



Cape Fear
Behavioral Health Center, LLC
"Solutions for a Healthy Life"

New Patient Registration Packet

Section 1: Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Last First Middle Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work (____) _____ Cell: (____) _____
The best number to contact me/parents: _____ Home _____ Work _____ Cell _____
Check the appropriate box: _____ Minor _____ Single _____ Married _____ Widowed
_____ Separated _____ Divorced
If a student, name of school: _____

Section 2: (Responsible Party- Spouse or Parent/Guardian information ONLY if patient is a minor)

Relationship to patient: _____ Self _____ Spouse _____ Parent _____ Other _____
Name (Printed) _____ SSN# _____
Address (If different from above): _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer: _____ Work Phone: (____) _____

Section 3: Emergency Contact Information

(1)Emergency Contact: _____ Relationship _____
Home Phone: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

(2)Emergency Contact: _____ Relationship _____
Home Phone: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Section 4: Primary Insurance Information

Insurance Company Name: _____
Policy ID #: _____
Group ID #: _____
Policyholder's Name: _____
Policyholder's SS#: _____
Relationship to Insured: ____ Self ____ Dependent ____ Spouse ____ Other
Date of Birth: _____

Secondary Insurance Information

Insurance Company Name: _____
Policy ID #: _____
Group ID #: _____
Policyholder's Name: _____
Policyholder's SS#: _____
Relationship to Insured: ____ Self ____ Dependent ____ Spouse ____ Other

Referred By: _____

Primary Care Physician: _____

Phone Number: _____

MEDICAL HISTORY

Please circle all of the following that apply to you and your medical history:

Arthritis	Headaches	Kidney Disease	Asthma
Glaucoma	Low Blood Pressure	Cancer	Hearing Impairment
Pain or Pressure in Chest	COPD	Diabetes	Herpes
Shortness of Breath	Dizziness	High Blood Pressure	Epilepsy
High Cholesterol	Tuberculosis	Hypoglycemia	Fainting
Thyroid Problem	Stomach Problems	Liver Problems	Intestinal Problems

Other:

Client Name: _____

DOB: _____

Medicaid ID #: _____

PIMSY Client Chart #: _____

Do you have any history of head injury with or without loss of consciousness? ☐ Yes ☐ No
If yes, please explain.

Please list any hospitalizations you have had due to **psychiatric illness in the past six months**; including the reason, date, and hospital location.

LIFESTYLE

Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind, and how often?

Do you smoke or chew tobacco? ☐ Yes ☐ No
If yes, what kind, daily use and how long ago did you start?

MEDICATIONS

Please list your daily medications, both prescription and over the counter as well as the dosages that you take for your **medical problem**.

Please list your daily prescription medications, doses, duration, and side effects of medication that you take for your **emotional and psychiatric problems**.

The above information is true to the best of my knowledge. I authorize my benefits to be paid directly to CFBHC. I understand that I am financially responsible for any balance. I also authorize CFBHC and/or my insurance company to release information required to process my claims.

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

We currently have openings for **individuals, couples, adolescent and child counseling**. Please add family members who you would like to make an appointment for: (If there is no one, please leave this sheet blank)

Name	Age	Insurance Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ Client/Legal Guardian Signature	_____ Date
_____ Provider Signature	_____ Date

Thank you for allowing CFBHC to serve you!

Client Name: _____	Medicaid ID #: _____
DOB: _____	PIMSY Client Chart #: _____

OFFICE POLICIES

Appointments must be cancelled at least 24 hours in advance.

- Your insurance company will not pay for missed appointments. In order for us to continue to provide services to those who need them, ALL appointment times must be filled with only those who desire to be at their appointment at the designated time.
- “No Shows” and last minute cancellations mean we are unable to fill that time slot with another patient who may be waiting on an opening.
- If you do not show up for an appointment or call to cancel at the last minute, there is a **\$50 fee**. (Real emergencies are an exception). If this happens more than once, your clinician may decide to take you off the “standing” (same appointment time/day every week) schedule in order that another patient may have that time slot.
- Please do not schedule an appointment if you aren’t sure you can make the appointment. Please call the office in order to reschedule your appointment when you know for sure.
- If you know ahead of time (days, weeks, etc.) that you will be out of town or unable to keep your standing appointment; please inform your clinician immediately. This will allow for other patients to be scheduled in that slot.

If you have an emergency:

- If you need to converse with your clinician, you may call during normal business hours Monday-Friday 8am-5pm to inquire about scheduling an appointment within the next 24 hours.
- If you cannot wait and it is the kind of emergency where there may be harm caused to yourself, your child, or another individual go to the Cape Fear Valley Hospital Emergency Room for an evaluation. If you are military, go to the Womack Army Hospital for an evaluation.
- If you experience an emergency after normal business hours; you may contact the Center’s 24/7 Crisis phone number (910-322-8382) and the clinician on-call will assist you with your emergency situation.

Your treatment is confidential and is shared with no one without your written consent. (For children, no information is shared with others without the parent/guardian written consent).

There are 4 exceptions to this rule:

- The underage patient is identified to be a danger to himself/herself or others. The parent’s will be informed. **(Some minors prefer to speak with their clinician alone at times; please be assured that you will be informed if your child is suicidal or wanting/planning to harm himself/herself and/or others).**
- The adult patient is identified to be a serious danger to others (homicidal).
- Information required to be released by a legal/appropriate subpoena or court order.
- Suspected abuse/neglect of a minor/elder/incompetent adult (DSS will be informed).

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

If your child is currently or soon to be involved in a custody or court case or if you suspect sexual or physical abuse; please notify our office of those issues first.

Authorizations:

- Please familiarize yourself with the coverage and authorization procedures of your insurance company's behavioral health services, including criteria for continued sessions.
- CFBHC, LLC will take care of all authorizations for you. Please be assured the Center will only provide the basic information necessary for this procedure. If you have questions or concerns about this process; please discuss this matter with our administrative staff.
- Medicaid authorizations require CFBHC, LLC to obtain a "service order" from your primary care doctor.
- Tricare patients who see an LPC (Licensed Professional Counselor) at CFBHC, LLC need an initial doctor referral. (Please discuss with the administrative staff if your questions).

Disability Rights North Carolina Contact Information

For assistance, contact Disability Rights NC:

Toll-Free: 877-235-4210

Phone: 919-856-2195

TTY: 888-268-5535

Fax: 919-856-2244

Email: www.disabilityrightsncc.org

Office and Mailing Address:

3724 National Drive, Suite 100
Raleigh, NC 27612

I have read and understand the policies above.

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Release of Personal Health Information (PHI) Form

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____ Fax Number _____
Information to Be Released What will be released?	<input type="checkbox"/> Whether the client is in treatment or not <input type="checkbox"/> Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) <input type="checkbox"/> Nature of the project (Services offered, purpose and philosophy of program) <input type="checkbox"/> Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) <input type="checkbox"/> Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs) <input type="checkbox"/> HIV/AIDS Information <input type="checkbox"/> Substance Abuse Information
Purpose of Release Why is information being released?	<input type="checkbox"/> Referral to other services <input type="checkbox"/> Coordination of care <input type="checkbox"/> Consultation with Doctor <input type="checkbox"/> Consultation with other mental health provider <input type="checkbox"/> Transfer of care <input type="checkbox"/> Other _____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time except to the extent that action has been taken in reliance of consent. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment (10A NCAC 26B.0202).

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential (GS130A-143). This information shall not be released or made public except under the following circumstances:

1. Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified;
2. Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardian;
3. Release is made for purposes of treatment, payment, research, or health care operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms "treatment," "payment," "research," and "health care operations" have the meaning given those terms in 45 Code of Federal Regulations § 164.501;
4. Release is necessary to protect the public health and is made as provided by the Commission in its rules regarding control measures for communicable diseases and conditions;
5. Release is made pursuant to other provisions of this Article;
6. Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties and those engaged in the trial of the case;
7. Release is made by the Department or a local health department to a court or a law enforcement official for the purpose of enforcing this Article or Article 22 of this Chapter, or investigating a terrorist incident using nuclear, biological, or chemical agents. A law enforcement official who receives the information shall not disclose it further, except (i) when necessary to enforce this Article or Article 22 of this Chapter, or when necessary to conduct an investigation of a terrorist incident using nuclear, biological, or chemical agents, or (ii) when the Department or a local health department seeks the assistance of the law enforcement official in preventing or controlling the spread of the disease or condition and expressly authorizes the disclosure as necessary for that purpose;
8. Release is made by the Department or a local health department to another federal, state or local public health agency for the purpose of preventing or controlling the spread of a communicable disease or communicable condition;

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

9. Release is made by the Department for bona fide research purposes. The Commission shall adopt rules providing for the use of the information for research purposes;
10. Release is made pursuant to G.S. 130A-144(b); or
11. Release is made pursuant to any other provisions of law that specifically authorize or require the release of information or records related to AIDS. (1983, c. 891, s. 2; 1987, c. 782, s. 13; 2002-179, s. 7; 2011-314, s. 4.)

