# *Adolescent, Child, and Adult Psychiatry of Raleigh P.A.*

**Raleigh Location: 4041 Ed Drive Suite 101 Raleigh NC 27612**
**Clayton Location: 501 Gateway Drive Suite 101 Clayton NC 27520**
**Phone: (919) 919-783-8377 Fax (919) 324-3404**

Date_____ SSN _____

Patient's Name _____

Patient's Age _____Date of Birth _____ Sex _____ Marital Status _____

Address_____

City _____ State_____ Zip Code _____

Home # _____Work #_____ Cell #_____

Email address _____

Preferred contact method _____

Employer _____ Occupation _____ Education _____

Spouse/Parent/Legal guardian's name_____

Best contact number _____Employer _____

Patient's relationship to you_____

Nearest relative not living with you _____ Phone # _____

In case of an emergency contact _____

Relationship _____ Phone # _____

Person responsible for the bill _____ Relationship_____

Primary Physician _____ Phone #_____

Referred by _____

Current Medications_____

Past illnesses/allergies _____

Pharmacy Name _____ Phone # _____

Insurance Company _____

Policy Number _____

Policy Holder's name _____ SSN _____

Date of Birth _____ Address _____

Patient relationship to insured _____

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## STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES AND AUTHORIZATIONS FOR CARE AND TREATMENT

This is to help you understand your rights and responsibilities and the level of cooperation that we need from you in order to help you realize the highest level of mental and emotional health of which you are uniquely capable. Our desire is to form a partnership with you regarding your mental health and related issues. Your assistance is crucial, and the interest and commitment that you bring to this partnership are essential to attaining significant resolution to your mental health concerns.

**SECTION 1: Your Rights**

**You are assured of the following rights:**

- The right to be treated with dignity and respect by our staff and treating professionals.
- The right to treatment including access to medical care and habilitation, regardless of your race, religion, gender, ethnicity, age, sexual orientation or degree of mental health, developmental disabilities or substance abuse.
- The right to have your treatment and other patient information kept private.
- The right to know about all your treatment choices, regardless of whether or not those choices are covered by your insurance, and regardless of the cost of those treatment choices, and to participate in the choice of treatment.
- The right to consent to or refuse treatment, refusal cannot be sole grounds for termination and consent can be withdrawn at any time.
- The right to obtain a copy of your treatment plan by completing a release form.
- The right to contact Disability Rights North Carolina at 919-856-2195.

**SECTION 2: Your Responsibilities**

**In order to provide you with the best of care, your commitment to your treatment and recovery is essential. We require that patients understand their role and responsibilities in their care:**

- You have the responsibility to give us, your provider(s) at Adolescent Child & Adult Psychiatry P.A., the information needed so that we can deliver the best possible care.
- You have the responsibility to let your treating professional(s) know if or when the treatment plan no longer works for you.
- You have the responsibility to follow your medication plan. You must tell your treating professional(s) about any medication changes, including medications prescribed for you by other health care providers.
- You have the responsibility to give our staff and treating professional(s) the same dignity and respect that you deserve.
- You have the responsibility to refrain from any action that could harm the lives of our employees, treating professionals, and/or other patients.
- You have the responsibility to keep your scheduled appointments. Missing your appointment(s) without proper prior notification could result in charges to your account, and repeated incidences of missed appointments with or without prior notification may result in your being unable to obtain medication refills on time and/or termination of our role as your treating professional.
- You have the responsibility to ask your treating professional(s) any questions you may have about your care, so that you can better understand your care and the role you play in that care.
- You have the responsibility to let our staff and your treating professional(s) know about any problems you may have paying your fees for services you are receiving, or plan to receive.
- You have the responsibility to follow your treatment plan and instructions for your care, once that care has been agreed upon by you and your treating professional(s). Failure to comply with your treatment plan may result in your being unable to obtain medication refills on time and/or termination of our role as your treating professional(s).

