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 a driver's license OR a valid photo ID at the time of service. You may email these items to info@cehcharlotte.com

Missed Appointments - There will be a **$85.00** 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 $85.00 fee, we cannot refill prescriptions, comply with requests for record transfers, or any other requests until this fee has been paid. Any balance must be paid prior to receiving any services.
If you receive three (3) no shows, you are subject to being discharged.

Inappropriate Behavior - Patients may be discharged due to disruptive behavior or non-compliance of treatment.

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

Prescription Refills - 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. If you are prescribed medication, you will be provided an initial prescription and refills to last until the suggested follow up visit. 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 is available to me in each CEH office or by request.

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Insurance Information

****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 if there are any changes to your coverage.

Insurance Waiver and Authorization for Payment of Services

I understand that fees paid by my insurance company to CEH for specific services rendered are subject to change. All payments and balances must be paid in order to receive services. Upon receiving final accounting and payment from my insurance company, an additional payment may be required to settle my account with CEH.

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 CEH. 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: ____ 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	___ Paranoid
___ Avoidance	___ Loss of interest	___ Decreased sex drive
___ Forgetfulness/Concentration	___ Excessive worry	___ Excessive drinking
___ Increased risky behavior	___ Increased sex drive	___ 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 consent to any medical care determined by the CEH medical staff

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 consent to any medical care determined by the CEH medical staff

X_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Urine Screen FAQ

Why do I need provide a urine sample?

For your health and safety of our patients, CEH collects urine samples to comply with suggested federal guidelines. By monitoring urine samples CEH is able to:

- Understand the actual levels of drugs present in a patient
- Identify dangerous drug to drug cross-reactivity
- Monitor compliance with treatment plans

How often will I have to do this?

CEH complies with federal guidelines that require providers to limit patient drug diversion. Patients are subject to random drug testing.

How was I chosen?

This office will collect samples from ALL patients initially, as well as perform random collections for all patients who are prescribed medications

Who will see the results?

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

** 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