CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

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

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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	

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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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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: