CENTER FOR EMOTIONAL HEALTH®

ANNUAL PATIENT INFORMATION & POLICY UPDATE

PATIENT INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

DOB: _____/_____/_____ **Sex:** ❑ **M /** ❑ **F**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (Cell): _____ **Phone (Home):** _____

Email: _____

Marital Status: _____

Employer: _____ **Occupation:** _____

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.

X_____ X_____

Signature of Patient (or Parent/Legal Guardian) Date

INSURANCE INFORMATION - (Please provide an updated copy of insurance ID card)

Insurance Provider: _____ **Medicaid:** ❑ Yes ❑ No

Subscriber/Member/Recipient ID Number: _____

(Medicaid - WellCare, HealthyBlue, and Carolina Complete - Please provide the recipient ID # and other ID # located on the insurance card)

Group Number (Does not apply to Medicaid)**:** _____

Provider Service Phone Number (Does not apply to Medicaid)**:** _____

Customer Service Phone Number (Does not apply to Medicaid)**:** _____

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CURRENT SYMPTOMS CHECKLIST:

- ❑ Depressed Mood
- ❑ Unable to Enjoy Activities
- ❑ Sleep Pattern Distubance
- ❑ 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: _____

_____

_____

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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

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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 (or Parent/Legal Guardian) 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 Patient (or Parent/Legal Guardian) Date

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Please read each statement carefully and thoroughly.
By initialing, you are stating you are aware and fully understand each policy statement.

_____ **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 no-show fee: $110.00
- Medication Management 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** - CEH does not offer disability services. CEH will provide records for disability claims initiated outside of CEH (subject to a fee paid in advance).

_____ **Medical Records** - $10 due in advance, requests may be denied per office policy, processing time takes 7-10 business days.

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

_____ **Medicare** - CEH does not accept any Medicare or Medicare supplemental plans as primary or secondary insurance. Please inform CEH if your insurance coverage changes to Medicare at any time. Patients who fail to inform of the changes may incur a balance, and/or are subject to discharge.

_____ **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.

_____ **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.

_____ **CEH Controlled Medications**

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.**

_____ **Update Acknowledgement** - I understand that I am required to complete the Center for Emotional Health's annual update paperwork each year. I will also notify CEH promptly of any changes to my information at any time.

By signing below, I affirm that all updated information provided on this form is accurate and valid. I have carefully read each policy statement and fully understand and acknowledge the policies outlined.

X_____ X_____

Signature of Patient (or Parent/Legal Guardian) Date