**SECTION 3: By signing at the bottom of this form you acknowledge that you fully understand your rights and responsibilities, and your consent for care and treatment:**

I have read and fully understand my rights and responsibilities in my partnership with Adolescent Child & Adult Psychiatry P.A. in providing for my care, and agree to adhere to them, and acknowledge that I have received a copy of this statement. Further, I hereby consent to outpatient treatment and give permission for the physician and/or clinician to provide the services deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment received in this facility. I understand that the patient has the right to withhold consent to any medical service that is deemed necessary or advisable by the physician and/or clinician. My signature below

indicates my understanding and approval of the above.

**SECTION 4: Consent to Disclose Information**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. Confidential information relative to a patient with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to alcohol or drug abuse, HIV infection, AIDS or AIDS related conditions. A general authorization for the release of medical or other information is not sufficient for this purpose.

**SECTION 5: Emergencies and Hospitalization**

Adolescent Child & Adult Psychiatry P.A. provide after-hours and weekend call coverage for emergencies by phone. The on-call physician may be reached by calling the main number 919-867-6779 after hours and weekends for true emergencies. Adolescent Child & Adult Psychiatry P.A. does not provide psychiatric inpatient treatment. Patients needing hospitalization will be referred to a local hospital emergency room for evaluation for psychiatric admission. Most patients requiring psychiatric hospitalization are referred to the Holly Hill Hospital.

**SECTION 6: Coordination of Care**

I understand that in the case that I see more than one provider in this office as part of my care, I will give permission to those providers to discuss my case for purposes of referral, coordination of services, and crisis/on-call services for as long as I am a patient of Adolescent Child & Adult Psychiatry P.A.

**SECTION 7: Confidentiality/ Release of Information**

Your privacy is very important and we will do everything we can to safeguard it. We will need a signed release to divulge information about your treatment to any other agency, employer, school, or family member.

We are required by law to release information in the following cases:

- If you present a danger of physical harm to yourself or others
- If a court offers the release of information in cooperation with legal commitment proceeding
- If requested by the protective services division of the Department of Social Services (DSS)
- If there is a suspicion of abuse, neglect, or exploitation of a child or disabled adult.

**SECTION 8: Insurance and Financial Policies**

Health insurance is a contract between you and your health insurance company. Each policy has different rules regarding which services are allowed, deductible amounts, how you are charged, where lab work is sent, etc. **You are responsible for knowing the terms of your health contract benefits**. We need all the information on the intake sheets that are attached as well as a copy of your insurance card(s). Be sure to give us your primary AND secondary cards, if applicable.

**Some policies require that you be referred to us by your Primary Care Physician. In those cases, you must be certain that he/she knows to send us such referral**. We must have such referral in hand before you can be seen by a Provider.

You may be limited by your policy in the number of mental health visits per year allowed or you have a dollar limit ("cap").

**At the time of service, deductible, co-payments and/or your percentage of fees are payable.** Any balance due after your insurance company pays or denies your claim is payable BY YOU when billed.

**If you insurance has changed please contact us and let us know at least 48 hours before your appointment so we can verify your benefits.**

**No Show/ Late Cancellations:**

Once an appointment time is scheduled, you will be expected to pay for it unless you provide 48 hour notice of cancellation. This charge is automatic unless we both agree that you were unable to attend due to circumstances beyond your control. All No Show/ Late Cancellations will be charged $100.00. You will be invoiced for these charges and payment is appreciated within 30 days. Two or

more missed appointments (with late or no cancellation) may result in termination of your care from the practice. Medicare and Medicaid are exempt from charges but not termination

**Additional Charges/ Fees:**

Occasionally your account may be assessed additional charges for other services provided by Adolescent Child & Adult Psychiatry P.A., to include, but not limited to, prescription refill requests, medical record requests, and completion of forms. These charges will be billed to you and payment is appreciated within 30 days.

No show and no call missed appointment - $100 charge. First emergency cancellation – no charge

Prescription refills between appointment - $25 charge, if due to a missed appointment or lost prescription

If you have any questions in reference to the Financial Policy of Adolescent Child & Adult Psychiatry P.A., please feel free to speak with our front office staff. They will be happy to assist you.

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In signing this document, you are acknowledging the terms under which we provide services. If you are 18 years old or older, you are personally consenting to treatment.

