CENTER FOR EMOTIONAL HEALTH

**In Office Policies**

**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/or driver's license at the time of service. If a driver's license is unavailable, a valid photo ID must be presented.

**Missed Appointments** - There will be a **$75.00** 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 $75.00 fee, we cannot refill prescriptions, comply with requests for record transfers, copies of records, or any other requests *until this fee has been paid*. If you receive three (3) no shows, you are subject to being discharged. Any balance must be paid prior to receiving any services.

**Late Appointments** - If a patient is 7 minutes late for a follow-up medication management appointment, the patient must reschedule. If a patient is 15 minutes late for an initial appointment, the patient must reschedule. If a patient is 30 minutes late for an follow up appointment with a therapist, the patient must reschedule.

**Insurance** - Initial Evaluations include urine drug testing charge of $5.00.

**Prescription Refills** - Please allow **48 to 72** hours for your prescription refill request to be completed. If you are prescribed medication, you will be provided an initial prescription and refills to last until the suggested follow up visit. 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. 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 **$95.00** charge for the completion of each set of disability paperwork. This fee must be paid in advance and may take up to 7-10 business days to be completed.

**Medical Records** - Medical record fees are based on the length of the record; however, there is a $10 minimum charge. This fee must be paid in advance. All medical record requests are subject to be denied per office policy. Please contact the medical record department with any further questions.

**Messages** - Messages will be returned in the order of which they are received, however if it is an emergency, please call 911.

**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.

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**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. By signing below, you are acknowledging that you have read and been made aware of this notice of our privacy practices.

X_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

**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
- Request and receive a copy of your medical records
- An individualized treatment plan to ensure quality care and coordination of care.
- Access medical care for treatment of physical ailments.

□ I acknowledge the above information and my patient rights and responsibilities. A copy of the patient bill of rights and the consumer handbook for mental health from NC Department of Health and Human Services was provided to me.

X_____ _____

Name of Patient/Guardian (Please Print) Date

X _____ _____

Signature of Patient/Guardian Date

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## Patient Information

**How did you hear about us? (circle one): Family Friend Internet School Other _____**

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: ____ Social Security # _____ 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
___ Forgetfulness/Concentration
___ Increased risky behavior
___ Racing Thoughts
___ Impulsivity
___ Crying Spells
___ Excessive guilt
___ Loss of interest
___ Excessive worry
___ Increased libido
___ Anxiety Attacks
___ Fatigue
___ Change in appetite
___ Suspiciousness
___ Decreased libido

### Family Psychiatric History Checklist

Has anyone in your family been diagnosed with and/ or treated for?

____ Bipolar Disorder
_____ Anger
_____ Violence
_____ Depression
_____ Other substance abuse
_____ Alcohol abuse
_____ Suicide
_____ Schizophrenia
_____ Anxiety
_____ Post- traumatic stress

### Past Psychiatric History

Outpatient treatment _____ Yes _____ No If yes, please describe below.

**Reason** **Dates** **Treated By Whom**

_____

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**Substance Abuse**

Have you ever been treated for alcohol or drug use/abuse? _____ Yes _____ No

How many days a week do you drink? _____

Have you ever felt that you should reduce your drinking or drug use? _____ Yes _____ No

Do you think you may have a problem with alcohol or drug use? _____ Yes _____ No

**Educational History**

Do you attend college? _____ Yes _____ No If so, where? _____

What is your highest level of education attained? _____

**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: _____

Please check one of the boxes below.

☐ **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

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**Insurance Information**
***(Please give card to receptionist)***
****We only bill primary insurance. No secondary insurance will be accepted.****

Primary Insurance: _____

Person responsible for payment: _____ Relationship: _____

Date of Birth (person responsible for payment): _____ Social Security #: _____

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 upon any coverage changes taking place.

X_____ _____
Signature of Patient (or Parent/Legal Guardian) Date

## Authorization for Payment of Services

I authorize and request my insurance benefits be paid directly to Center for Emotional Health. 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

## Insurance Waiver

I understand that amounts paid by my insurance company to Center for Emotional Health for specific services rendered may change from time to time. Any payment amounts requested at check-in/check-out or insurance adjustments appearing on my visit summaries and statements are just estimates. As such, upon receiving final accounting and payment from my insurance company, an additional payment may be required to settle my account with Center for Emotional Health.

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.

X_____ _____
Signature of Patient (or Parent/Legal Guardian) Date

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**Urine Screen FAQ**

**Why are you asking me to provide a urine sample?**
For your safety, this office is complying with suggested Federal guidelines. Many physicians feel that drug testing allows the clinic ensure the highest level of patient safety. This drug monitoring program wills this office to:
• Understand the actual levels of drugs present in a patient
• Identify dangerous drug to drug cross-reactivity
• Monitor compliance with treatment plans
• Help physicians, staff, and patients to be safe

**How often will I have to do this?**
This office will comply with federal guidelines that require physicians to limit patient drug diversion.
Patients are subject to random drug testing.
**How was I chosen?**
Since this drug monitoring program applies to new and existing patients, this office will collect samples from ALL patients initially, as well as perform random collections for all patients who are prescribed controlled substances.

**Who will see the results?**
Our office staff and lab personnel are authorized to view your lab results.

**May I have a copy of the results?**
Results may be provided for a fee.

**What's going to happen if the lab results come back negative?**
What the results show and the actions taken because of the results, are up to the physician.

****It is CEH policy that we can not prescribe medication to patients that fail a drug test or have 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_____ _____
Print Name of Patient (or Parent/Legal Guardian) Date

X_____ _____
Signature of Patient (or Parent/ Legal Guardian) Date

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## 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 do not consent to _____

X_____ _____

Name of Patient (Please Print) Date

X _____ _____

Signature of Patient 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 do not consent to _____

X_____ _____

Name of Parent/Guardian (Please Print) Date

X _____ _____

Signature of Parent/Guardian Date

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## PATIENT QUESTIONNAIRE – PHQ-9

**Patient Name:** _____ **MRN** _____

**Physician:** _____ **Date:** _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

| | **Not at all** **0** | **Several days** **1** | **More than half the days** **2** | **Nearly every day** **3** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things. | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless. | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling/staying asleep, sleep too much. | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy. | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating. | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | ☐ | ☐ | ☐ | ☐ |
| 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. | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☐ | ☐ | ☐ |
| | 0 | _____ | _____ | _____ |

A. 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

B. In the past **two years** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

**Symptoms** _____ **Severity Score** _____