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 requests 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.

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

__ Depressed mood
__ Unable to enjoy activities
__ Sleep pattern disturbance
__ Excessive energy
__ Avoidance
__ Decreased sex drive
__ Fatigue
__ Forgetfulness/concentration
__ Increased risky behavior
__ Racing thoughts
__ Impulsivity
__ Crying spells
__ Excessive drinking
__ Change in appetite
__ Excessive guilt
__ Excessive worry
__ Loss of interest
__ Increased sex drive
__ Anxiety attacks
__ Substance abuse
__ 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...

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

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
	☐	☐	☐	☐

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 ☐