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Confidentiality Agreement Form

Confidentiality may be broken and information shared without client permission **only** in specific situations. They are:

- When all adults sign a "Release of Information" that states the people/institutions can be given this information.
- When the clinician must, by law report abuse or neglect of children, elderly or disabled.
- When a patient is in danger to him/herself or others.
- When a clinician is sued by a client for malpractice. When a patient uses his or her mental health as a defense in court.
- When a court orders a clinician to share records of therapy or to testify. A subpoena for records or testimony does not release confidential information. The order to break confidentiality must be given by the judge.
- Request from funding source and audit.

Signing below means that I (we) were provided this information. I (we) have been told about these procedures. I (we) will be given a copy of this information.

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Client Rights

The following basic human rights are afforded to every client receiving services from Cape Fear Behavioral Health Center, LLC (CFBHC):

1. Right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation.
2. Right to live as normally as possible while receiving care and treatment.
3. Right to receive age-appropriate treatment, access to medical care and habilitation and the right to an individualized written program plan upon admission to maximize his/her development; regardless of age or degree of MH/IDD/SA disability.
4. Right to be informed in advance to the potential risks and alleged benefits of treatment and program options.
5. Right to confidentiality.
6. Right to be free from unnecessary or excessive medication. Medication shall not be used as punishment, discipline or staff convenience.
7. Right to consent to refuse treatment offered, including behavior management policies; except in certain emergency situations without threat or termination of services.
8. Right to be informed of emergency procedures.
9. Right to be free of corporal punishment and to be free from harm, abuse and exploitation.
10. Right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.
11. Right to obtain a copy of client's treatment plan from his/her provider. To obtain a copy of your treatment plan; notify your provider (10A NCAC 27D.0201).
12. Right to know the fee, assessment and collection practices for treatment.
13. Right to the rules that the client is expected to follow and possible penalties for violations of the rules.
14. Right to the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.
15. Right to grievance procedures including the individual to contact and a description of the assistance the client will be provided.

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Medicaid Recipients

Client Name: _____

Medicaid ID#: _____

DOB: _____

PIMSY Client Chart #: _____

- If following the evaluation, it is determined that further treatment is appropriate, I hereby consent treatment/habilitation as deemed necessary; which may include individual, couple and family counseling. I further understand that goals of treatment/habilitation will be discussed with me and I may refuse/withdraw from services at any time. In case of an accident or illness, I also give my consent for the Center staff to provide and/or obtain emergency medical/dental treatment.
- The fee schedule for Cape Fear Behavioral Health Center, LLC has been explained to me. I understand that my health insurance may cover a portion of treatment costs and I am responsible for charges not covered or reimbursed by my insurance company. In the event of non-payment, I agree to assume the cost of the interest, collection, and legal action (if required). I have been informed and understand that if I refuse to allow Cape Fear Behavioral Health Center, LLC to file my insurance that I will be required to pay the full charges for each session.
- I authorize my insurance carrier, BCBS and/or Medicaid to release information regarding my coverage to Cape Fear Behavioral Health Center, LLC.
- I authorize Cape Fear Behavioral Health Center, LLC to release information as requested by my insurance carrier, BCBS, Medicaid or other government sponsored programs to support the filing of the claim and medical necessity for the services provided.
- I acknowledge that my signature in this document authorizes Cape Fear Behavioral Health Center, LLC to submit claims for benefits of services rendered without obtaining my signature on each claim and that I will be bound by this signature as though I had personally signed the claim. My rights to all payments of all benefits filed are hereby assigned to Cape Fear Behavioral Health Center, LLC. This assignment covers any and all benefits under Medicaid, other government sponsored programs, private insurance and any other health plans. In the event that my insurance carrier does not accept assignment of benefits or if payments are made directly to me or my representative, I will insure such payment to Cape Fear Behavioral Health Center, LLC.
- I understand that payment is expected at the time of each visit. I agree to notify Cape Fear Behavioral Health Center, LLC at least **24** hours in advance if I am unable to keep an appointment in accordance with Cape Fear Behavioral Health Center's, LLC attendance policy. Normal business hours of operation are 8am-5pm, Monday-Friday.
- I hereby authorize Cape Fear Behavioral Health Center, LLC to release diagnostic and treatment records when required to my insurance carrier, Medicaid, BCBS, or any other third party payor.

