New Patient Checklist

(Please call 919-636-5695 if you have any questions about the registration forms and /or policies.)

_____ New Patient Information Form

_____ Authorization for Treatment

If prior authorization (PA) is required, and you do not obtain PA, you will be liable for the cost of the appointments. (See CHPA Policies and Procedures for important information regarding your financial liability for unpaid charges.)

_____ Authorization to Obtain and Use Protected Health Information

_____ CHPA Policies and Procedures

This contains important information about cancelled/failed appointments, charges not covered by insurance, issues of confidentiality and other important policies.

_____ Consent to Use Electronic Communication

_____ New Patient History

_____ Cardiac Screen, Screening for risk of long QTc form.

Give to receptionist:

- ❑ Registration paperwork
- ❑ Insurance Card If you have insurance but do not bring your insurance card, you will have to pay for your appointment.
- ❑ Photo id – personal ID for adults, parent ID for a child

Note: Copays, deductibles and self-pay fees are collected at the time of the appointment.

Patient Information:

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

Address_____ City: _____

State: ____ Zip: _____ Date of Birth: _____ Sex: F M

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 box if 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 _____

AUTHORIZATION FOR TREATMENT

In order to utilize your mental health benefits, it is likely that your insurance carrier requires you to obtain an authorization for treatment within ***24 hours of your first appointment***. In order to bill the insurance on your behalf, we ask that you contact your insurance carrier and obtain the following information. When completed, please provide the front desk staff with the completed information or fax to us at 919.442.1105.

NAME OF CLIENT: _____

NAME OF INSURANCE: _____

EFFECTIVE DATE OF AUTHORIZATION: _____

EXPIRATION DATE OF AUTHORIZATION: _____

NUMBER OF VISITS AUTHORIZED: _____

AUTHORIZATION NUMBER: _____

PROVIDER: □ Kathleen Transue, ANP □Tracy Ware, MD □Tracey Lee-Jones, PMHNP-BC
□ Andrea Treimel, LCSW □ Lizzette Potthoff, LCSW
□ Elizabeth Parker, LCSW □ Brad Prinzhorn, PsyD

SERVICE CODE(S)		
Dr Ware, K. Transue, ANP, and Tracey Lee-Jones, PMHNP-BC	□ 99205 □ 90792 □ 99215 □ 99214	New Patient Eval and Mngmt New Patient Eval and Mngmt (Magellan) 35+ Minute Med Management 15-25 Minute Med Management
Therapists	□ 90791 □ 90834 □ 90837 □ 90847 Other: _____	Intake Evaluation with Therapist 45 Minute Psychotherapy 60 Minute Psychotherapy Family Therapy

WAIVER:

My insurance company does not require preauthorization for mental health services. I understand that any insurance denials due to lack of preauthorization will result in my being responsible for the full amount of the bill.

_____ _____

Signature of Client Date

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Authorization to Obtain and Use Protected Health Information

This authorization implements the requirements for client authorization to use and disclose health information protected by the Health Privacy Law (45 CFR, Parts 160,164) HIPAA; the federal drug and alcohol confidentiality law (42 CFR Part 2) and the NC state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 112C).

Patient Name: _____ **Date of Birth: _____/_____/_____**

Information to be released □ to □ from:

_____

_____

_____

Information to be released □ to □ from:
Chapel Hill Psychiatric Associates, PA
610 Jones Ferry Road, Suite 208
Carrboro, NC 27510
Tel: (919) 636-5695
Fax: (919) 442-1105

Dates of Treatment: _____/_____ to _____/_____

Purpose of Release: □ Continuity of Care □ Legal Representation □Primary Care Provider □ Request of the Individual □ Other: _____

Information to be released:
□ History and Physical Exams □ Diagnostic test Results □ Psychological Assessments
□ Psychotherapy Notes □ Admission Information □ Discharge Summary
□ Psychiatric Evaluations □ Medication Records □ Substance Use/Treatment
□ Progress Update/ Verbal □ Treatment Plans □ AIDS/HIV Status
□ Educational Testing and Grades □ Other**:** _____
□ **All records including secondary records from outside evaluations and hospitalizations** _____ - Initialed by patient or representative

