HOW TO COMPLETE THIS PACKET

New Patient Forms
- Patient Information – please complete and sign.
- Consents and Acknowledgements Form – please sign.
- Financial Policy Form – please sign.
- Patient Rights and Responsibilities – please sign.

Medical Record Request Form – please complete and submit to any providers who have relevant records. If there are no providers to get history from, please write not at this time under information to be requested from and sign.

Medical Record Release Form – please complete for anyone you want us to send medical records to and sign.

Health Questionnaire – please complete and sign.

PREPARING FOR YOUR NEW PATIENT VISIT

Be Prepared for a Long First Appointment
New patient appointments are very comprehensive and can take 3 - 5 hours or more. The time may include some intermittent waits while the patient is tested and information is gathered. Bring snacks, drinks (non-caffeinated) and any medication that will need to be taken during this time. Also bring quiet activities such as books, tablets, etc. We do have toys and magazines in the reception area. Please note that our office does not have wheelchairs for patient use.

Make Sure We Have Any Previous Records
Fill out the Release of Information Form included in this packet and we can fax it to any providers the patient has seen who may have important information for our clinic to review. Medical Records may include: MRI, EEG or any other brain scan reports, Lab work or blood work results if the patient is taking a medication where blood levels are monitored and Provider Reports from therapists, psychologists, psychiatrists, neurologists, medical doctors, primary care providers, pediatricians, etc.

No Stimulant Medication Should Be Taken on the Day of the Visit
If the patient is currently taking a stimulant medication, it should not be taken on the day of the appointment. Some common stimulant medications are Adderall, Adderall XR, Concerta, Dextedrine, Metadate CD, Metadate ER, Methylin ER, Ritalin, Ritalin LA, Ritalin SR, and Vyvanse.

What to Bring to the New Patient Visit
- If the patient has dementia or is not comfortable with computers, please bring someone to assist during testing
- All forms in the New Patient Packet
- Your primary and secondary insurance coverage cards
- A photo identification card (driver’s license, etc.)
- List of current medications
- Your co-pay, co-insurance, or self-pay payment
PATIENT REGISTRATION

Today’s Date: ___________________________ Date of Birth: ___________________________

Name (first, middle, last): ____________________________________________________________

Preferred Name or Nickname: ___________________________ Gender: M F

Address (street//apt): ________________________________________________________________

Address (city/state/zip): _____________________________________________________________

Phone: Mobile: ______ Work: __________________ Home: _____________________________

Email: ____________________________________________________________

Occupation: ___________________________ Employer: _____________________________

Circle One: Married Single Divorced Widowed

Emergency Contact Name: ___________________________ Relationship to You: __________________________

Emergency Contact Phone Number: __________________________________________________

Who referred you to our clinic? ______________________________________________________

What family members may discuss your care and/or billing information with us?

<table>
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<tr>
<th>NAME</th>
<th>PHONE NUMBER</th>
<th>RELATIONSHIP TO PATIENT</th>
<th>DISCUSS CARE?</th>
<th>DISCUSS BILLING?</th>
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Primary Insurance: ___________________________ Secondary Insurance: ___________________________

Effective Date: ___________________________ Effective Date: ___________________________

Policy #: ___________________________ Policy #: ___________________________

Group #: ___________________________ Group #: ___________________________

Policy Holder Name: ___________________________ Policy Holder Name: ___________________________

Policy Holder DOB: ___________________________ Policy Holder DOB: ___________________________

Claims Address: PO BOX ___________________________ Claims Address: PO Box ___________________________

Patient/Parent/Legal Guardian Signature: ___________________________ Date: ___________________________
Consents and Acknowledgements

Patient Name: ___________________________________________ Medicaid ID: _______________________

CONSENT TO TREAT. I hereby agree to receive treatment from NC Neuropsychiatry, PA, and understand that I may withdraw this consent in writing at any time. I understand that I have the right to consent to treatment, refuse to consent to treatment, and to withdraw from treatment. Voluntary refusal of consent shall not be used as the sole grounds for termination or threat of termination of treatment unless the treatment provided is the only viable treatment option available at NCNP. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment or I am legally authorized to initiate and consent to treatment on behalf of this individual. I will provide a copy of my custody and/or guardianship papers as requested.

EMERGENCY MEDICAL TREATMENT. I give permission for NC Neuropsychiatry to seek emergency medical treatment on my behalf in case of an emergency if patient or legal guardian are unable to give consent.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES. I hereby acknowledge that I have been offered a copy of and have had an opportunity to ask questions concerning the Notice of Privacy Practice of NC Neuropsychiatry.

