)? How much have things improved?

1. _____ _____ % improved
2. _____ _____ % improved
3. _____ _____ % improved
4. _____ _____ % improved

Please check all events that may have occurred within the family in the past 12 months:

- □ Death of parent
- □ Divorce
- □ Parent's separation
- □ Significant marital conflicts
- □ Marriage
- □ Pregnancy
- □ Birth of sibling
- □ Gain of new family member
- □ Child leaving home
- □ Death of close family member
- □ Loss or move of close friends
- □ Personal injury or illness
- □ Change in financial status
- □ Change in residence
- □ Change in schools
- □ Legal problems
- □ Parent losing job
- □ Parent with emotional difficulties
- □ Violence in neighborhood or school
- □ Other stress _____

Please list the brothers and sisters of the child:

Name	Sex	Age	Living at home (Y/N)	Relationship with child

Please list other people who are living in the same household as the child

Name	Sex	Age	Relationship to child	Occupation/Education

Check if any <u>natural</u> parent, brother, sister, uncle, aunt, cousin or grandparent has:

- □ Attention-deficit/hyperactivity disorder
- □ Learning disabilities
- □ Mental retardation
- □ "Blues", depression
- □ Attempted suicide
- □ Bipolar – Manic depressive illness
- □ Medical problems
- □ Problems with anxiety or panic attacks
- □ Problems with alcohol or drugs
- □ Schizophrenia
- □ Other psychiatric problem
- □ Tics, seizures or neurological problem
- □ Legal problems

Please describe_____

_____

_____

DEVELOPMENTAL HISTORY

Mother's age when child was born _____ Planned pregnancy: □ Yes □ No

Was the pregnancy free of problems? □ Yes □ No. Explain _____

_____

_____

During pregnancy mother: □ Drank alcohol □ Smoked tobacco □ Used drugs
□ Took medication □ Was depressed □ None

Was child born full term? □ Yes □ No. Explain _____

Was labor and delivery normal? □ Yes □ No. Explain _____

_____

Child's condition at birth was □ Normal □ Blue baby
□ Jaundice □ Other. Explain _____

Child's weight at birth was _____ Apgar scores if known _____

What was your child like in early infancy?

□ Affectionate	□ Cried a lot	□ Irritable	□ Moody
□ Content	□ Cuddly	□ Overly active	□ Aggressive
□ Fearful	□ Playful	□ Fussy	□ Colicky
□ Sleepy	□ Quiet	□ Under active	□ Physically sick

Did your child have any feeding problems? □ No □ Yes. Explain _____

_____

Did your child have any sleeping problems? □ No □ Yes. Explain _____

_____

What was mother like in the first year of child's life?

□ Nervous	□ Sick	□ Tired and uninvolved
□ Depressed	□ Working out of home	□ Doing well

□ Other problem. Explain _____

What was father like in the first year of child's life?

□ Nervous □ Uninvolved □ Depressed

□ Unemployed □ Sick □ Supportive/helpful

□ Other problem. Explain _____

Approximate age at which your child

Sat alone _____ Walked alone _____ Pedaled tricycle _____

Said "dada/mama" _____ Used short sentences _____ Was toilet trained _____

Were there difficulties in toilet training? □ No □ Yes. Explain _____

_____

Do you think your child is clumsy compared to children his/her age? □ No □ Yes

Are you concerned about your child's handwriting? □ No □ Yes

Has your child had any traumatic experiences, including sexual or physical abuse? □ No

□ Yes. Explain _____

_____

Has your child ever been placed out of home? □ No □ Yes. Explain _____

_____

Does your child have access to weapons? □ No □ Yes. Explain _____

_____

MEDICAL HISTORY

Child's physician or clinic _____

Is your child allergic to medication or anything else? □ No □ Yes. Explain _____

_____

Are your child's immunizations up to date? □ Yes □ No. Explain _____

_____

Has your child ever been hospitalized? □ No □ Yes. Explain _____

_____

Does your child have or had any of the following?

□ Eye problems	□ Staring spells	□ Head trauma
□ Hearing problems	□ Seizures	□ Asthma
□ Speech problems	□ Motor/Vocal tics	□ Liver disease
□ Severe headaches	□ Heart trouble	□ Kidney problems
□ Diabetes	□ Weight problems	□ Other

Explain _____

Please describe any concerns you may have about your child's physical health _____

_____ □ None

List all clinicians that have evaluated or treated your child for behavioral or emotional problems

Clinician	Reason	Type of treatment	Year and length

List all the medications your child has received for behavioral or emotional problems □ None

Medication	Reason	Dosage	Length of treatment

Do you have any concern about your child using drugs/alcohol? □ No □ Yes

Explain _____

_____

Is he/she sexually active? □ No □ Do not know □ Yes. Explain _____

_____

Only for females:

Date of first menstrual period _____ Date of last menstrual period _____

Are the menstrual periods regular? □ Yes □ No. Explain _____

_____

Is she on birth control? □ Yes □ No. Explain _____

SCHOOL AND WORK HISTORY

Name of current school _____

Grade level _____ Homeroom teacher _____

List all pre-schools and schools attended:

School name	Year / Grade level	Academic grades	Conduct

Has your child passed each grade? □ Yes □ No. Explain _____

_____

Has your child ever been enrolled in special services for

□ Reading problems □ Speech and language disorder

□ Mathematics problems □ Emotional/Behavioral problems

Compared to children of the same age, how would you rate your child's intellectual ability?

□ Average □ Below □ Above

What were the date and results of the last IQ/Educational testing done at school? _____

_____

How is your child getting along with peers and teachers? _____

_____

_____

List of past jobs and duties _____

_____

Current job and position _____ Length _____

Has he/she ever been suspended or fired from a job? □ No □ Yes. Explain _____

_____

LEGAL HISTORY

Has your child ever been in trouble with the law? □ No □ Yes. Explain _____

_____

_____

YOUR CHILD

List the good things about your child. What can he/she do well? Any special talents? What does he/she seem to enjoy the most? _____

_____

_____

_____

_____

_____

BEHAVIOR/EMOTIONS CHECKLIST

Please complete this form regarding your child not taking into account what anyone else thinks

	Not at all	Just a little	Quite a bit	Very much
1. Sits fiddling with small objects				
2. Hums and makes other odd noises				
3. Falls apart under stress				
4. Poor concentration				
5. Restless or overactive				
6. Excitable				
7. Inattentive				
8. Difficulty in concentrating				
9. Oversensitive				
10. Overly serious or sad				
11. Daydreams				
12. Sullen or sulky				
13. Selfish				
14. Disturbs other children				
15. Quarrelsome				
16. “Tattles”				
17. Acts “smart”				
18. Destructive				
19. Steals				
20. Lies				
21. Temper outbursts				
22. Isolates self from children				
23. Unaccepted by peer group				
24. Appears to be easily led				
25. No sense of fair play				
26. Appears to lack leadership				
27. Does not get along with other sex				
28. Compassionate				
29. Teases other children				
30. Obedient				
31. Antagonistic or defiant				
32. Shameless				
33. Shy				
34. Fearful				
35. Excessive demands for attention				
36. Stubborn				
37. Overly anxious to please				
38. Uncooperative				
39. Impulsive/Acts without thinking				