Celeste Good, MD
Kathy Mayo, MD
Susan Lally, NP
Donna Rackley, NP
Jonathan Ganfin, NP

Jean Hansson, MSW, LCSW
Cathy McLean, LMFT

1103 Corporate Drive Suite A • Greenville, NC 27858 • (252) 758-6080 • Fax (252) 758-0009

PATIENT INFORMATION FORM

Cell Phone _____

Name _____ Home Phone _____ Work Phone _____

Home Address _____ City _____ Zip Code _____

Spouse Name _____ Work Phone _____

Nearest Friend Not Living With You _____ Phone _____

Nearest Relative Not Living With You _____ Phone _____

Physician _____ Phone _____

Whom May We Contact in Case of Emergency? _____ Phone _____

Whom May We Thank for Referring You to Us? _____ Phone _____

Social Security # _____ Date of Birth _____

Who is Financially Responsible for This Bill? _____

Home Address _____ City _____ Zip Code _____

Will Be Paying Today By: Cash _____ Check _____ Credit Card _____

Insurance Company _____ Policy# _____

Policy Holder Name _____ Relationship _____

Employer _____

Social Security # _____ Date of Birth _____

I authorize Medical Park Psychiatric Associates to release any information acquired in the course of my mental health treatment to my insurance company and assign the insurance payment to my designated doctor or therapist.

Signature _____ Parent/Guardian _____ Date _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my it for any professional services rendered. I have read all of the information on both sides of this sheet and have completed above answers. I certify that this information is correct to the best of my knowledge. I will notify you of changes in my health status or the above information. Should my account become delinquent and require collection service, I agree to pay all reasonable collection and handling charges on the outstanding balance.

Signature _____ Parent/Guardian _____ Date _____

Associates Medical Park
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OFFICE POLICIES

Our commitment is to provide you with the best possible mental health care. With this goal in mind please understand the following office policies.

Payment for services is due at the time services are rendered. We accept cash, checks, Master-Card or Visa. The assessed return check fee is $30.00. Failure to make restitution within 10 days may result in legal action. This could also prevent the acceptance of your check in the future.

We must emphasize that as a mental health provider, our relationship is with you, not your insurance company. To ensure payment, you should contact your insurance company for pre-authorization to receive services in our office. It is your responsibility to understand your insurance policy for your mental health benefits. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. You are required to notify us of any insurance change within 60 days. Failure to do so will result in a processing fee of $30.00. This fee is the patient's responsibility and is not covered by your insurance company.

Your next appointment time will be made at checkout window. If you are unable to keep an appointment, please notify the office 24 hours in advance. Failure to do so will result in a charge for the missed appointment. The answering service is open 24 hours everyday, so notice of cancellation can be given at any time.

Generally there is no charge for brief telephone calls unless they become unusually frequent or lengthy, in which case you will be charged.

There is a $35.00 charge for completion of all single page disability/insurance forms (8 1/2x11). Each additional page is at the physician's discretion not to exceed $150.00. This charge is the patient's responsibility and must be paid in full before the form will be completed.

_____ _____

Patients Signature Parent/Guardian

_____

Date

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PRESCRIPTION POLICY

If you are on medication prescribed by one of our psychiatrists, you are required to request prescriptions at your scheduled appointment time. There is a $25.00 charge for prescription request in between appointment's and any time office is closed. You will be charged $10.00 for completion of prior authorization required by your insurance company for prescribed medication. This policy will be enforced. Your insurance company will not pay for these charges.

_____ _____

Patient's Signature Parent/Guardian

_____

Date

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Medical Park Associates is not responsible for the confidentiality of patient information once given to your insurance company or managed care company.

Patient Acknowledgement

Signature

Parent/Guardian

Date

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WAIVER STATEMENT

Provider Notice

Managed Care companies (i.e., Cigna, Magellan) will only pay for services that are contracted with Medical Park Psychiatric Associates.

I believe that, in my case, the Managed Care Company will deny payment for No Shows and preparation of forms, insurance disability forms and letters.

Patient Agreement

I have been notified by my provider that my Managed Care Company will deny payment for the services identified above. If payment is not made by my Managed Care Company, I agree to be personally and fully responsible for payment.

Medical Park Associates is not responsible for the confidentiality of patient information once given to your insurance company or managed care company.

Patient Acknowledgement

_____ _____

Signature Parent/Guardian

_____

Date

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WAIVER STATEMENT

Medicare will only pay for services that are determined To be "reasonable and necessary" under Section (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary" under Medicare program standards Medicare will deny payment for that sendee. I believe that, in your case. Medicare is likely to deny payment for No Shows and completion of disability insurance forms for the following reason: NOT COVERED.

Beneficiary Agreement

I have been notified by my provider that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If Medicare denies payment I agree to be personally and fully responsible for payment.

