



# Carolina Psychiatry P.C.

## Authorization for Treatment

Today's Date: \_\_\_\_\_

### Patient Information:

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Language: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Spouse (or responsible party name): \_\_\_\_\_

Spouse (or responsible party employer): \_\_\_\_\_

Business Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

SSN: \_\_\_\_\_ If Military Rank: \_\_\_\_\_ Active: \_\_\_\_\_ Retired: \_\_\_\_\_

### Insurance Information:

Do you have medical Insurance: (please circle) Yes / No

If no: will you be paying by: (please circle) Cash Check Credit Card

If yes: Primary Insurance? \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

In case of emergency, notify

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Pharmacy Information:

Your Drugstore Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/ or dependents. I further expressly agree and acknowledge that my signature of this document authorizes the physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each claim. I further understand that I am responsible for any co-pay and/ or deductible amount as per my particular insurance coverage on my account and that although my claims are filed; it's not a guarantee of benefits.

I, \_\_\_\_\_, hereby authorize, Carolina Psychiatry, to pay and hereby assign directly to Carolina Psychiatry, P.C. all benefits, if any, otherwise payable to me for his/ her services as described on the attached forms. I further acknowledge that any insurance benefits, were received by and paid to Carolina Psychiatry, P.C. will be credited to my account in accordance with the above said assignment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Carolina Psychiatry P.C.

## Adult History Form

To be completed by patient.

All information on this will be confidential

The following information will be helpful in our work together

## Personal History

### Family

Marital Status: \_\_\_\_\_ # of Marriages? \_\_\_\_\_ # of Pregnancies? \_\_\_\_\_

Do you have any children? Yes / No If "Yes", please list:

Name	Age	Birth/ Step/ Adopted	Living With You

### Work/ School

What kind of work do you do?

\_\_\_\_\_

How long have you done this type of work? \_\_\_\_\_

How many employers/ jobs have you had in the last five years? \_\_\_\_\_

Have you had any problems in the workplace?

\_\_\_\_\_  
\_\_\_\_\_

Have you served in the military? Yes No If "Yes", branch: \_\_\_\_\_

What is your spouse/ partner occupation? \_\_\_\_\_

Do you have any financial problems? \_\_\_\_\_

Highest grade or degree you completed in school: \_\_\_\_\_

Do you now or have you ever had any problems in school: Yes No If "Yes" please explain.

\_\_\_\_\_  
\_\_\_\_\_





# Carolina Psychiatry P.C.

Do you have any medication allergies?      Yes / No      If yes please explain:

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What is the reaction:

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Other allergies?      Yes / NO      If yes please list:

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Reaction: \_\_\_\_\_

Have you ever had surgery? If yes please list:

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## Family History

Is your father living?    Yes / No      Is your mother living    Yes / No

Please list the ages and sex of any brothers or sisters and indicate if any are deceased:

Name	Age	Sex	Living / Deceased

Have any of your blood relatives ever had any of the following?

Please check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Depression                     | <input type="checkbox"/> Schizophrenia            |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcohol or Other Drug Problems | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Violent Behavior               | <input type="checkbox"/> Liver Disease            |
| <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Nerves                         | <input type="checkbox"/> Other emotional problems |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Bipolar Disease                |   |



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Have you ever seen a psychologist or counselor before?      Yes    /    No    If "YES", please list:

Name	Date From- Till	Problem	Did it help?

Please list any medications you have taken in the past to treat mental health problems:

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Have you ever been hospitalized because of mental health problems? Yes    /    No    If yes please explain:

Name	Date from- Till	Problem	Did it Help?

Have you ever attempted suicide?      Yes    /    No    If "Yes", how and when:

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Has anyone close to you attempted or committed suicide?      Yes    /    No    If "Yes", who?

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Do you have any current thoughts about hurting yourself or committing suicide?      Yes    /    No

Do you have any current thoughts about hurting or killing someone else?      Yes    /    No

Do you have any history of hurting others mentally, physical, or sexually?      Yes    /    No

Please describe any current or past drug usage:

Drug	Currently Use (Y/ N)	How much/ How Often	Last Used
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Heroin			
LSD			
Amphetamines			
Barbiturates			
Prescription Pain Medication			
Other:			



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Have you ever felt that you need to cut down on your drinking or drug use?      Yes / No

Have you or others ever been annoyed by your drinking or drug use?      Yes / No

Have you ever felt bad or guilty about your drinking or drug use?      Yes / No

Have you ever had a drink or used drugs first thing in the morning  
to steady your nerves or get rid of a hangover or just to get the day started?      Yes / No

Have you ever been in treatment for drug or alcohol problems      Yes / No

If "Yes", please list:

Program	When	Problem	Did it Help?

Please check any of the following problems you have experienced in the past six months.

- Nightmares
- Sleeping too little
- Sleeping too much
- Eating problems
- Self-Care or grooming
- Mood Swings
- Irritability
- Crying spells
- Anxiety Attacks
- Worrying
- Can't concentrate
- Racing thoughts
- Unusual thoughts
- Unusual fears
- Dizziness
- Nausea
- Breathing problems
- Lack of energy
- Heart palpitations
- Blackouts
- Constipation
- Headaches
- Vomiting
- Tremors
- Fainting
- Diarrhea
- Difficulty urinating
- Sexual problems
- Hearing voices
- Seeing things that are not there
- Night Sweats

Are there any additional problems or major life events that would be important to your care?

