CAROLINA PSYCHOLOGICAL HEALTH SERVICES (CPHS)

UPDATE PATIENT INFORMATION PACKET (ADULT/INCAPACITATED ADULTS)

Date: _____ Chart # _____

ONLY ONE PERSON IS TO COMPLETE THIS PACKET

Patient Name: _____ Prefer Name: _____
(Last Name First Middle)

Address: _____ _____ _____ _____
(Street Name City State Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

(Only provide us contact numbers where we can contact you and/or we can leave a message in regards to appointments, inquiries and office/medical related issues.)

Preferred Method of Appointment Reminder [ ]None [ ] Call [ ]Text [ ]E-mail Address:_____

DOB: _____ SSN: _____ Sex (circle one): M / F

Patient Current Marital Status:_____

Name Employer/School: _____

Primary Care Provider:_____Phone:_____
(Required for billing purposes)

IN CASE OF EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship:

[ ] Spouse [ ]Mom [ ]Dad [ ]Step-[ ] Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other: _____

AUTHORIZE TO TREAT

I affirm that I am the (circle one) patient/ legal guardian and responsible party of the above patient and, I hereby acknowledge that I authorize and give permission to the staff of ***Carolina Psychological Health Services(CPHS)*** to render treatment and/or services to myself/above named minor child, and I hereby acknowledge that staff is responsible for treatment and/or services rendered in the course of treatment (therapeutic time in facility) and cannot be held responsible for my behavior/behavior of minor child outside of the context of the therapeutic treatment session.

_____ _____
Signature of Patient/Legal Guardian Date

Legal Guardian For Incapacitated Adult:_____ Phone:_____

Responsible Party For Incapacitated Adult _____ Phone: _____

Responsible Party DOB: _____ Responsible Party SSN: _____

_____
CPHS Witness Signature

INSURANCE: (If you have more than two insurances please let us know) Please be prepared to show your insurance card at each visit. For TRICARE members: We require a copy of your military ID (which is authorized under DoDI # 1000.13 and Force Protection Advisory (0050-09-FPA (Change 1)).

Check Here For No Secondary Insurance [ ]

Primary Insurance	***Secondary Insurance***
Insurance Company: _____	Secondary Insurance: _____
Policyholder: _____	Policyholder: _____
Policyholder DOB: _____	Policyholder DOB: _____
Policyholder SSN: _____	Policyholder SSN: _____
Policy ID Number: _____	Policy ID Number: _____
Group Number: _____	Group Number: _____
Policyholder Address: _____	Policyholder Address: _____
_____	_____
Relationship to policyholder: [ ] Self [ ] Spouse [ ]Mom [ ]Dad [ ]Daughter/Son [ ]Step Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other:	Relationship to policyholder: [ ] Self [ ] Spouse [ ]Mom [ ]Dad [ ]Daughter/son [ ]Step- Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ]Other:

INSURANCE AUTHORIZATION AND ASSIGNMENT (INITIAL BOX THAT APPLIES)

[____] ***NonMedicare****:* I assign directly to Carolina Psychological Health Services all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions; I authorize any CPHS holder of medical /psychotherapy/psychiatric information about me to be released to the health care finance administration, insurance company and its agents any information needed to determine these benefits or benefits payable to related services. I agree a photocopy of this form may be used in place of the original.

[____] ***Medicare:*** I request payment of authorized Medicare benefits be made on my behalf to *Carolina Psychological Health Services for any services furnished to me. To the extent permitted by law, I authorize any holder of medical and other information about me to be released to the Center of Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services.*

_____ _____

Signature of Patient/ Legal Guardian Date

_____

CPHS Witness Signature

ACCESS PERMISSION FORM

Patient Name: _____ Chart # _____

I DO NOT WISH TO GRANT ACCESS: _____ SKIP TO SIGNATURE SECTION TO CONTINUE

I, _____ (Patient, Legal Guardian), authorize ***Carolina Psychological Health Services*** (CPHS) staff to allow the following person access to the above patient:

_____ _____

Printed name of one person authorized access Relationship to patient

to: (check appropriate choices **(If all boxes are checked we are not liable for error in communication to others)**):

- _____ have knowledge of appointments
- _____ make, change or cancel appointments
- _____ pick up prescriptions
- _____ pick up medical record requested by me
- _____ verbal/open communication regarding case discussion information with CPHS Providers
- _____ verbal/open communication regarding billing (do diagnosis info will be given out)
- _____ bring and attend my minor child's appointments

This <u>DOES NOT</u> give authorization for this individual to request release of records. This authorization shall remain in effect for one year from the date of signature, unless cancelled by me in writing.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Witness Signature

CANCELLATION OF ACCESS

I, _____, hereby revoke the above access to my information.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Witness Signature

CAROLINA PSYCHOLOGICAL HEALTH SERVICES

1703 Country Club Rd, Suite 204
Jacksonville NC 28546
Telephone: 910-347-3010
Fax: 910-347-6137

ACKNOWLEDGEMENT/RECEIPT OF *Patient/Client Bill Of Rights, Responsibilities, and The Limits Of Confidentiality; Carolina Psychological Health Services (CPHS) Patient Policies and Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information*

I acknowledge that I have been given copies of the ***Patient/Client Bill Of Rights, Responsibilities, And The Limits Of Confidentiality; Our Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information and our Carolina Psychological Health Services (CPHS) Patient Policy*** to have and read. If I have any questions, it is my responsibility to ask them.

I understand I must read the "***Patient/Client Bill Of Rights, Responsibilities, And The Limits Of Confidentiality."*** It describes how my psychological and medical information may be used and disclosed and how I can get access to the information. I have read and understood the Bill of Rights, Responsibilities, and Limits of Confidentiality above.

I also understand I have been offered "***Carolina Psychological Health Services (CPHS) Patient Policies"*** handout describes CPHS patient policies regarding treatment rendered, state and local law required reporting, no show and cancellation fees, Co-Pays/Deductible and Co-Insurance Payments, policy on electronics/cell phones, patient bringing minor children to appointments, bringing under aged guests to appointments and insurance.

I understand I have been offered CPHS "***Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information***" handout describes how psychological and psychiatric information about you may be used and disclosed and how you can get access to this information.

By signing, I have read and understand all of the above listed handouts/forms and I accept a copy of these handouts. I also understand, it is my responsibility to read them and ask any questions I may have.

_____ _____

Patient Name: Chart#

_____ _____

SIGNATURE of Patient / Legal Guardian Date

_____

Witness Signature