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.)

____

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

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

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

Phone: 919.636.5695
Fax: 919.442.1105

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**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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	

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.

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*

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

Chapel Hill Psychiatric Associates, PA

Telehealth/Electronic Communications and Payment Policy

By signing this document, you acknowledge that you have read and understand the following information regarding telehealth and electronic communications and agree to the terms described herein.

- **Privacy Risks and Encryption:**
  - CHPA recognizes the privacy risks inherent to telehealth, email, and text messaging.
  - To limit these risks, we use a fully encrypted HIPAA compliant telehealth platform, and offer the option for free, fully encrypted email.
  - Note that while encryption secures the transmission of the communication, it does not address privacy risks that are under your control, such as the location you select for your participation in telehealth, or your use of non-secure email platforms.
  - If you would like to use fully encrypted email, please go to protonmail.com and register for a free account.

- **CHPA Communication:**
  - CHPA uses email communication for some appointment reminders, to send a rare advisory message by mass email, and to facilitate our compliance with the mandated programs "No Surprises," also known as "Good Faith Estimate."
    - If you are not receiving two appointment reminders, or want the type of reminder changed, please call the main office at 919 636-5695 to discuss your preferences.

- **Additional risks of electronic communication include but are not limited to:**
  - Employers and online services may have a legal right to inspect 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.

- **Your Rights with Respect to Telehealth/Telephone/Email Communication:**
  - You have the right to withhold or withdraw your consent to the use of telehealth/telephone/email communication at any time. If you wish to withdraw consent, please contact your provider(s) and the front desk, by phone or voicemail, and then in writing.
  - Providing a text-capable phone number and/or email is considered consent for CHPA to use those methods for communication of routine information such as appointments and notices.
  - Initiation of communication that includes personal information is considered consent for CHPA to reply using that form of contact.

- **Concerns Regarding Insurance Coverage as the Public Health Emergency expires May 11, 2023:**
  - Waivers regarding copays, telehealth coverage, and encryption of communication may now expire.
  - It is your responsibility to contact your insurance company regarding whether your scheduled form of appointment will be covered, and to discuss any restrictions with your provider(s).
  - By signing this document, you acknowledge that you will be responsible for charges that are denied.

- **Emergency and Crisis Situations:**
  - By signing this document, you agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health services. If you are in crisis or in an emergency, you should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in your immediate area.

By signing this document, you hereby affirm that you have read and understand the information provided above regarding telehealth and electronic communications.

- You consent to the use of telehealth services for treatment under the terms described herein.
- You acknowledge that it is your responsibility to determine whether your appointment type is covered by your insurance and that you will be responsible for charges that are denied.

Signature________________________________ Date________________

- You consent to the use of email and text communication. Please call 919 636 5695 if you do not agree to email and/or text communication.

Signature: ________________________________ Date________________

Revised 3/2023

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

Phone: 919.636.5695
Fax: 919.442.1105

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: