

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 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