NEW PATIENT

Identification - To protect our patients and prevent medical identity theft, all patients must present:
- A valid insurance ID card, AND
- A valid driver's license or photo ID at the time of service.

You may also email these items to: newpatients@cehcharlotte.com

Missed Appointments - Effective August 1st, 2025, a minimum of 48 hours' notice is required to cancel or reschedule an appointment to avoid a fee.
- **Therapy Appointment No-show Fee:** $110.00
- **Medication Management Appointment No-show Fee:** $85.00

Fees apply regardless of whether you receive a reminder call. CEH does not schedule appointments without your knowledge. If you incur a fee:
- Prescription refills will be withheld.
- Record transfers and other services will be delayed until the fee is paid.
- Balances must be paid before future appointments.
- After three (3) no shows, you are subject to being discharged.

Inappropriate Behavior - Patients may be discharged due to disruptive behavior or non-compliance with treatment.

Late Arrivals - Appointments will be rescheduled if a patient is:
- **5+ minutes late** for a **Medication Management** follow-up
- **15+ minutes late** for a **Therapy** session

Prescription Refills - Patients must schedule follow-up appointments before running out of medication.
- Refill requests will be denied if follow-up appointments are missed.
- No routine refills are processed on weekends.
- Initial prescription includes refills up to the next recommended follow-up.

Disability - As of April, 4th, 2022, CEH no longer offers disability services. We continue to support FMLA requests and will provide records for disability claims initiated outside of CEH (subject to a fee paid in advance).

Medical Records:
- Record release fee: **$11.00 due in advance.**
- Requests may be **denied per office policy.**
- Processing time: **7-10 business days**.

Custody Disclaimer - CEH does not participate in custody proceedings or disputes. Services may be discontinued if related to custody issues.

Messages - Messages are returned in the order received. For emergencies, call 911.

Parent/guardian(s) of children 12 and under must stay on the premises during your child's entire therapy session. Patients 17 and under must be accompanied by a parent or legal guardian to all medication management appointments and other treatment services.

X____________________________________ X____________________
Name of Patient (Print) Date

X____________________________________ X____________________
Signature of Patient (or Parent/Legal Guardian) Date

X____________________________________ X____________________
Name of Parent/Legal Guardian (Print) Date

PATIENT INFORMATION

Name: ______________________ DOB: ____/____/______ Sex: ❑ M / ❑ F / ❑ Other

Address: ____

City: __________________________ State: __________ Zip: _______________

Phone (Cell): ______________________ Phone (Home): ______________________

Email: ____

Marital Status: _____________________

Employer: __________________________ Occupation: _______________________

Are you a veteran? ❑ Yes / ❑ No (If yes, please inform the provider you are seeing).

Reason for Visit: ____

How did you hear about us? (Please check one)
❑ Family ❑ Friend ❑ Internet ❑ School ❑ Other: _____________________

EMERGENCY CONTACT INFORMATION

Name: _____________________________ Relationship: _____________________

Phone: _________________________ Alternate Phone: ________________________

❑ I authorize this contact to schedule/cancel appointments on my behalf.

❑ I do NOT authorize this contact to schedule/cancel appointments on my behalf.

X____________________________________ X__________________
Signature of Patient (or Parent/Legal Guardian) Date

CEH
CENTER FOR EMOTIONAL HEALTH®

CURRENT SYMPTOMS CHECKLIST:

- ❑ Depressed Mood
- ❑ Unable to Enjoy Activities
- ❑ Sleep Pattern Disturbance
- ❑ Loss of Interest
- ❑ Forgetfulness/Concentration
- ❑ Excessive Drinking
- ❑ Substance Abuse
- ❑ Fatigue
- ❑ Change in Appetite
- ❑ Paranoia
- ❑ Excessive Guilt
- ❑ Increased Risky Behavior
- ❑ Excessive Worry
- ❑ Racing Thoughts
- ❑ Excessive Energy
- ❑ Impulsivity
- ❑ Increased Sex Drive
- ❑ Decreased Sex Drive
- ❑ Anxiety Attacks
- ❑ Crying Spells

Other: ____

____

MEDICATIONS:

Medication allergies: ____

____

Other Allergies (Foods, Bees, Soaps, Ect.): ____

____

Current Medications (Including over the counter): ____

____

Herbs, Vitamins, and/or Supplements: ____

____

CONTINUANCE OF CARE INFORMATION

Local Pharmacy Name: ______________________________ Phone: ________________________

Specialist seen (Other than CEH): _________________________ Phone: ______________________

Specialist Office: ____

Primary Care Physician: ______________________________ Phone: ______________________

PCP Office: ____

Current Therapist/Counselor: ___________________________ Phone: ______________________

Therapy Office: ____

❑ I authorize and consent for CEH to exchange/disclose my treatment or my child's treatment with the following Providers listed above.

❑ I do NOT authorize and consent for CEH to exchange/disclose my treatment or my child's treatment with the Providers listed above.

X____ X____________________

Signature of Patient (or Parent/Legal Guardian) Date

INSURANCE INFORMATION

Medicare

Please be advised CEH does not accept any Medicare or Medicare supplemental plans as primary or secondary insurance. If at any time your insurance coverage changes to Medicare, you must inform the CEH billing department or your CEH office immediately. Patients who fail to inform of the changes 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 if there are any changes to your coverage.

X____ X____________________

Signature of Patient (or Parent/Legal Guardian) Date

Insurance Waiver and Authorization for Payment of Services

I understand that fees paid by my insurance company to CEH for specific services rendered are subject to change. All payments and balances must be paid in order to receive services. Upon receiving final accounting and payment from my insurance company, an additional payment may be required to settle my account with CEH. 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. I authorize and request my insurance benefits be paid directly to CEH. This authorization will cover all treatment and services rendered until a written notice of cancellation is received.

X____ X____________________

Signature of Patient (or Parent/Legal Guardian) Date

Refund Policy

There are no refunds to services received for therapy, medication management, processing of forms, or completion of any paperwork, except where CEH is unable to provide services. In such a case, the request for a refund must be reviewed by upper management. Patients that dispute charges for services rendered will be charged a $50 administration fee and will no longer be permitted to pay by credit card or debit card. All future payments must be paid in cash to receive services.

X____ X____________________

Signature of Patient (or Parent/Legal Guardian) Date

CONSENT TO TREAT

For Adults:

I, ________________________________, consent to the following:
(Patient's Name)

- ❑ Outpatient Therapy
- ❑ Medication Management
- ❑ Drug Testing
- ❑ Medical care deemed necessary by CEH medical staff
- ❑ Emergency medical intervention on my behalf

X________________________________ X__________________
Name of Patient (Print) Date

X________________________________ X__________________
Signature of Patient Date

For Minors:

I, ___________________________, (Parent/Guardian of _____________________________,
(Parent/Guardian's Name) (Patient's Name)

DOB:____/____/______), consent to the following:

- ❑ Outpatient Therapy
- ❑ Medication Management
- ❑ Drug Testing - We do NOT conduct drug testing on minors unless specifically required, and only with prior parental or legal guardian consent.
- ❑ Medical care deemed necessary by CEH medical staff
- ❑ Emergency medical intervention on my behalf

X________________________________ X__________________
Name of Patient (Print) Date

X________________________________ X__________________
Signature of Parent/Legal Guardian Date

URINE SCREEN FAQ

Why do I need to provide a urine sample?
For the health and safety of our patients, CEH collects urine samples to comply with suggested federal guidelines. By monitoring urine samples, CEH is able to:

- Understand the actual levels of drugs present in a patient
- Identify dangerous drug to drug cross activity
- Monitor compliance with treatment plans

How often will I have to do this?
CEH complies with federal guidelines that require providers to limit patient drug diversion. Patients are subject to random drug testing.

How was I chosen?
CEH will collect samples from ALL patients initially, as well as perform random collections for all patients who are prescribed medications.

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

CEH Controlled Medications Policy
We will not prescribe controlled medications to patients who:

- Decline to consent to urine drug screening,
- Fail a drug screen, or
- Have a known or documented history of substance misuse.

In such cases, we will offer appropriate non-controlled treatment alternatives, including safer pharmacological options or non-pharmacological therapies, tailored to the patient’s clinical needs. Statistical and clinical guidelines support using structured monitoring and offering alternatives to mitigate risks. For instance, clinicians are advised to conduct urine drug testing prior to prescribing controlled substances and to explore safer medication and integrative treatment strategies when concerns arise.

A $5.00 drug screening fee will be added to the copay for any appointment that requires a urine drug screening.

❑ I **consent** to drug testing. ***(Minors - We do NOT conduct drug testing on minors unless specifically required, and only with prior parental or legal guardian consent.)***

❑ I **do not consent** to drug testing. By checking this option, I understand I will not receive any controlled medications. I have reviewed this form and understand the CEH policy above.

X______________________________ X____________________
Name of Patient (Print) Date

X______________________________ X____________________
Signature of Patient (or Parent/Legal Guardian) Date

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.

PATIENT'S RIGHT & 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.
- An individualized treatment plan to ensure quality care and coordination of care.

❑ I acknowledge the above information and my patient rights and responsibilities. A copy of the patient rights and consumer handbook for mental health from NC Department of Health and Human Services is available to me in each CEH office or by request.

X______________________________________ X____________________

Signature of Patient (or Parent/Legal Guardian) Date

NOTICE OF PRIVACY PRACTICES

Your health information is protected under HIPAA and federal confidentiality laws. CEH:
Will not release your information without written consent (except as permitted by law).
Will provide you access to your records (Requests may be denied per office policy).
Will not use or sell your data for marketing or fundraising.
You have been provided a copy of our Notice of Privacy Practices for your review and records.

I acknowledge I have received and understand CEH's Notice of Privacy Practices.

X____ X______________________
Signature of Patient (or Parent/Legal Guardian) Date

OUT OF STATE CONSENT - *(Please read and sign even if you are not an out-of-state patient)*

I confirm that I am seeking services from the Center of Emotional Health, a mental health facility licensed in North Carolina. I will be physically located within the state of North Carolina for all telehealth appointments.

OUT OF STATE CONSENT FOR VIRTUAL APPOINTMENTS

I consent to Telehealth virtual appointments and understand that this form of care is not an in-person communication. I acknowledge and agree to the following:

1. The provider will attempt to deliver medically appropriate care based on my history, test results, and available records.
2. Telehealth visits are not the same as in-person visits, and I understand their limitations.
   a. The telephone visit will substitute for an in-person session.
   b. The service is clinically appropriate, necessary and covered under my benefits.
3. I will ensure privacy during the visit and avoid distractions (e.g., not driving or multitasking).

X____ X______________________
Signature of Patient (or Parent/Legal Guardian) Date

INFORMATION & UPDATE ACKNOWLEDGEMENT

I acknowledge that all information and consents provided on this form are accurate and complete and will remain valid for the duration of my care at CEH. I understand that I am required to complete the Center for Emotional Health's annual paperwork update each year. I will also notify CEH promptly of any changes to my information at any time.

X____ X______________________
Signature of Patient (or Parent/Legal Guardian) Date