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**

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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.

_____

_____

Additional Information

Have you ever been arrested? Yes No Dates Incarcerated: _____

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Reason: _____

Result: _____

Has Spirituality been important in your life? Yes / No

Are you active in a church, synagogue, mosque, or community organization? Yes / No

What are some of your hobbies/ interest:

_____

_____

Sexual Orientation (circle answer): Heterosexual Homosexual Bisexual

Medical History

Who is your family/ primary care doctor? (Please include phone number):

_____

_____

During the last 6 months, have you had any problems performing daily actives as a result of physical problems?

YES NO

(If yes please explain.)_____

_____

_____

Are you presently experiencing physical pain? Yes / No

If yes, on a scale of 1(least) to 10 (most) how server is your pain? _____ **Where is your pain?** _____

What does the pain feel like (i.e., sting, ache, radiate, etc.)

_____

_____

Do you have any health problems which need to be addressed by your primary care physician? Yes / No

If yes please explain:

_____

_____

_____

Please List all medications that you currently take:

Medication Name	Dose/ Times per Day	Who Prescribed?

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

_____

_____

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What is the reaction:

_____

_____

Other allergies? Yes / NO If yes please list:

_____

_____

Reaction: _____

Have you ever had surgery? If yes please list:

_____

_____

_____

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 decreased:

Name	Age	Sex	Living / Deceased

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

Please check all that apply:

□ Diabetes
□Depression
□Schizophrenia
□Heart Disease
□Alcohol or Other Drug Problems
□High Blood Pressure
□Stroke
□Violent Behavior
□Liver Disease
□Lung Disease
□Nerves
□Other emotional problems
□Cancer
□Bipolar Disease

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

Name	Date From- Till	Problem	Did it help?

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

_____

_____

_____

_____

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:

_____

_____

_____

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

_____

_____

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:			

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

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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 palpations
□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?

_____
_____
_____
_____
_____
_____

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**

Primary Care Mood Disorders Questionnaire

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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 that usual?	**YES**	**NO**
	…you got much less sleep that 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 that usual?	**YES**	**NO**
	…you were more social or outgoing that 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**

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)** **NO PROBLEM MINOR PROBLEM MODERATE PROBLEM SERIOUS PROBLEM**	**YES**	**NO**

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**

Your Name: _____Today's Date: _____

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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
___Psychiatric Evaluations
___Psychological Evaluations
___Diagnoses
___Service Notes
___Service Plan/ Goals
___Other:_____
___Discharge Summary
___Financial/Reimbursement
___Substance Abuse/Treatment
___HIV/ AIDS Information
___Social, Developmental, Medical History

Information requested should be mailed to this address:

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

REDISCLOSURE

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.

REVOCATION 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)