CEH

CENTER FOR EMOTIONAL HEALTH

Identification - For the protection of our patients, and to reduce medical identity theft, all patients are required to present a valid insurance ID card and/or driver's license at the time of service. If a driver's license is unavailable, a valid photo ID must be presented.

Missed Appointments - There will be a **$75.00** fee for any missed appointments unless the appointment was canceled or rescheduled at least 24 hours in advance. It is still considered a no show, even if you do not receive a courtesy call. If you incur this $75.00 fee, we cannot refill prescriptions, comply with requests for record transfers, or any other requests until this fee has been paid. If you receive three (3) no shows, you are subject to being discharged. Any balance must be paid prior to receiving any services.

Late Appointments - If a patient is **5 minutes** late for a follow-up medication management appointment, the patient must reschedule. If a patient is **15 minutes** late for an initial appointment, the patient must reschedule. If a patient is **15 minutes** late for a follow up appointment with a therapist, the patient must reschedule.

Prescription Refills - Please allow 48 to 72 hours for your prescription refill request to be completed. If you are prescribed medication, you will be provided an initial prescription and refills to last until the suggested follow up visit. It is the patient's responsibility to schedule a follow up appointment before the prescription runs out to ensure a continued supply of the prescription. Medication refill requests will be denied if the patient fails to keep follow up appointments. Routine prescription refills will not be provided on the weekends.

Disability - There is a **$150.00** charge for the completion of each set of disability paperwork. Any extension or additional paperwork will be subject to a **$75.00** fee**.** This fee must be paid in advance and may take up to 7-10 business days to be completed.

Medical Records – Records can be released for a fee of $10.00. This fee must be paid in advance. All medical record requests are subject to be denied per office policy. Record request may take up to 7-10 business days to be completed.

Messages - Messages will be returned in the order of which they are received, however if it is an emergency, please call 911.

Patients 17 and under must be accompanied by a parent or legal guardian to all medication management appointments and other treatment services.

X ____ ______________________

Name of Patient (Please Print) Date

X____ ______________________

Signature of Patient (or Parent/Legal Guardian) Date

X____ ______________________

Name of Parent/Legal Guardian (Please Print) Date

Above policies and procedures are not applicable to all CEH programs and services offered.

Compliance Assurance Notification

All health professionals and office staff continuously undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with HIPAA. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. We want to ensure our patients that our practice will not knowingly contribute in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implanted a Compliance Program that will help prevent any inappropriate use of PHI. Any questions regarding this policy may be directed to the Office Manager.

Patient's Rights & Responsibilities

If you are or have been a patient of mental health services, you have the right to

- Access services that are appropriate to your disability, culture, language, gender, and age
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- Participate in decisions regarding your health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- An individualized treatment plan to ensure quality care and coordination of care.

□ I acknowledge the above information and my patient rights and responsibilities. A copy of the patient rights and the consumer handbook for mental health from NC Department of Health and Human Services was provided to me.

X____ ______________________

Signature of Patient (or Parent/Legal Guardian) Date

Insurance Information (Please give card to receptionist)

****We only bill primary insurance. No secondary insurance will be accepted.****

Do you have Medicare? □ Yes/ □ No

Please be advised CEH does not accept Medicare as primary or secondary insurance. If at any time your insurance coverage changes to Medicare, you must inform the CEH billing department immediately. Patients who fail to inform the billing department may incur a balance, and/or are subject to discharge. Please sign below acknowledging that you do not have Medicare coverage and that you will inform CEH upon any coverage changes taking place.

Insurance Waiver and Authorization for Payment of Services

I understand that amounts paid by my insurance company to Center for Emotional Health for specific services rendered may change from time to time. Any payment amounts requested at check-in/check-out. As such, upon receiving final accounting and payment from my insurance company, an additional payment may be required to settle my account with Center for Emotional Health.

I understand it is my responsibility to inform the office if my insurance coverage changes at any point in time. I understand that I am financially responsible for any unpaid balance and/or charges not covered/paid by my insurance company.

I authorize and request my insurance benefits be paid directly to Center for Emotional Health. This authorization will cover all treatment and services rendered until a written notice of cancellation is received.