This authorization shall be valid until all claims have been processed not to exceed 1 year from date of discharge.

- I have read and had explained to me by a member of Cape Fear Behavioral Health Center, LLC staff the above statements and fully understand my treatment and financial obligations.
- I have been informed and received a copy of the Notice of Privacy Practices for Cape Fear Behavioral Health Center, LLC. I understand that the Notice of Privacy Practices discusses how my personal information may be used, and/or disclosed, my right with respect to health information, and how and where I may file a privacy-related complaint. I understand I have a right to restrict disclosures of my health information and the right to request alternative ways of communication.

Preferred method for communication: ☐ Mail to home address ☐ Home Telephone
☐ Answering Machine ☐ Cellular Phone

Home Address: _____ Phone: _____

Other- Address: _____ Phone: _____

I understand that the terms of this notice may be changed in the future and these changes will be posted in the waiting area of the office. I may also request a copy of the new notice by contacting Cape Fear Behavioral Center, LLC at: (910) 339-0400.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANYTIME EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Medicaid Client's Unmanaged Visits

Patient Name: _____

Date: _____

Medicaid patients are allowed only a certain number of unmanaged visits per calendar year. (January through December) for outpatient mental health services.

Adults: 24 visits

Children: 24 visits

The patient is responsible for notifying his/her mental health provider on the number of visits he/she has used at other offices. If the patient does not notify his/her provider and the Center receives a denial for a patient's claim due to unit limits being exceeded; the patient will be financially responsible for all services rendered.

Have you received mental health services at any other office/facility this year?

Yes _____ No _____

If yes, how many visits have you used? # _____

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of an emergency. This is extremely important, in that, medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

Minor's Full Name: _____

Minor's Address: _____

City, State, Zip Code: _____

Minor's Age: _____

The undersigned do hereby authorize _____ or such substitute as he/she may designate as agent for the Undersigned to consent to any medical treatment, hospital care and/or office visits, inpatient and/or outpatient for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or clinician, licensed under the North Carolina Mental Health and Substance Abuse Licensure Boards, of whether such diagnosis or treatment is rendered at the office of said physician or clinician, at a hospital, or elsewhere.

Address of Parent or Legal Guardian

Home and Work Phones of Parent or Legal Guardian

Family Physician/Pediatrician (Name and Phone Numbers)

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information.

Your health record contains information about you and your health. This information about you that may identify you and that relates to your past, present and future physical or mental condition and related health services is referred to as Protected Health Information (PHI). This notice of privacy practices describes how the Center may use and disclose your PHI in accordance with applicable laws and the professional Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

The Center is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. The Center is required to abide by the terms of this Notice of Privacy Practices. The Center reserves the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. The Center will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing you a copy.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or peer review members. The Center may also disclose PHI to any other consultant **ONLY** with your authorization.

For Payment: The Center may use and disclose PHI so that it may receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, the Center will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: The Center may use and disclose, as needed, your PHI in order to support our business activities including, but not limited to: quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, the Center may share your PHI with third parties that perform various business activities (ex: billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed **ONLY** with your authorization. Your PHI will also be used to remind you of your appointments.

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

Uses and Disclosures Requiring Authorization: You may give written permission which allows the Center to use or disclose PHI for purposes other than treatment, payment or healthcare operations. The Center will always obtain your written permission before your psychotherapy notes (notes about our conversation during private, couple or family counseling). These notes are given a greater degree of protection than PHI.

Revocation of Authorization: You may revoke this authorization at any time, in writing, except to the extent that your clinician or the office has taken an action on the use or disclosure indicated in the authorization. If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy, you may not revoke this authorization.

Uses and Disclosures without Consent or Authorization: The Center may use and disclose PHI without your consent or authorization in the following circumstances: instances of child abuse, instances of adult and domestic abuse of a disabled adult, health oversight, judicial or administrative proceeding only as required by law, serious threat to health or safety, medical emergency, worker's compensation claims, or as required by law.