AUTHORIZATION TO RELEASE INFORMATION. I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, including providers to whom I am referred, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to NC Neuropsychiatry any and all of my medical record information, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

NONDISCRIMINATION POLICY: All patients have the right to receive care and treatment at NCNP and will not be discriminated against on the of basis of age, color, disability, gender, gender expression, gender identity, genetic information, national origin, race, religion, sex, sexual orientation, veteran status or degree of MH/IDD/SA disability. You have the right to contact the Disability Rights North Carolina, the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities. Their contact information is:

Disability Rights North Carolina
3724 National Drive, Suite 100
Raleigh, NC 27612
Toll-Free: 877-235-4210
Phone: 919-856-2195
TTY: 888-268-5535

Patient/Parent/Legal Guardian Signature: ____________________________ Date: _______________
Financial Policy

Patient Name: ________________________________ Medicaid ID: ____________________________

COLLECTION OF CO-PAYMENTS, DEDUCTIBLES, and FEES. All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. We accept cash, checks and credit cards (VISA/MasterCard/Discover/American Express).

INSURANCE FILING. You must present a current insurance card at the time of your visit. If you do not have a current card, you will be responsible for payment at the time of your visit. NCNP will reimburse you if your insurance pays the claim at a later date. If your insurance carrier is not one we are in network with, you are responsible for payment in full.

ASSIGNMENT OF BENEFITS. I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to NC Neuropsychiatry for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

PROMPT PAYMENT EXPECTATION. We expect that you will make every effort to pay your bill promptly. If you have a financial hardship, please discuss payment options with the staff.

ADDITIONAL CHARGES:

- **NO-SHOW APPOINTMENTS.** You may be charged a no-show fee. If you no-show three (3) times, you may be discharged from the practice.
- **CALLING THE AFTER-HOURS EMERGENCY LINE FOR NON-EMERGENCIES.** $25
- **ELECTROCARDIOGRAM (EKG).** $40 if not covered by insurance
- **PHONE CONSULTATIONS.** $25 - $80 depending on time
- **MEDICAL RECORDS FEES.** Per NC State regulations.
- **RETURNED CHECKS.** $40

Patient/Parent/Legal Guardian Signature: ____________________________ Date: ________________
PATIENT RIGHTS AND RESPONSIBILITIES

- Individuals have the right to be treated with dignity and respect.
- Individuals have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability, race, religion, gender, ethnicity or source of payment.
- Individuals have the right to a confidential relationship with their provider and to have their treatment and other personal information kept private, except when laws or ethics dictate otherwise such as if the patient is in danger of harming him/herself or others, or if the patient is suspected of being abused. Any disclosure to another party will be made with the informed consent of the individual. Only by law, may records be released without the patient’s permission.
- Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.
- Individuals have the right to have easily access care in a timely fashion.
- Individuals have the right to receive full information from the potential treating professional about that professional’s knowledge, skills, preparation, experience, and credentials.
- Individuals have the right to have a clear explanation of their condition.
- Individuals have the right to be informed about the options available for treatment interventions (including risks and benefits) and the effectiveness of the recommended treatment. This is regardless of cost or coverage by the patient’s benefit plan.
- Individuals have the right to consent to treatment.
- Individuals have the right to refuse to consent to treatment.
- Individuals have the right to share in developing their treatment plan. A copy of the treatment plan may be obtained by asking your health care provider.
- Individuals have the right to information about their treatment in a language they can understand.
- Individuals have the right to know about advocacy and community groups and prevention services.
- Individuals have the right to information about their insurance/third party payer, its practitioners, services and role in the treatment process.
- Individuals have the right to provide input on their insurance/third party payer policies and services.
- Individuals have the right to freely file a complaint, grievance, or appeal and to learn how to do so.
- Individuals have the right to know about the laws that relate to their rights and responsibilities.
- Individuals have the right to know of their rights and responsibilities in the treatment process.
- Individuals have the responsibility to treat those giving them care with dignity and respect.
- Individuals have the responsibility to give providers accurate information that they need. This is so providers can deliver the best possible care.
- Individuals have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in their care.
- Individuals have the responsibility to follow treatment plans for their care. The treatment plan is to be agreed upon by the patient and provider.
- Individuals have the responsibility to follow their agreed upon medication plan.
- Individuals have the responsibility to tell their provider about medication changes, including medication given to them by others.
- Individuals have the responsibility to keep their appointments. Individuals should call their providers as soon as possible if they need to cancel visits.
- Individuals have the responsibility to let their providers know when their treatment plan and/or medication regimen no longer works for them.
- Individuals have the responsibility to let their providers know about problems with paying fees.
- Individuals have the responsibility to not take actions that could harm themselves or others.
- Individuals have the responsibility to report abuse.
- Individuals have the responsibility to report fraud.
- Individuals have the responsibility to openly report concerns about the quality of their care.

I understand my rights and responsibilities as outlined in this document:

Patient/Parent/Legal Guardian Printed Name: ____________________________________________________________

Patient/Parent/Legal Guardian Signature: ________________________________________________________________

Medicaid ID (if applicable): ___________________________________________________________ Date: ______________

1829 East Franklin Street
400 Franklin Square
Chapel Hill, NC 27514
T: 919-933-2000
F: 984-234-3656

13251 Falls of Neuse Road
Suite 121
Raleigh, NC 27614
T: 919-785-5055
F: 919-573-6689
Authorization for Request of Information  
(ALL INFORMATION MUST BE COMPLETE TO PROVIDE RECORDS)

Patient Name: ___________________________________________  Date of Birth: ________________________

Address: ______________________________________________________________________________________

Phone #: ___________________________  Email: ________________________________________________________

Information To Be Released To:
☐ NC Neuropsychiatry, PA – Chapel Hill, 1829 E. Franklin Street, Building 400, Chapel Hill, NC 27514,  
  FAX: (984) 234-3656
☐ NC Neuropsychiatry, PA – Raleigh, 13251 Falls of Neuse Road, Suite 121, Raleigh, NC 27614,  
  FAX (919) 573-6689

Who is this information to be released from?

Person: ______________________________________________________________________________________

Clinic: ______________________________________________________________________________________

Address: ______________________________________________________________________________________

Fax Number: ____________________________________________________________________________________

Information to be disclosed:
☐ All Information including clinical findings, diagnosis, treatment, assessment, laboratory results, progress notes,  
  psychotherapy notes, recommendations for further care, names of healthcare personnel, dates of hospitalizations,  
  charges and visits for the dates: ________________________ to ________________________.

☐ Specific information (identify): ______________________________________________________________________________________
  for the dates: ________________________ to ________________________.

This information will be used for:
☐ Continuing Treatment  ☐ Legal Involvement  ☐ Worker’s Compensation
☐ Disability Determination  ☐ Personal  ☐ Moving out of the area
☐ Insurance  ☐ Other (please describe): ______________________________________________________________________________________

I understand that if my records contain information relating to the following, this disclosure will include this  
information, UNLESS I initial that I do not want the following information released:

HIV infection, AIDS or AIDS-related condition
psychiatric or psychological conditions
alcohol abuse or drug abuse
 genetic testing

I have reviewed this authorization and understand what information will be used or disclosed. I may revoke this  
authorization at any time in writing. If I do revoke it, it will not affect any actions already taken by NC Neuropsychiatry  
based upon this authorization; uses and disclosures already made cannot be revoked. Unless revoked sooner by the  
client or the client’s legally responsible person, a consent for release of information shall be valid for a period not to  
exceed one year.

Patient/Parent/Legal Guardian Signature: ___________________________  Date: ________________________

NCNP Use

Date Requested: ___________________________  Scanned Into EMR: ___________________________

Date Records Received: ___________________________  Completed By: ___________________________
Authorization for Release of Information
(ALL INFORMATION MUST BE COMPLETE TO PROVIDE RECORDS)

Patient Name: _______________________________ Date of Birth: _______________________________

Address: __________________________________________________________

Phone #: ___________________________ Email: ________________________________

Information To Be Released From:
☐ NC Neuropsychiatry, PA – Chapel Hill, 1829 E. Franklin Street, Building 400, Chapel Hill, NC 27514
☐ NC Neuropsychiatry, PA – Raleigh, 13251 Falls of Neuse Road, Suite 121, Raleigh, NC 27614
☐ NC Neuropsychiatry, PA – Charlotte, 6911-400 Shannon Willow Road, Charlotte, NC 28226

Who is this information to be released to?

Person: ____________________________________________________________

Clinic: _____________________________________________________________

Address: __________________________________________________________

Fax Number: _______________________________________________________

Information to be disclosed:
☐ All Information including clinical findings, diagnosis, treatment, assessment, laboratory results, progress notes, psychotherapy notes, recommendations for further care, names of healthcare personnel, dates of hospitalizations, charges and visits for the dates: ________________ to ________________.

☐ Specific information (identify): ________________________________

for the dates: ________________ to ________________.

This information will be used for:
☐ Continuing Treatment ☐ Legal Involvement ☐ Worker’s Compensation
☐ Disability Determination ☐ Personal ☐ Moving out of the area
☐ Insurance ☐ Other (please describe): ________________________________

I understand that if my records contain information relating to the following, this disclosure will include this information, UNLESS I initial that I do not want the following information released:

☐ HIV infection, AIDS or AIDS-related condition ☐ psychiatric or psychological conditions
☐ alcohol abuse or drug abuse ☐ genetic testing

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Patient/Parent/Legal Guardian Signature: ___________________________ Date: ______________

NCNP Use
Date Received: ___________________________ Method of Record Delivery: ___________________________
Date Records Delivered: ___________________________ Completed By: ___________________________