



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. The individual requesting disability services must be a compliant patient at CEH for at least 6 months in order to have disability paperwork completed by CEH.

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 requests may take up to 7-10 business days to be completed.

Custody: CEH does not participate in any type of custody preceding's or disputes. CEH has the right to discontinue services for custody related services.

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

Parent/guardian(s) of children 12 and under must stay on the premises during the entire appointment.

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

Refund Policy

There are no refunds to services received for therapy, medication management, processing of forms, or completion of any paperwork, except where CEH is unable to provide services. In such case, the request for a refund must be reviewed by upper management. Patients that dispute charges for services rendered will be charged a \$50 administration fee and will no longer be permitted to pay by credit card or debit card. All future payments must be paid in cash in order to receive services.

X _____
Signature of Patient (or Parent/Legal Guardian) Date

Patient Information

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

Reason for Visit: _____

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

- | | | |
|-----------------------------------------------------|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Forgetfulness/concentration | <input type="checkbox"/> Excessive guilt |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Increased risky behavior | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Loss of interest |
| <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Increased sex drive |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Excessive drinking | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Paranoia |

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 to 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

“The patient health questionnaires on the next page only need to be completed by patients 16 and older”



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PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ - 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Use "✓" to indicate your answer

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you have been better off dead or of hurting yourself in some way	0	1	2	3

For office coding _____

= total score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult



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MOOD DISORDER QUESTIONNAIRE

1. Has there been a period in time when you were not your usual self and...

- ... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? Yes No
- ... you were so irritable that you shouted at people or started fights or arguments? Yes No
- ... you felt much more self confident than usual? Yes No
- ... you got much less sleep than usual and found you didn't really really miss it? Yes No
- ... you were much more talkative or spoke much faster than usual? Yes No
- ... thoughts raced through your head or you couldn't slow your mind down? Yes No
- ... you were so easily distracted by things around you that you had trouble concentrating or staying on track? Yes No
- ... you had much more energy than usual? Yes No
- ... you were much more active or did many more things than usual? Yes No
- ... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night Yes No
- ... you were much more interested in sex than usual? Yes No
- ...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? Yes No
- ...spending money got you or your family in trouble? Yes No

2. If you have checked YES to more than one of the above, have several of these ever happened during the same period of time?

Yes No

3. How much of a problem did any of these cause you - like being unable to work; having family money or legal troubles; getting into arguments or fights?

No problem	Minor problem	Moderate problem	Serious problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunt, uncles) had manic-depressive illness or bipolar disorder?

Yes No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

Yes No