Your rights regarding your PHI:

You have the following rights regarding PHI the Center maintains about you. To exercise any of these rights, please submit your cause in writing to your clinician.

***Right of access to inspect and copy:** You have the right, which may be restricted only in exceptional circumstances to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in situations where there is compelling evidence that access would cause serious harm to you.

***Right to request amendment:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

***Right to an accounting of Disclosures:** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any twelve month period.

***Right to request restrictions:** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. The Center is not required to agree with your request.

***Right to request Confidential Communication:** You have the right to request the Center communicate with you about medical matters in a certain way or at a certain location.

***Right to a copy of this notice:** You have a right to a copy of this notice.

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

COMPLAINTS: If you feel the Center has violated your privacy rights and wish to file a complaint with this office, you may send a written complaint to this office or you may contact your clinician. You may also send a written complaint to the Secretary of the UD Department of Health and Human Services. You have specific rights under the Privacy Rules. No retaliation will be taken against you for exercising your rights.

Client/Legal Guardian Signature (Received copy of HIPAA
Notice of Privacy Practices)

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS

Receipt of Privacy Practices

_____ I have read and understand the HIPAA Notice of Privacy Practices for Cape Fear Behavioral Health Center, LLC. **By initialing I acknowledge receipt of Cape Fear Behavioral Health Center's, LLC Privacy Practices.**

No Show/Cancellation Policy

_____ It is the responsibility of the patient to attend all scheduled appointments. Should the client be unable to make an appointment, a 24 hour notice is required. **If a patient fails to call and cancel or attend an appointment, a service fee of \$50.00 may be charged at the provider's discretion. This will be billed directly to the patient; medical insurance does not pay for no shows.** Cape Fear Behavioral Health Center, LLC does understand that there are extenuating circumstances and those will be taken into consideration should a patient perpetually no show their appointments; Cape Fear Behavioral Health Center, LLC reserves the right to terminate services. **By initialing I acknowledge that I have read and understand the above no show/cancellation policies.**

Late Arrival Policy

_____ It is the responsibility of the patient to call and reschedule an appointment if they are going to be 10 minutes or later to their scheduled appointment. If the patient arrives more than 10 minutes late for their appointment; our office reserves the right to reschedule the appointment at that time. **By initialing I acknowledge that I have read and understand the above late arrival policy.**

Closed Circuit Video Taping

_____ I have been informed and understand that Cape Fear Behavioral Health Center, LLC has an audio and video closed circuit videotaping for security purposes. These video cameras are in clear view in the lobby, main hallway and receptionist area only. I understand that the cameras are being utilized to provide added safety and security and I am giving permission for Cape Fear Behavioral Health Center, LLC to continue using them for this purpose with my consent. **By initialing I acknowledge that I have read and understand the above closed circuit videotaping policy.**

Payment Policy

_____ We bill your health insurance as a courtesy to you. To do so, we will require that you present an updated insurance card at every visit. **If you have no health insurance or you present no insurance card at the time of your visit, a minimum deposit of \$100 or the actual charge amount will be due at the time services are rendered.** If your insurance company requires a co-pay, deductible, or co-insurance, this too is due upon check-in of your scheduled appointment. **Please note, ALL Medicaid clients age 18 and older may be required to pay a \$3.00-\$5.00 co-pay.** If you are unable to make payment at

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____

the time of service, you may be asked to reschedule your visit. You are responsible for the timely payment of your account. Should it be necessary for us to use an outside collection agency, you will be additionally responsible for any charges our office incurs as a result. **By initialing I acknowledge I have read and understand the above payment policy.**

Weapons on Premises

_____ I have read and understand that no firearms or weapons are allowed whether concealed or not even if permitted. Individuals' will be asked to leave the building premises and parking lot when carrying a firearm and/or weapon.

Consent to Treatment

_____ I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request the payment of authorized funds be made to Cape Fear Behavioral Health Center, LLC. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges not paid by insurance. Some insurance companies pay a fixed amount. **It is my responsibility to pay any co-pay, deductible, or balance not paid by my insurance.** Cape Fear Behavioral Health Center, LLC requests that my portion of the fee be paid at the beginning of each visit. **This is a legal document and with it, I authorize treatment of myself by a contractor of Cape Fear Behavioral Health Center, LLC.**

Client/Legal Guardian Signature

Date

Provider Signature

Date

Client Name: _____
DOB: _____

Medicaid ID #: _____
PIMSY Client Chart #: _____