X____ ______________________

Signature of Patient (or Parent/Legal Guardian) Date

Patient Information

How did you hear about us? (circle one): Family Friend Internet School Other ____________

Are you a veteran? Yes No If yes, please inform the provider you are seeing.

Patient's name (Last):________________________ (First:) ______________________ MI: ______

Date of Birth: __________ Age: ____ Social Security # ___________________ Sex (circle one): M or F

Marital Status: __________ Phone # (Home): ___________________ Cell #: ___________________

Home Address: ____

City: ___________________________________ State: ___________ Zip Code: _______________

Employer: __________________________________ Occupation: ______________________________

Emergency Contact (Full Name): ____________________________ Relationship: ________________

Phone #: _____________________________ Alternate Phone #: ____________________________

Current Symptoms Checklist

___ Depressed Mood
___ Racing Thoughts
___ Anxiety Attacks
___ Unable to enjoy activities
___ Impulsivity
___ Fatigue
___ Sleep pattern disturbance
___ Crying Spells
___ Change in appetite
___ Excessive energy
___ Excessive guilt
___ Suspiciousness
___ Avoidance
___ Loss of interest
___ Decreased libido
___ Forgetfulness/Concentration
___ Excessive worry
___ Excessive drinking
___ Increased risky behavior
___ Increased libido
___ Substance Abuse

General Questions

Local Pharmacy Name: _______________________________ Phone #: _______________________

Specialist seen (other than CEH): _______________________ Phone #: _______________________

Current Therapist/Counselor: ______________________

Medication Allergies: ____

Other Allergies (foods, bees, soap, etc): ____

Current Medications (including over the counter):____

Herbs, vitamins, supplements: ____

Your email address: ____

Primary Care Physician: ____

Primary Care Physician Contact Number: ____________________________

□ I authorize and consent for CEH to exchange/disclose my treatment or my child's treatment with the primary care physician listed above.

□ I do NOT authorize and consent for CEH to exchange or disclose my treatment or my child's treatment with the primary care physician listed above.

X______________________________________ ____________________

Signature of Patient (or Parent/Legal Guardian) Date

Consent to Treat for Adults

I, _______________________________________ do hereby consent to any medical care determined by Center for Emotional Health Medical Staff.

□ I consent to Outpatient Therapy □ I consent to Drug Testing

□ I consent to Medication Management □ I do not consent to _____________________

X____ ____________________

Name of Patient (Please Print) Date

X____ ____________________

Signature of Patient (or Parent/Legal Guardian) Date

Consent to Treat Minors

I, ____ (parent, or legal guardian), of ____, born ______________________________, do hereby consent to any medical care determined by Center for Emotional Health Medical Staff for the welfare of my child.

□ I consent to Outpatient Therapy □ I consent to Drug Testing

□ I consent to Medication Management □ I do not consent to _____________________

X____ ____________________

Name of Patient (Please Print) Date

X____ ____________________

Signature of Patient (or Parent/Legal Guardian) Date

Urine Screen FAQ

Why are you asking me to provide a urine sample?

For your safety, this office is complying with suggested Federal guidelines. Many physicians feel that drug testing allows the clinic ensure the highest level of patient safety. This drug monitoring program wills this office to:

- Understand the actual levels of drugs present in a patient
- Identify dangerous drug to drug cross-reactivity
- Monitor compliance with treatment plans
- Help physicians, staff, and patients to be safe

How often will I have to do this?

This office will comply with federal guidelines that require physicians to limit patient drug diversion. Patients are subject to random drug testing.

How was I chosen?

Since this drug monitoring program applies to new and existing patients, this office will collect samples from ALL patients initially, as well as perform random collections for all patients who are prescribed controlled substances.

Who will see the results?

Our office staff and lab personnel are authorized to view your lab results.

What's going to happen if the lab results come back negative?

What the results show and the actions taken because of the results, is up to the physician.

**** It is CEH policy that we cannot prescribe medication to patients that fail a drug test or have a prior history of substance abuse. We will be able to assist in alternative medications to treat patients.**

_____ I consent to drug testing.

_____ I do not consent to drug testing. By checking this option, I will not receive any controlled medications.

I have reviewed this form and agree to the CEH policy above.

X ____ ____________________

Name of Patient (Please Print) Date

X____ ____________________

Signature of Patient (or Parent/Legal Guardian) Date