Important Rights You Should Know:

-1- This authorization shall expire 1 year from the date of signature below unless revoked prior to that date by submitting a written revocation to Chapel Hill Psychiatric Associates. If you revoke this authorization, it will not apply to information that has already been used or disclosed. The information disclosed based on this authorization may be used or re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

-2- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure. You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

-3- If you refuse to sign this authorization, Chapel Hill Psychiatric Associates will not deny or refuse to provide you treatment. However, our inability to obtain pertinent information or to coordinate care may alter the risk benefit analysis of your treatment options and therefore which treatments are recommended.

Please document your permission or refusal by checking and initialing the appropriate section below:

I am: □ *the individual signing below*

Signature of Client_____ **Date (required) _____**

□ *a personal and legal representative because the patient is a minor, incapacitated, or deceased*

Signature _____

Relationship to the Client: _____ **Date (required) _____**

□ *Refusing consent to release information as requested.* Please Initial here: _____

Witness: _____ Date: _____

Chapel Hill Psychiatric Associates, PA

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Patient name: _____
Patient address: _____
Patient home phone: _____
Patient mobile phone: _____
Patient email (if applicable): _____
Other account information required to communicate electronically (if applicable):
_____

CHPA has offered to communicate using the following means of electronic communication:

___Email (appointment reminders only) (not encrypted)
___Email (clinical information) (encrypted if using ProtonMail.)
___Videoconferencing
___Text messaging
___Other (specify): _____

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

- I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form.
- I accept the risks and consent to the selected forms of electronic communication.
- I agree to follow the instructions outlined in the Appendix.
- I understand that CHPA recommends that email communication be conducted using the encryption platform ProtonMail, but that I may, at my own risk, choose to use an unencrypted email program. (Information on ProtonMail is available on the CHPA website: www.chapelhillpa.com.)
- I understand that using any other email program may leave my information at risk and that CHPA does not accept liability for disclosures that may occur if I choose to use an unencrypted email system.
- I acknowledge that I may, at any time, withdraw the option of communicating electronically upon providing written notice to CHPA.
- CHPA reserves the right to restrict or discontinue electronic communication without notice.
- Any questions I had have been answered.

Patient signature: _____
Date: _____
Witness signature: _____
Date: _____

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Fax: 919.442.1105

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen

Screening for risk of long QTc and "sudden death"

All patients of Dr. Ware, Ms. Transue, and Ms. Lee-Jones are requested to complete the first section of this packet and return it to your medication provider or the front desk.

The rest of the packet is yours to keep and contains extremely important safety information. Please read it, keep it for reference, and address any questions to your medication provider.

Name of patient: _____ Date of Birth _____

Patient sees: _____ Ms. Transue _____Dr. Ware _____Tracey Lee-Jones

Name of person filling out the form, if different: _____

Relationship to patient: _____

I have received the "Important Information on Prolonged QTc…" handout.

X_____ Date: _____

Please read the handout "Important Information on Prolonged Qtc…"

Please answer the following screening questions.

Does the patient have a history of heart disease or heart problems? _____

Does the patient have a history of fainting? _____

Has anyone in the patient's biological family died suddenly before age 40? _____

If yes, what was the cause of death? _____

Does the patient have a history of an abnormal EKG or long QTc? _____

Does the patient have a very slow heart rate (less than 50 beats per minute)? _____

Does the patient have a history of low potassium, magnesium or calcium in the blood? (circle which was low) _____

Does the patient take any of the medications listed on the next two pages, either routinely or when needed? Please circle the medication(s) the patient is taking currently. Please also circle any medications that are taken occasionally and write "prn" next to the medication. Prn means "as needed." *Please note the same medications are listed on both pages. The first page is alphabetical by brand name. The second page is alphabetical by generic name.*

