

NEW PATIENT INFORMATION FORM

PATIENT'S NAME: _____ **MIDDLE:** _____ **LASTNAME:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK OR CELL PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER** _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

FULL NAME: _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK OR CELL PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

GENERAL INSURANCE INFORMATION

Insurance Co. Name: _____ **Phone Number:** _____

Insurance ID Number: _____ **Insurance Group Number:** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth** _____

Policy Holder's

Employer: _____

Policy Holder's Relationship to the patient (Please check one) **Self** **Spouse** **Other** _____

PAYMENT METHOD

Visa/Mastercard **Cash** **Check** **Amount to be charged: \$** _____

Cardholder's Name: _____

Credit Card Number: _____ **ExpirationDate:** _____

Card Holder's Signature: _____ **Date:** _____

CONSENT FOR TREATMENT: *I, the undersigned, have voluntarily applied for and agree to participate in counseling and or psychological services. I hereby authorize Central Carolina Centers for Counseling, P.A. to release treatment and psychological information to my primary physician and health insurance carrier. I understand that I am fully responsible for all fees relating to my treatment which are not covered by my insurance plan and I further agree to pay my co-payment at the time of each visit. In the event I miss or cancel an appointment without 48 hours notice, I understand I am responsible for paying for the session.*

SIGNATURE:: _____ **DATE:** _____

GENERAL INFORMATION (PLEASE CHECK ALL THAT APPLY)

Marital Status

_____ *Single*
_____ *Married*
_____ *Other*

Employment Status

_____ *Employed*
_____ *Full Time Student*
_____ *Part Time Student*

Condition Related to:

_____ *Employment*
_____ *Auto Accident*
_____ *Other Accident*

BACKGROUND INFORMATION

Primary Care Physician: _____

Phone: _____

LIST ALL HOUSEHOLD MEMBERS BELOW:

| NAME | RELATIONSHIP | AGE | KEY WORDS |
|-------------|---------------------|------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you been in a committed relationship or marriage previously? _____ *No* _____ *Yes* _____ *# OF TIMES*

PLEASE CHECK ALL THAT APPLY

_____ *Have you ever attempted suicide?* _____ *Have you ever threatened to harm others?*
_____ *Are you currently suicidal?* _____ *Do you illicit drugs? How often?* _____
_____ *Have you ever been psychiatrically hospitalized?* _____ *Do you drink alcohol? How much per week?* _____

WHAT PROBLEMS BRING YOU IN FOR SERVICES AND HOW LONG HAVE YOU HAD THEM? _____

WHAT CHANGES DO YOU PLAN TO MAKE IN THERAPY? _____

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES: _____

Central Carolina Center for Counseling, PA

223 Highway 70
Suite #130
Garner, North Carolina 27529

Telephone (919) 772-9371
Fax (919) 779-6999

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name: _____ DOB _____

Address: _____

Home Phone: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations .

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations in which we may use or disclose your PHI. And other detailed information concerning your PHI.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If policy changes are made, a revision will be issued and made available. A copy of the Notice of Privacy is available for reference in our waiting area.

Right to Revoke: You have the right to revoke this consent at any time by giving written notice, submitted to the Garner office listed above. Please understand that revocation of this consent will not affect any action already taken in reliance to this consent. Treatment may be declined or discontinued without this consent.

Signature: I _____, have had the opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices of Central Carolina Centers for Counseling And Psychological Services, PA. I give my consent for use and disclosure of my PHI to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

Witness: _____ Date: _____

If this consent is signed by a personal representative on behalf of the client:

Representative: _____ Date: _____

Relationship to client: _____

Central Carolina Centers for Counseling, PA

CLIENT FINANCIAL POLICIES AND PROCEDURES

Missed Appointments/Cancellations: If you are unable to keep your appointment please provide 48 hours advance notice to avoid being billed a missed appointment charge of \$65.00. If you are calling after 3:00 pm, please leave a voice mail message at (919) 772-9371.

Co-Pays and Deductibles and Fees: Payment is due at the time of each visit. We accept cash, checks, and credit cards. If you need to make special financial arrangements please talk with Dr. Norris prior to your appointment.

Credit Cards: If you elect to leave a credit card on file with our office, all co-pays, deductibles, and missed appointment charges will be charged to your credit card the day of your scheduled appointment.

Return Checks: All return checks will be charged an additional \$25.00 to cover bank charges and processing costs.

Insurance Information: It is the client's responsibility to notify our office of all insurance changes and provide us with updated information. Charges not covered by the insurance company are the responsibility of the client.

Contacting Patient for Billing Purposes: In order for Central Carolina Centers for Counseling or its representatives to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending e-mails, using any email address you provide us.

Completion of Forms: A fee of \$25 per form will be charge as patient responsibility for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability and FMLA.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY AND PROCEDURES. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS THIS NEEDS TO BE BROUGHT TO OUR ATTENTION PRIOR TO BEING SEEN.

I understand and agree to the provisions stated above.

Signature

Date

Central Carolina Centers for Counseling, PA

Client's Name: _____ Today's Date: _____

INITIAL MENTAL HEALTH WELLNESS ASSESSMENT

Thinking about your experiences in the past week, please respond to the following symptoms.

| | Not at All | A little | Somewhat | A Lot |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>Nervousness or shakiness</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Feeling sad or blue</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Feeling hopeless about the future</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Feeling no interest in things</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Your heart pounding or racing</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Trouble Sleeping</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Feeling fearful or afraid</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Difficulty at home</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Difficulty socially</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Difficulty at work or school</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

How much do you agree with the following?

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>I feel good about myself</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I can deal with my problems</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I am able to accomplish the things I want</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I have friends or family I can count on</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please answer the following questions:

In general, would you say your health is ___Excellent ___Very Good ___Good ___Fair ___Poor

Do you have any serious medical conditions: ___Asthma ___Diabetes ___Heart Disease ___Chronic Pain ___Other, please explain: _____

In the past 6 months how many times did you visit a medical doctor: ___None ___1-3 ___4-5 ___6+

In the past 6 months how many days were you unable to work due to your physical or mental health: _____ days

In the past 6 months how many days did you have to cut back on how much you worked due to your physical or mental health? _____ days.

In the past month have you felt you ought to cut down on your drinking or drug use: ___yes ___no

In the past month have you felt annoyed by people criticizing your drinking or drug use: ___yes ___no

In the past month have you felt bad or guilty about your drinking or drug use: ___yes ___no