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, P.A.

5530 Munford Road, Suite 119 • Raleigh, NC 27612
www.nrpsych.com
Phone (919) 782-9554
Fax (919) 782-9130

CHILD / ADOLESCENT INTAKE FORM

Today's date:_____

Patient Information:

Name:_____ Date of Birth:_____ Age:____
(first) (last)

Gender M/F Ethnicity (Optional)_____

Patient Contacts:

Mother's name:_____ Age:____
(first) (last)

Father's name:_____ Age:____
(first) (last)

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address:_____
(street) (city) (state) (zip)

Contact phone number(s):_____

Father's Address:_____
(street) (city) (state) (zip)

Contact phone number(s):_____

Who has legal/physical custody?_____ Type:_____

Referral Information:

Who referred you to this practice?

_____
(name) (phone)

_____
(address)

Presenting Problem:

What concerns you most about your child?

When did you first notice this problem?

How has this problem affected his / her function?

At home:

At school / work:

Community:

Do you have other concerns you want addressed?

What are your goals / expectations for treatment?

Have you recently worried that your child has (please circle items relevant to your child):

☐ Yes ☐ No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal / isolative behaviors, lack of interest in things, etc)

☐ Yes ☐ No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

☐ Yes ☐ No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

☐ Yes ☐ No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

☐ Yes ☐ No ATTENTION / HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

☐ Yes ☐ No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc)

☐ Yes ☐ No SOCIAL ANXIETY (shy and/or afraid to be around others)

☐ Yes ☐ No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

☐ Yes ☐ No AUTISM (social and language impairments, rigidity)

☐ Yes ☐ No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

☐ Yes ☐ No DISSOCIATION (feeling outside your body or things are not real, etc.)

☐ Yes ☐ No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others?_____
_____
_____

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs)

Diagnosis *Length of Stay* *Treatment* *Response*

_____

_____

_____

Please list any current or prior outpatient psychiatrists and therapists your child has seen

Name *Title* *Location* *How long?*

_____

_____

_____

Please list your child's current psychiatric medications:

Name *Dosage* *Duration* *Response*

_____

_____

_____

Please list his / her current non-psychiatric medications:

Name *Dosage* *Duration* *Response*

_____

_____

_____

Please list all the psychiatric medications that have been tried in the past (if greater than 4 medications, please attach separate list):

Name *Highest Dosage* *Duration* *Response* *Reason for Stopping*

_____

_____

_____

_____

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

___Depression_____

___Anxiety_____

___ADHD_____

___Bipolar (manic depressive)_____

___Schizophrenia_____

(Family History cont.)

___Alcohol / Drug Problems_____

___Learning Disabilities_____

___Autism / Aspergers / Pervasive Developmental Disorder_____

___Mental Retardation_____

___Nervous Breakdown_____

___Psychiatric Hospitalizations_____

___Suicide (or attempts)_____

___Panic Disorder_____

___PTSD (Post Traumatic Stress Disorder)_____

___OCD (Obsessive Compulsive Disorder)_____

___Seizures_____

___Migraines_____

___Heart or lung problems_____

___Thyroid_____

___Immunological disorders (lupus, scleroderma, inflammatory bowel disease)_____

___Cancer_____

___Other_____

Developmental History:

At what age did your child achieve the following milestones?

_____ Language (age at first using words, sentences, etc…)?

_____

_____ Fine Motor Skills (building towers with cubes, drawing circle)?

_____

_____ Gross Motor Skills (rolling over, standing, walking)?

_____

_____ Toilet training?

_____

Has your child experienced any regression of these? _____ if yes, explain:_____

_____

Pregnancy and Birth History:

How old was this child's biological parents when he / she was conceived?_____

Baby's birth weight and length:_____

Length of pregnancy (in weeks):_____

Did you take any medication (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) Taken (1-9)	Reason for Taking

Did you consume alcohol during this pregnancy? _____ If yes, how much and how often? _____