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**For Staff Use Only (Check One)**

Base on the information in the medical history of this patient

- Has been referred to his/ her primary care physician for a physical exam
- Has medical condition(s) and is already under care of his/ her primary care physician.
- is not reporting any medical condition(s) requiring his/ her primary care physician intervention at this time.

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date



# Carolina Psychiatry P.C.

## Primary Care Mood Disorders Questionnaire

1	Has there ever been a period of time when you were not your usual self and (while not using drugs or alcohol)...	YES	NO
	...you felt so good or so hyper that other people thought you were not your normal self; or hyper that you got into trouble?	YES	NO
	...you were too irritable that you shouted at people or started fights or arguments?	YES	NO
	...you felt much more self-confident than usual?	YES	NO
	...you got much less sleep than usual and found you really didn't miss it?	YES	NO
	...you were much more talkative or spoke faster than usual?	YES	NO
	...thoughts raced through your head or you couldn't slow your mind down?	YES	NO
	...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	YES	NO
	...you had much more energy than usual?	YES	NO
	...you were much more active or did many more things than usual?	YES	NO
	...you were more social or outgoing than usual; for example, you telephone friends in the middle of the night	YES	NO
	...you were much more interested in sex than usual?	YES	NO
	...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	YES	NO
	...spending money got you or your family into trouble	YES	NO

2.	If you checked yes to more than one of the above, have several of these ever happened during the same period of time?	YES	NO
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3.	How Much of a Problem did any of these cause you – Like being unable to work; having family, money or legal troubles; getting into arguments or fights? (circle one)	YES	NO
	NO PROBLEM    MINOR PROBLEM    MODERATE PROBLEM    SERIOUS PROBLEM		

4.	Draw a line connecting any (blood relative to any problem (this doesn't have to be neat):
	Parents      Grandparent      Aunts/Uncles      Brothers/ Sisters      Children
	Suicide    Alcohol/ Drug Problems    Mental Hospital    Depression Problems    Manic or Bipolar

5.	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	YES	NO
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Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_



# Carolina Psychiatry P.C.

## Child/Adolescent (Ages 4-18)

*Parent/Legal guardian / Foster parent of the child*

Name:

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Address:

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Phone Number:

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	Father's Information	Mother's Information
Address		
City, State, Zip		
Phone Number		
Occupation		
Employer		

Where was child born?

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Was the pregnancy full term? (9 months):      Yes \_\_\_\_\_ No \_\_\_\_\_

If the child was born early, how many weeks early? \_\_\_\_\_

Place of delivery? Home \_\_\_\_\_ Hospital \_\_\_\_\_ Other \_\_\_\_\_

Type of delivery? Vaginal \_\_\_\_\_ C-section \_\_\_\_\_ Birth Weight: \_\_\_\_\_

How long was child in hospital after delivery? \_\_\_\_\_

Were there any major problems during the first year of life?

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Hospitalizations?

Seizures?

Head Injury?

Other?

Are patient's immunizations current?

Yes \_\_\_\_\_ No \_\_\_\_\_

Name of school: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_

Has child ever repeat or failed a grade?

Yes \_\_\_\_\_ No \_\_\_\_\_

Does child have any special help or classes at school?

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# Carolina Psychiatry P.C.

## Authorization for Use and Disclosure of Protected Health Information

45 C.F.R. Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C

This authorization from implements the requirements for client authorization and to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2) and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C)

CLIENTS' NAME: \_\_\_\_\_

PATIENT NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SSN: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize Carolina Psychiatry, P.C. 548 Sandhurst Drive Fayetteville, NC 28304 to use, exchange or disclose to/with (Please list name of agency or person to whom the requested use or disclosure will be made. Include name and address if applicable below)

\_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

THIS DATA SHALL INCLUDE (Client is encouraged to initial beside data to be used or disclosed)

\_\_\_ Assessments

\_\_\_ Discharge Summary

\_\_\_ Psychiatric Evaluations

\_\_\_ Financial/Reimbursement

\_\_\_ Psychological Evaluations

\_\_\_ Substance Abuse/Treatment

\_\_\_ Diagnoses

\_\_\_ HIV/ AIDS Information

\_\_\_ Service Notes

\_\_\_ Social, Developmental, Medical History

\_\_\_ Service Plan/ Goals

\_\_\_ Other: \_\_\_\_\_

Information requested should be mailed to this address:

**Carolina Psychiatry P.C. 548 Sandhurst Drive Fayetteville NC, 28304 or Faxed to 910-484-3404.**

### REDISCLASURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information protected by state law (G.S. 122C) or substance abuse treatment information protected health information protected by federal law (42 C.F.R. Part), we must inform the recipient of the information that disclosure is permitted or required by these laws.

### REVOCAION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, and explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

Date of Expiration: \_\_\_\_\_

Event, if less than one year: \_\_\_\_\_

### NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Carolina Psychiatry, P.C. will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

\_\_\_\_\_  
Client (Print)

\_\_\_\_\_  
Client (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Legally Responsible Person (Print)

\_\_\_\_\_  
Parent/ Legally Responsible Person (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Print)

\_\_\_\_\_  
Witness (Signature)

\_\_\_\_\_