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CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen – Patient Education

Home Reference

Important Information on Prolonged QTc Risk for Sudden Cardiac Death

X

The electrical system that controls when and how the heart beats can be disrupted by medications. In extreme cases, this change in electrical activity may cause the heart to stop beating normally. A person experiencing Prolonged QTc may feel **short of breath, dizzy, or may lose consciousness without warning ("syncope"). In extreme cases they may die suddenly.**

There is a great deal of controversy and debate over how frequently this happens and how best to minimize the risk to people who might benefit from the medications.

> Some organizations and publications have called for routine EKG's, but only for a few of the many medications associated with an increased risk of Prolonged QTc *(American Heart Association, New England Journal of Medicine)*.
>
> Others have endorsed screening for risk before ordering an EKG *(World Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, Society for Developmental and Behavioral Pediatrics, National Initiative for Children's Healthcare Quality, National Association of Pediatric Nurse Practitioners, Children and Adults with Attention Deficit/Hyperactivity Disorder).*

Chapel Hill Psychiatric Associates, PA recognizes the validity and complexity of this debate while respecting the right of the patient, parent and/or guardian to be part of the decision-making process.

Our policy is based on an expansion of the screening questions recommended by the World Psychiatric Association and our commitment to educating our patients regarding this complex issue. Neither the screening questions nor an EKG can guarantee that each person who is at risk can be identified. There will always be some, we hope very limited, risk of abnormal heartbeat and death when these and many other medications are used.

The following is a copy of the screening questionnaire you completed. These questions are used to establish a relative baseline risk. If your answer to any of these questions changes, please advise us as soon as possible.

> Does the patient have a history of heart disease or heart problems? _____
>
> Does the patient have a history of fainting without explanation and possibly without warning? _____
>
> Has anyone in the patient's biological family died suddenly before age 40? _____
>
> If yes, what was the cause of death? _____
>
> Does the patient have a history of an abnormal EKG or long QTc? _____
>
> Does the patient have a history of having a very slow heart rate (less than 50 beats per minute)? _____
>
> Does the patient have a history of low potassium, magnesium or calcium in the blood? (circle which was low) _____

Estimating risk also requires a recognition of relative risk among medications.

> There are three levels of risk for medications that we prescribe.

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CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen – Patient Education

The first level includes medications known to cause Prolonged QTc. (***Haldol, Thorazine, Mellaril, Orap***)

The evidence for the second level is less clear. (***Lithium, Effexor, Geodon, Seroquel, Amantadine, Risperdal, Invega***)

The third level includes medications believed to be safe at normal doses as long as the person does not have another major risk factor. (***Stimulants, Strattera, Celexa, Prozac, Zoloft, Paxil, Anafranil, Imipramine, Nortriptyline, Amitriptyline, Desipramine, Reminyl, Sineguan, Surmontil, Vivactyl***

Risk also increases with each additional medication that is associated with possible Prolonged QTc.

For a current list of medications that may cause prolonged QTc please go to www.azcert.org

The issue of risk is complex. **Besides the risks already reviewed, the risk of Prolonged QTC is increased by taking a medication that increases the blood level of the medication that may cause Prolonged QTc.** If you are taking one of the medications listed below in bold, you should not take any of the medications or food listed in the corresponding subparagraph without contacting your medication provider. Depending on the medication and the patient's other risk factors, we can usually adjust the dose. If we are prescribing both medications, we will already have been adjusting the dose clinically, but please contact us if you have any concerns.

1. **Amitriptyline (Elavil), Chlomipramine (Anafranil)**

Fluvoxamine, ciprofloxacin, fluconazole, amiodarone, Wellbutrin (buproprion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil.

2. **Haldol (haloperidol)**

Fluvoxamine, ciprofloxacin, amiodarone, Wellbutrin (buproprion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem.