Did you smoke or use tobacco products during this pregnancy? _____ If yes, please describe how much and how often? _____

Did you use any drugs during this pregnancy? _____ If yes, please name drug(s), how much and frequency of use: _____

_____

_____

Labor Information:

Were there any problems with the baby's health right before or immediately after delivery? _____ If yes, please describe: _____

_____

Apgar Scores: _____

Past Medical History:

Primary Care Provider: _____ Years Involvement: _____

Phone: _____

Address: _____

Approximate Date of Last Visit: _____

Number of Visits in Last Year: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Drug Allergies? _____ If yes, please name and describe your child's reaction: _____

_____

Has your child ever experienced a head injury, loss of consciousness, or seizure? _____

If yes, please describe: _____

_____

Does your child have any chronic medical problems? _____ If yes, please describe: ___

_____

Does your child have a history of any serious injuries or medical hospitalizations? _____

If yes, please describe: _____

_____

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? _____ If yes, please describe: _____

_____

Social History:

Is your child your biological child? _____

If no, at what age was he /she adopted? _____

Is there any contact with their biological parents? _____

Where was your child born and raised? _____

Parents: (including Step-Mother and Step-Father, if applicable)

Name *Education* *Occupation* *How is your relationship with child?*

_____

_____

_____

_____

Please list the other children in the family and other household members who may also be living in your home:

Name *Age* *Lives at Home?* *Relation to Child* *Relationship with Child*

_____

_____

_____

_____

Abuse History:

Has your child ever been the victim of abuse or neglect? _____ If yes, what was the nature of the abuse? _____

_____

_____

Are you struggling with your marital relationship or parenting? _____ If yes, please describe: _____

_____

_____

Has your child ever been involved with the following and if yes, please explain:

☐ Yes ☐ No Child Protective Services:_____

☐ Yes ☐ No Probation / Juvenile Probation / Detention: _____

☐ Yes ☐ No Head Start: _____

☐ Yes ☐ No Early Intervention Services (ages 0-3): _____

School:

Where does your child attend school? _____

In what grade level is he / she? _____

What are his / her typical grades? _____

What are your child's academic strengths? _____

_____

Academic weaknesses? _____

_____

Has there been a change in your child's performance at school? _____ If yes, please describe: _____

_____

_____

Has your child received IQ or Academic Testing? _____ If yes, what were the results?

_____

_____

Does or has your child participated in any of the following?

☐ Yes ☐ No Resource (for which classes / how many hours?): _____
_____

☐ Yes ☐ No Accelerated or Honors programs, explain: _____

☐ Yes ☐ No 504 Plan, explain: _____

☐ Yes ☐ No Individual Education Plan (IEP), explain: _____

Has your child had problems with any of the following?

☐ Yes ☐ No Truancy, explain: _____

☐ Yes ☐ No Fights, explain: _____

☐ Yes ☐ No Absenteeism, explain: _____

☐ Yes ☐ No Detention, explain: _____

☐ Yes ☐ No Suspension, explain: _____

☐ Yes ☐ No School refusal, explain: _____

Peers:

Does your child have quality relationships with other children? _____ If no, please explain: _____

_____

Culture:

Do you have a religious preference in the household? _____ If yes, what is that preference? _____

Has your child experienced any problems related to race, religion, or culture? _____ If yes, please explain: _____

_____

TEEN / YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? _____

(Please circle all that apply)

Too Old	Too Young	Truant	Gang	Fringe
Drug/Alcohol Use	Violence	Too Many	Too Few	Sexual Promiscuity
Too much time together		Other: _____		

Has your adolescent had a recent change in friendships? _____ If yes, what changes, if any, are concerning you? _____

_____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? _____ If yes, please describe: _____

_____

Are you concerned about your child's sexual activities? _____

Is your adolescent sexually active? _____

Does your adolescent have a job? _____

Has your adolescent's behavior ever resulted in police, detention, or court involvement? _____ if yes, please explain: _____

_____

_____

Is there anything else you would like us to know about your child? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____