If the patient is other than yourself and you are the legal guardian or parent, you are consenting to treatment for the patient. If the patient is under the age of 18 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.

Your signature below indicates that you fully understand the form in its entirety and received a copy of Adolescent Child & Adult Psychiatry P.A.'s Notice of Privacy Policies.

Should you have any questions about these policies or procedures, please feel free to talk to your provider. We are interested in any suggestions you may have on how we may improve our services to you and your family.

Patient Name (Please Print): _____ Date: _____

Signature of Patient or Parent or Legal Guardian: _____

If the patient is unable to consent or is a minor, please complete the following:

Patient is _____ Unable to consent because _____

_____ Minor

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## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Adolescent Child & Adult Psychiatry P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Adolescent Child & Adult Psychiatry P.A. I understand that diagnosis or treatment of me by Adolescent Child & Adult Psychiatry P.A.'s Physicians and/or Clinicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Adolescent Child & Adult Psychiatry P.A. is not required to agree to the restrictions that I may request. However, if Adolescent Child & Adult Psychiatry P.A. agrees to a restriction that I request, the restriction is binding on Adolescent Child & Adult Psychiatry P.A. and Adolescent Child & Adult Psychiatry P.A.'s Physicians and/or Clinicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Adolescent Child & Adult Psychiatry P.A.'s Physicians and/or Clinicians or Adolescent Child & Adult Psychiatry P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Adolescent Child & Adult Psychiatry P.A. Notice of Privacy Practices prior to signing this document. The Adolescent Child & Adult Psychiatry P.A. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Adolescent Child & Adult Psychiatry P.A.. The Notice of Privacy Practices for Adolescent Child & Adult Psychiatry P.A. is also provided at 4041 Ed Drive Suite 108 Raleigh NC 27612. This Notice of Privacy Practices also describes my rights and the Adolescent Child & Adult Psychiatry P.A. duties with respect to my protected health information.

Adolescent Child & Adult Psychiatry P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient _____

Signature of Patient or Parent or Legal Guardian: _____

Date _____

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## Informed Consent to Treatment

- I will be given a clear description from my mental health provider regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed.

- I will be given a clear recommendation for the types of treatment recommended, such as individual counseling/therapy and/or psychiatric services. Times, dates, and session length will be discussed with my mental health provider.

- I voluntarily agree to undergo mental health treatment and understand that I may end or refuse treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment.

- I understand that my mental health provider may make diagnostic and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).

- I understand that my mental health provider cannot guarantee results (e.g. less depressed, improved marital satisfaction, etc.) of mental health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing mental health treatment. This will be discussed with my mental health provider.

- I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my concerns.

- I understand that confidentiality of records of information collected about me with be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as is outlined in the Privacy Notice provided to me.

- I understand that my provider may disclose and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance or utilization of this facility and to the extent necessary to facilitate the provision of administrative and professional services.

- I understand that state and local laws require my provider report all cases in which there exists a danger to self or others.

I agree and consent to participate in psychiatric services offered by a provider at Adolescent Child & Adult Psychiatry P.A.

Name of Patient _____

Signature of Patient or Parent or Legal Guardian: _____

Date _____

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**Phone: (919) 324-3385 Fax (919) 324-3404**

# CANCELLATION & MISSED APPOINTMENT POLICY

A therapeutic relationship is built on trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call when you are unable to keep your appointment. Please read, sign, and date the cancellation and missed appointment policy below.

1. **If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 48 hours in advance.**

2. If you fail to notify the office of your cancellation within the time stated above, and miss your scheduled appointment, a $100 fee for the session you have missed will be charged and must be paid before you can schedule another appointment.

3. At the time of cancellation, another appointment will be offered to you that may work better for your schedule.

4. Two (2) missed appointments – they need not be consecutive – can result in an administrative discharge from the practice.

5. To cancel or reschedule appointments, or if you need additional information, please call 919-324-3385.

**I HAVE READ AND UNDERSTAND THE CANCELLATION/MISSED APPOINTMENT POLICY OF ADOLESCENT CHILD & ADULT PSYCHIATRY.**

_____
PRINT NAME

_____ _____
PATIENT SIGNATURE DATE