3. **Antidepressants: desipramine, imipramine, nortriptyline, paroxetine (Paxil), venlafaxine (Effexor)**
   Antipsychotics: Mellaril (thioridazine), Thorazine (chlorpromazine)
   Other: Strattera (atomoxetine), Amphetamines (Adderall, Dexedrine etc…

Wellbutrin (buproprion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline).

4. **Geodon (ziprasidone), Seroquel (quetiapine), Orap (Pimozide)**

Indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem, Tagamet (cimetidine).

5. **Risperdal (risperidone), Invega (Paliperidone)**

Wellbutrin (buproprion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem, Tagamet (cimetidine).

If you experience any of the warning signs of Prolonged QTc, including dizziness and shortness of breath, you should contact your medication provider or primary care provider as soon as possible. If you have experienced loss of consciousness or "fainting" you should call 911 for transportation to an emergency room.

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Generic Name (Brand Name)
Albuterol (Ventolin®)
Albuterol (Proventil®)
Alfuzosin (Uroxatral®)
Amantadine (Symmetrel®)
Amiodarone (Pacerone®)
Amiodarone (Cordarone®)
Amitriptyline (Elavil®)
Amphetamine (Dexedrine®)
Amphetamine (Adderall®)
Arsenic trioxide (Trisenox®)
Astemizole (Hismanal®)
Atazanavir (Reyataz®)
Atomoxetine (Strattera®)
Azithromycin (Zithromax®)
Bepridil (Vascor®)
Chloral hydrate (Noctec®)
Chloroquine (Aralen®)
Chlorpromazine (Thorazine®)
Ciprofloxacin (Cipro®)
Cisapride (Propulsid®)
Citalopram (Celexa®)
Clarithromycin (Biaxin®)
Clomipramine (Anafranil®)
Clozapine (Clozaril®)
Desipramine (Pertofrane®)
Dexmethylphenidate (Focalin®)
Diphenhydramine (Benadryl®)
Diphenhydramine (Nytol®)
Disopyramide (Norpace®)
Dobutamine (Dobutrex®)
Dofetilide (Tikosyn®)
Dolasetron (Anzemet®)
Domperidone (Motilium®)
Dopamine (Intropine®)
Doxepin (Sinequan®)
Dronedarone (Multaq®)
Droperidol (Inapsine®)
Ephedrine (Rynatuss®)
Ephedrine (Broncholate®)
Epinephrine (Bronkaid®)
Epinephrine (Primatene®)
Erythromycin (Erythrocin®)
Erythromycin (E.E.S.®)
Escitalopram (Lexapro®)
Escitalopram (Cipralex®)
Felbamate (Felbatrol®)
Fenfluramine (Pondimin®)
Flecainide (Tambocor®)
Fluconazole (Diflucan®)
Fluoxetine (Prozac®)
Foscarnet (Foscavir®)
Fosphenytoin (Cerebyx®)
Galantamine (Reminyl®)
Gatifloxacin (Tequin®)
Gemifloxacin (Factive®)
Granisetron (Kytril®)
Halofantrine (Halfan®)
Haloperidol (Haldol®)
Ibutilide (Corvert®)
Imipramine (Norfranil®)
Indapamide (Lozol®)
Isoproterenol (Medihaler-Iso®)
Isoproterenol (Isupres®)
Isradipine (Dynacirc®)
Itraconazole (Sporanox®)
Ketoconazole (Nizoral®)
Lapatinib (Tykerb®)
Lapatinib (Tyverb®)
Levalbuterol (Xopenex®)
Levofloxacin (Levaquin®)
Levomethadyl (Orlaam®)
Lisdexamfetamine (Vyvanse®)
Lithium (Lithobid®)
Lithium (Eskalith®)
Mesoridazine (Serentil®)
Metaproterenol (Metaprel®)
Metaproterenol (Alupent®)
Methadone (Methadose®)
Methadone (Dolophine®)
Methylphenidate (Ritalin®)
Methylphenidate (Concerta®)
Mexiletine (Mexitil®)
Midodrine (ProAmatine®)
Moexipril/HCTZ (Uniretic®)
Moxifloxacin (Avelox®)
Nicardipine (Cardene®)
Nilotinib (Tasigna®)
Norepinephrine (Levophed®)
Nortriptyline (Pamelor®)
Octreotide (Sandostatin®)
Ofloxacin (Floxin®)
Ondansetron (Zofran®)
Oxytocin (Pitocin®)
Paliperidone (Invega®)
Paroxetine (Paxil®)
Pentamidine (NebuPent®)
Pentamidine (Pentam®)
Perflutren lipid microspheres (Definity®)
Phentermine (Fastin®)
Phentermine (Adipex®)
Phenylephrine (Neosynephrine®)
Phenylpropanolamine (Dexatrim®)
Phenylpropanolamine (Acutrim®)
Pimozide (Orap®)
Probucol (Lorelco®)
Procainamide (Pronestyl®)
Procainamide (Procan®)
Protriptyline (Vivactil®)
Pseudoephedrine (PediaCare®)
Pseudoephedrine (Sudafed®)
Quetiapine (Seroquel®)
Quinidine (Quinaglute®)
Quinidine (Cardioquin®)
Ranolazine (Ranexa®)
Risperidone (Risperdal®)
Ritodrine (Yutopar®)
Ritonavir (Norvir®)
Roxithromycin* (Rulide®)
Salmeterol (Serevent®)
Sertindole (Serlect®)
Sertindole (Serdolect®)
Sertraline (Zoloft®)
Sibutramine (Meridia®)
Solifenacin (VESIcare®)
Sotalol (Betapace®)
Sparfloxacin (Zagam®)
Sunitinib (Sutent®)
Tacrolimus (Prograf®)
Tamoxifen (Nolvadex®)
Telithromycin (Ketek®)
Terbutaline (Brethine®)
Terfenadine (Seldane®)
Thioridazine (Mellaril®)
Tizanidine (Zanaflex®)
Tolterodine (Detrol®)
Tolterodine (Detrol LA®)
Trazodone (Desyrel®)
Trimethoprim-Sulfa (Sulfa®)
Trimethoprim-Sulfa (Bactrim®)
Trimipramine (Surmontil®)
Vardenafil (Levitra®)
Venlafaxine (Effexor®)
Voriconazole (VFend®
Ziprasidone (Geodon®)