Patient Acknowledgement

_____ _____

Signature Parent/Guardian

_____

Date

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPPA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your PHI

Your privacy rights in your PHI

Our obligation concerning the use and disclosure of your PHI

The terms of the notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain, in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Operations Manager
707 W.H. Smith Blvd.
Greenville, NC 27834
252-758-6080

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment with your consent. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use or disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Disclosure Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use and disclose your PHI:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

   Reporting child abuse or neglect
   Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

4. **Workers Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

We have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Operations Manager, 252-758-6080 specifying the requested methods of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for the request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care. In order to request a

restriction in our use or disclosure of your PHI, you must make your request in writing to the Operations Manager, 252-758-6080.
Your request must describe in a clear and concise fashion:

(a) the information you wish restricted
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing, but not including psychotherapy notes. You must submit your request in writing the Operations Manager, 252-758-6080 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Operations Manager, 252-758-6080. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All our patients have the right to request an "accounting of disclosures." An "Accounting of Disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operation purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or billing department using your information to file your insurance claim. In order to obtain an accounting disclosures, you must submit your request in writing to the Operations Manager, 252-758-6080. All requests for an "accounting disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at anytime. To obtain a paper copy of this notice, contact the Operations Manager, 252-758-6080.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file with our practice, contact the Operations Manager at 252-758-6080. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right To Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reason described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policy please contact the Operations Manager at 252-758-6080.

Receipt of Notice of Privacy Practices Written Acknowledgement Form.

I,_____, have received a copy of Medical Park Psychiatric Associates Notice of Privacy Practices.

_____ _____

Signature of Patient Parent/Guardian

_____

Date

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Controlled Substance Agreement

My physician and I have a common treatment goal to improve my ability to function and/or work. In consideration of that goal, I am being treated with medications such as benzodiazepines, stimulants, or hypnotics. These medications may impair my alertness, reflexes, coordination and judgment. The use of these types of medications is controlled and monitored by local, state and federal agencies. These medications can be highly effective when taken as directed under medical supervision but have the potential of abuse and misuse.

I have been informed that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my physician's guidance and participate in any treatment programs recommended, which may include medical detoxification, psychological counseling pertaining to substance misuse.

I have never been diagnosed with or treated for a substance use problem. I have never been involved in the illegal sale, possession or transportation of controlled substances.

I understand that the giving or sale of my prescription medication to any other person is illegal and WILL result in my dismissal from Medical Park Psychiatric Associates as well as being reported to law enforcement officers.

I have been informed by my psychiatrist and I understand I should not consume alcohol with taking these types of medications.

I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or doing any other activity in which alertness, reflexes, coordination and/or judgment are necessary.

For women: I am not pregnant.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

1. I will follow the treatment plan that my psychiatrist and I have agreed upon.

2. I agree to always be truthful with all my psychiatrist and my other physicians regarding my history, illness, and use of medication.

3. I will report any suspected side effects to my psychiatrist immediately.

4. I understand that my psychiatrist is not obligated, nor wilt he/she automatically refill prescriptions for controlled medications that I have been receiving from another physician.

5. I will not ask for, nor accept controlled substance medications or prescriptions from any other individuals or physicians while I am receiving such medications from Medical Park Psychiatric Associates. This is not only ILLEGAL but could endanger my health. The only exception to this would be if I were hospitalized.

6. I will take the medications as directed. If I use my medication up sooner than prescribed, lose my prescription or medication, or if my medication is stolen, I understand Medical Park Psychiatric Associates will not refill my medication until it is time for the scheduled refill.

7. I will bring the unused portion of my medication to the office for a medication count if requested by my psychiatrist.

8. In the event that my prescription needs to be changed to another medication, I understand I may be asked to return the remaining portion of the prior prescription for disposal.

9. I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my psychiatrist to be re-evaluated before my medication will be increased.

10. I understand that stopping my medications abruptly maybe dangerous and lead to withdrawal symptoms, including increased anxiety, sweats, tremors, nausea, vomiting and possible seizures, hallucinations or confusion. If medications need to be discontinued, I will follow my psychiatrist's supervision.

11. I will submit to drug testing if required, including urine, saliva or hair testing.

12. I authorize Medical Park Psychiatric Associates and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy, In the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize Medical Park Psychiatric Associates to provide a copy of this agreement to my pharmacy. I also authorize my pharmacy to provide records documenting prescriptions that I have received to Medical Park Psychiatric Associates, if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

13. I am responsible for keeping track of the amount of medication and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours by Medical Park Psychiatric Associates.

14. For women: am not pregnant and agree to utilize birth control at all times while taking these types of medications. Should I become pregnant, I agree to notify Medical Park Psychiatric Associates. I will accept the risk to my baby and myself if I should use these medications while pregnant.

My signature below means I have read and understand the terms of this agreement and have had questions answered to my satisfaction. I understand if I violate this agreement, my controlled substance prescriptions and/or treatment will be terminated immediately, and I will be dismissed from Medical Park Psychiatric Associates.

Patient Name (Print): _____ MRN _____

Patient Signature: _____ Date: _____

Physician Name (Print): _____ Date: _____

Physician Signature: _____