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	***Employment Status***	***Condition Related to:***
_____ *Single*	______ *Employed*	______ *Employment*
_____ *Married*	______ *Full Time Student*	______ *Auto Accident*
_____ *Other*	______ *Part Time Student*	______ *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 INFORMATION SHEET

Appointments: 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 are 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.

I have read and accepted 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
Nervousness or shakiness	☐	☐	☐	☐
Feeling sad or blue	☐	☐	☐	☐
Feeling hopeless about the future	☐	☐	☐	☐
Feeling no interest in things	☐	☐	☐	☐
Your heart pounding or racing	☐	☐	☐	☐
Trouble Sleeping	☐	☐	☐	☐
Feeling fearful or afraid	☐	☐	☐	☐
Difficulty at home	☐	☐	☐	☐
Difficulty socially	☐	☐	☐	☐
Difficulty at work or school	☐	☐	☐	☐

How much do you agee with the following?

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel good about myself	☐	☐	☐	☐
I can deal with my problems	☐	☐	☐	☐
I am able to accomplish the things I want	☐	☐	☐	☐
I have friends or family I can count on	☐	☐	☐	☐

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 may time did you visit a medical doctor: ___None ___1-3 ___4-5 ___6+

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

In the past 6 months how may 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