New Patient History

Name_____ Date_____

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 list therapists, psychiatrists, medications, hospitalizations and approximate dates. Include substance abuse treatment.) _____

_____

_____

_____

_____

_____

_____

(Please have records forwarded to our office.)

Current Medications (prescription and over the counter):

Name	Dose	When started	Side Effects	Prescribed by

_____

_____

_____

_____

_____

_____

Medication Allergies _____

_____

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New Patient History continued

Primary Care Provider (name, address, phone, fax) _____

_____

For women only – Please inform your provider if there is any chance you are, or will become pregnant, now or at any time during treatment. Psychiatric meds are not proven safe in pregnancy. Abruptly discontinuing medication and/or psychiatric illness may also pose a risk to a 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 any significant illnesses or injury.) _____

_____

_____

_____

_____

Substance Use History

Alcohol - How much 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?_____

Cigarettes – Do you smoke and if so how much?_____

Street Drugs – Do you or have you used any street drugs? (Please state what and how much.)_____

_____

Over the counter and prescription medications - Do you, or have you, ever used more than the prescribed dosage or for longer than recommended?_____

_____

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.) _____

_____

_____

New Patient History continued

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

_____

_____

_____

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

_____

_____

_____

_____

Family and Family 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 _____

_____

Children _____

_____

_____

_____

_____

Parents _____

_____

_____

_____

Extended Family Members (if relevant) _____

_____

_____

_____

Other information you would like us to know _____

_____

_____

_____

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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: