

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Address _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Preferred phone (messages/courtesy appointment reminders) **(Home Cell Work):** _____

Alt. phone: _____ **Email address**** _____

Emergency Contact: _____ Relation: _____ Telephone: _____

***Email will be used for appointment reminders and for invitations to our patient portal.*

All copays, deductibles, estimated co-insurance, and other charges must be paid at each check in

Address to which statements should be mailed: Please check the box if the same address as above.

Name: _____ Relationship to patient: _____

Address _____ City: _____

State: _____ Zip: _____ Preferred Telephone: _____

If the person assuming financial responsibility for treatment will not be present at the appointment, the patient must bring the payment to the appointment.

Insurance Information: (We must make a copy of your card(s) in order to have all of the information needed to manage your claim submission. If you do not bring the card(s), you will be required to pay the full estimated cost of the appointment(s) at check-in.)

Name of primary insurance: _____

Name of secondary insurance, if applicable: _____

REQUIRED: When does your plan year start? _____ (mo/yr) What is your deductible? _____

If you do not know this information please contact your insurance customer service. Without correct information we must assume you have an active, unmet deductible and collect the estimated cost of the appointment. Incorrect information will incur a \$20 service fee and require immediate full payment of the outstanding balance.

****Prior Authorization:** see prior authorization page. Please obtain any needed prior authorization(s). Claims that are denied because you did not obtain a needed prior authorization will be billed to you. _____ **Initials**

I authorize the release of all medical records to clinicians involved in my treatment and to my insurance company. I further authorize insurance payments to be made directly to CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA.

I understand co-payments, deductibles, self-pay charges are due at time of service. Charges for services not covered by insurance are due at the next appointment or when billed, whichever occurs first.

Signature of patient or parent/guardian for minors _____ **Date** _____

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

New Patient History

Name _____ Date _____

Preferred name if different: _____

Legal gender: _____ Gender identity if different: _____

Name of person completing form if different from patient _____

Referred by _____

Reason for appointment _____

Name and phone number for any current mental health provider _____

Previous Treatments (Please have records forwarded to our office.)

Please list therapists, psychiatrists, hospitalizations and approximate dates. Please include substance abuse treatment.) _____

Previous medications (Please indicate if you think they helped and if they caused side-effects.)

Current Medications, Vitamins, and Supplements (List both prescription and over the counter medications and all vitamins and supplements)

Medication Allergies _____

Primary Care Provider (Please include office phone number) _____

610 Jones Ferry Road Suite 208
Carrboro, NC 27510-6113

Phone: 919.636.5695
Fax: 919.442.1105

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

New Patient History cont'd

For women only – Psychiatric meds are not proven safe in pregnancy.

I am not pregnant and, if sexually active, am using reliable birth control to prevent pregnancy. I will contact my mental health provider and advise them of any pregnancy or plan to become pregnant so that risks and benefits may be discussed. Initials _____

Medical and Neurologic History (Please list all current diagnoses and any significant illnesses or injury.)

Cardiac Screen: Do you have a history of: Heart disease or heart problems? _____ Fainting without explanation and possibly without warning? _____ An abnormal EKG or Long QTc? _____ A very slow heart rate (less than 50 beats per minutes)? _____ Low potassium, magnesium or calcium in your blood? _____ Has anyone in your biologic family died from a heart attack before age 40? _____

Sleep Screen: Do you have a known sleep disorder such as: Obstructive Sleep Apnea? _____, Restless Leg Syndrome? _____ Narcolepsy? _____ Other (please list) _____
Do you feel rested most mornings? _____ Frequently feel tired during the day? _____ Snore? _____ Sometimes have a strange feeling in your legs, or have to move them, especially at night? _____

Substance Use History

Alcohol - How much alcohol do you drink? _____
Do you have, or have you had, a problem with alcohol? _____
Have family or friends ever been concerned about your use of alcohol? _____
Caffeine – How much caffeine do you have on an average day? _____

Developmental History (Please list any problems, complications or delays in development from pre-birth through early childhood.)

Education History (Please list any problems you had in school and your highest level of education.) _____

Work History (Please list your current or most recent employment and any employment problems that may be related to mental health concerns.)

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New Patient History cont'd

Psychosocial History (Please list recurrent or current interpersonal problems, and any history of verbal, physical, sexual or emotional abuse.)

Family Members and Family Medical and Psychiatric History (Please list first names, ages and medical or mental health history of family members. Please indicate if there is any adoption history including your own.)

Spouse/Significant other _____

Children _____

Parents _____

Extended Family Members (if relevant) _____

Other information you would like us to know _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

**If you have changed insurance to a plan where your CHPA provider is out of network, or have decided not to use insurance, please let us know as soon as possible. This will allow us to provide the required GFE.*

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

**Your provider(s) at CHPA can provide a GFE regarding anticipated costs at CHPA. GFE’s regarding “medical tests, prescription drugs, equipment, and hospital fees” must be obtained from the company providing the service or item.*

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose for a Good Faith Estimate before you schedule an item or service.

**Your CHPA providers require at least two business days’ notice in order to provide a written GFE at least one business day before your appointment. If your circumstances change at the last minute, we can still provide a GFE but it will be verbal.*

If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

** Indicates information provided by and specific to CHPA*

Chapel Hill Psychiatric Associates, PA

Updated Electronic Communications Policy

Email and text have become the standard means for rapid communication between CHPA and our patients. They are used for appointment reminders, and both administrative and clinical communication.

Our previous policy involved a detailed and specific consent form completed by each patient. As electronic communication has expanded, accessing and referencing that document prior to initiating communication, has become impractical if not impossible. We are therefore, revising our policy to one in which an individual may opt out of a form of communication by contacting the front desk, and requesting that the relevant contact information be deleted. If your only phone is a cellphone, we will relabel the number and work to limit text messages, but we cannot guarantee full success.

For reference: CHPA has addressed some of the specific risks of email security by using protonmail.com accounts. Protonmail.com is encrypted from our computers through the protonmail servers and then typically unencrypted upon reaching outside email systems. Anyone interested in full encryption of their emails with CHPA may open a free protonmail account and update their email contact with the office.

As a reminder: Email and text should not be used for urgent communication

Risks of electronic communication include, but are not limited to:

- *Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.*
- *Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.*
- *Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of CHPA or the patient.*
- *Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist.*
- *Electronic communications may be disclosed in accordance with a duty to report or a court order.*

Revised 1/7/22

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PLEASE READ THE [POLICIES AND PROCEDURES](#).

It contains important information regarding your financial liability for services provided.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE REVIEWED THE AGREEMENT TITLED
“**Policies and Procedures – Chapel Hill Psychiatric Associates, PA**” AND YOU AGREE TO ITS TERMS. THE
LATEST POLICY IS AVAILABLE ON OUR WEBSITE WWW.CHAPELHILLPA.COM.

YOU MAY REQUEST A PRINTED COPY OF THE POLICIES AND PROCEDURES..

Signature of Client/Patient/or Patient’s Legal Representative

Date: