Date:_____

Carolina Wellness Psychiatry, PLLC

INTAKE FORM

CONFIDENTIAL

Last Name: _____ First: _____ MI: _____
Date of Birth: _____ Age: ____ Sex:____ M ___ F SSN: _____
Mailing Address:

_____
City/State: _____ Zip: _____ Marital Status:____
Cell: (____) _____ - _____ Work: (____) _____ - _____

Name of Person(s) Financially Responsible:

_____
Relationship to Patient:

_____
Address (if different than patient's):

_____
City/State: _____ Zip: _____

Employer/School Information:
Name:

_____
Occupation:_____Grade:_____
City/State:_____
Education/Degrees:_____

Parent/Spouse's Information:
Name: _____ Phone: (____) _____ - _____
Relationship to patient:

_____
Employer Name: _____ Phone: (____) _____ - _____
Address: _____
City/State: _____ Zip: _____

Emergency Contact Information:
*In Case of Emergency, Contact _____Relationship to Patient:_____
Cell: (____) _____ - _____ Work: (____) _____ - _____
Who can we thank for referring you here today?_____Internet _____Friend _____Doctor/Psychologist?
(Name)_____

Medical History

Patient

Name:_____

Primary Care Physician:

Name of Practice: _____

Doctor: _____ Address: _____

Phone: (___) ____ - _____

Past Psychiatric and Medical Diagnoses (please give the year):

_____

_____

_____

Current Medications (Include dosage and frequency):

1)_____2)_____

3)_____4)_____

5)_____6)_____

7)_____8)_____

9)_____10)_____

Known Allergies:

_____

Severe Illness (childhood to present):

_____

_____

Previous Out/Inpatient Therapy (please specify which):_____

_____

_____

Previous Hospitalizations (Include year):

_____

_____

Stressors affecting you or your family in the past 1-2 years:

__Deaths __Births __Marriage __Divorce __Moving

__Job Change __School __Chronic Illness __Separation __Physical Abuse __Other

__Sexual Abuse __Broken Relationship __Unwanted Pregnancy __Substance Abuse

__Medical

Presenting Problem/Reason for Visit*:*_____

_____

_____

_____

Carolina Wellness Psychiatry, PLLC

FINANCIAL POLICY AND APPOINTMENTS

The keeping of regular appointments is crucial to successful treatment. As schedule permits, we will find the most convenient time for your appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

_____Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at the rate of the reserved session. You will be billed directly for this time.

PAYMENT OF FEES

_____Carolina Wellness Psychiatry does not participate with any insurance plan nor do we file on your behalf.

We will provide you with all necessary paperwork to assist you in filing with your insurance company. Payment to Carolina Wellness Psychiatry is to be made in full at the time of service. We accept cash, check, and major credit cards. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

_____I am not a Medicare or Medicaid patient.

By signing this, you are informing our office that you are not a Medicare or Medicaid patient. If you are a Medicare or Medicaid patient, please inform our front desk staff.

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

_____Any reports or professional consultations involving time beyond that of the regular scheduled session will be billed in fifteen minute increments at a pro-rated charge for the professional time involved at the usual and customary rate.

_____We will charge for telephone, email and/or communication consultations with your provider, which are <u>longer than five minutes</u>, in fifteen minute increments at the usual and customary rate should your provider deem it appropriate.

CONSENT TO RELEASE OF INFORMATION

Patient agrees that his/her clinician may share information with other professional staff at Carolina Wellness Psychiatry, PLLC with regard to his/her case in order to better provide quality treatment. This information will be kept strictly confidential.

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

Signature of Patient/Responsible Party Date

_____Date_____

Carolina Wellness Psychiatry, PLLC

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friend, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2019 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights,

about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.
Please contact us for more information at the address listed at the bottom of the page.
For more information about HIPPA or to file a complaint:
The U.S. Dept. of Health & Human Services Office of Civil Right
200 Independence Avenue, S.W. Washington, D.C. 20201

PATIENT ACKNOWLEDGEMENT

I understand that the patient's health information is private and confidential. I understand that Carolina Wellness Psychiatry, PLLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.
I understand that Carolina Wellness Psychiatry, PLLC may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)
Carolina Wellness Psychiatry, PLLC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices". If I ask, Carolina Wellness Psychiatry, PLLC will provide me with the most current "Notice of Privacy Practices".
Within the Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records: restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.
Carolina Wellness Psychiatry, PLLC has established procedures which help them meet their obligations to patients. Their procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist Carolina Wellness Psychiatry, PLLC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".
My signature below indicates that I have been given the chance to review a current copy of Carolina Wellness Psychiatry, PLLC "Notice of Privacy Practices".

Signature of Patient/Responsible Party Date

_____Date_____

Carolina Wellness Psychiatry, PLLC

ABBREVIATED ADHD SYMPTOM CHECKLIST (please complete if applicable to your symptoms/diagnosis)

DIRECTIONS: INDICATE THE DEGREE TO WHICH EACH ITEM BELOW IS A PROBLEM BY CIRCLING THE CORRESPONDING NUMBER. PLEASE RESPOND TO ALL ITEMS.

PATIENT'S NAME:

DATE:

PERSON COMPLETING FORM:

PARENT:

TEACHER:

INSTRUCTIONS: For each item please write THE NUMBERS CORRESPONDING TO "never"=0, "sometimes"=1, "often"=2, or "very often"=3 in the space provided

1. DOESN'T PAY ATTENTION TO DETAILS; MAKES CARELESS MISTAKES____
2. DIFFICULTY PAYING ATTENTION ____
3. DOES NOT SEEM TO LISTEN ____
4. DIFFICULTY FOLLOWING INSTRUCTIONS; DOES NOT FINISH THINGS____
5. DIFFICULTY GETTING ORGANIZED ____
6. AVOIDS DOING THINGS THAT REQUIRE A LOT OF MENTAL EFFORT ____
7. LOSES THINGS ____
8. EASILY DISTRACTED ____
9. FORGETFUL ____
10. FIDGETS WITH HANDS OR FEET; SQUIRMS IN SEAT ____
11. DIFFICULTY REMAINING SEATED ____
12. RUNS ABOUT OR CLIMBS ON THINGS ____
13. DIFFICULTY PLAYING QUIETLY ____
14. "ON THE GO"; ACTS AS IF "DRIVEN BY A MOTOR" ____
15. TALKS EXCESSIVELY ____
16. BLURTS OUT ANSWERS TO QUESTIONS ____
17. DIFFICULTY AWAITNG TURN ____
18. INTERRUPTS OTHERS OR BUTTS INTO THEIR ACTIVITIES ____

NEVER=0 SOMETIMES=1 OFTEN=2 VERY OFTEN=3

Carolina Wellness Psychiatry, PLLC

Release of Information

ELIZABETH BULLARD, MD; BRIAN MOORE, MD; ALLISON FOROOBAR, MD

I, _____, consent to allow all clinicians of Carolina Wellness Psychiatry, PLLC listed above to release and/or exchange information regarding_____.(Patient)

This information will include:

___Psychiatric Records ___Procedures ___Medical Records ___Educational Records
___Discharge Summary___Psychological Testing ___Therapy Notes ___Lab Work
___Other _____
___All of the above

Information can be shared with the following people/agencies (please include address):

_____

_____

_____

I understand that this information will be used in the patient's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.
It is the policy of Carolina Wellness Psychiatry, PLLC not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.
I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

Signature: _____

Witness:_____

Relationship to Patient: _____Date: _____
This consent is valid until _____. If I fail to specify an expiration date, this authorization will expire 12 months from the date of signature.
Rescind Consent: I hereby rescind the prior consent granted to Carolina Wellness Psychiatry, PLLC to release and/or discuss any information with the individual(s) and/or agencies listed above.
Signature:_____ Date:_____