Patient Information Update 2024

Patient First Name:_____ Last Name:_____

D.O.B.:_____ SSN:_____

Address:_____

_____

Home Phone:_____ Best Contact: Home / Cell

Cell Phone:_____ Best Message: Email / Text/ Phone

Emergency Contact: Name:_____ Contact Number:_____

****Mandatory****Please provide your email address for Patient Online Portal Registration.*

Email address:_____

****Please note that once you are registered with the ***patientonlineportal.com***, you will be able to check appointment times, message the front staff and your provider directly, as well as update your information.****

Insurance Information

Primary Insurance Name:_____ ID/Policy ID:_____

Secondary Insurance Name:_____ ID/Policy ID:_____

Pharmacy Name and Phone Number:_____

Cell phones in the waiting room need to have the volume off. Also, please refrain from taking any calls or playing music/games with sound as it causes disturbances

MEDICATION(S) CONSENT FORM

By becoming a patient of a provider at Psychiatric Services of Carolinas, PC, I understand that medication(s) can be prescribed to me, myself, or _____ a person for whom I am the legal guardian and I consent to be prescribed medication.

It is recommended that women who are pregnant, breastfeeding, or who are trying to become pregnant discuss this with their doctor before taking any medications.

It is recommended that patients become educated on reporting all side effects they experience, including but not limited to which side effect to report immediately to a health care provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include, but may not be limited to:

1. What medications (prescribed and over the counter) the patient is or has been taking.
2. What food/drug allergies the patient has.
3. What medical conditions the patient has.

Those patients who are prescribed controlled substances, including but not limited to benzodiazepines, stimulants, and/or Suboxone are required to complete a drug screening on a routine and/or random basis. These patients may also be required to see the provider more frequently as these medications have a high potential for dependence and abuse and must be closely monitored.

_____ _____

Patient/Guardian Signature Date

_____ _____

Provider Signature Date

CONSENT FOR TREATMENT INCLUDING EMERGENCY MEDICAL TREATMENT

I hereby, voluntarily grant authorization for such treatment, procedures and other therapies that may be deemed necessary and recommended by my attending physician. I also grant permission to seek emergency medical care from a hospital or physician as well as the Mobile Crisis Units which may be deemed necessary and appropriate by my attending physician.

I consent for myself or on behalf of the patient named above the selection and assignment of a physician and/or clinician and agree to make arrangements with the physician and/or clinician for obtaining diagnosis and continuation of treatment as needed.

I certify that I have read the above consent for the patient treatment and fully understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from this treatment.

_____ _____

Patient/Guardian Signature Date

Psychiatric Services of Carolinas, PC

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ D.O.B.: _____

Many of our patients allow family members such as spouse, parents, or others to call and request appointment dates/times, billing information, and/or medication information. Under the Health Insurance Portability and Accountability Act (HIPAA) requirements, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your appointment dates/times, billing information and/or medication information released to family members, you must sign this form. Your signing this form will only give information to family members indicated below.

Additionally, the HIV/AIDS related conditions statue for protection mandates that the information will only be released in accordance with G.S. 130A-143 (CONFIDENTIALITY OF RECORDS) and the statues for Substance Abuse include "Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law 45 CFR Part 164 (PRIVACY OF INDIVIUALLY IDENTIFIABLE HEALTH INFORMATION) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it". Other laws, however, may prohibit re-disclosure. When information is released from this agency protected by state law (NC G.S. 122C) or substance abuse treatment information protected by federal law 42 CFR, Part 2 (CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS), the recipient of the information is informed of that consent voluntarily. Re-disclosure is prohibited except as permitted or required by these two laws.

Please check what information you would like to release to each person you put on the list.

A= Appointment Dates/Times **B**= Billing Information **M**= Medication Information

I authorize Psychiatric Services of Carolinas to release my medical and/or Billing information to the following:

1. _____ Relationship to Patient _____ **A B M**
2. _____ Relationship to Patient _____ **A B M**
3. _____ Relationship to Patient _____ **A B M**
4. _____ Relationship to Patient _____ **A B M**

I understand that I have the right to revoke this authorization in writing at anytime.

Signature: _____ Date: _____

This Authorization for Release of Information expires one year from the date of signature

Expiration Date: _____

I do not wish to release any of my information to anyone at any time

Signature: _____ Date: _____

2024 Patient Policy Updates

Attendance Policy:

Patients must come in to their appointments in order to receive medication. If a patient misses more than 1 appointment (this includes no shows, cancellations and rescheduled appointments or late arrivals), medications may not be sent in (especially controlled substance medications.)

If patients arrive 10 minutes past their appointment times, there is **NO** guarantee that they will be seen or medication will be sent in. After 3 no show, late cancels or late arrivals (that result in late cancels), the patient's chart will be up for review and/or discharge.

Medication Policy:

Controlled Substance medications are required by law to be monitored. This means that this office, is now implementing a stricter policy in adherence to the law. This means that the providers are starting to lower the dosages of some medications to a safer dosage. With that being said, urine drug screens are required as well. If patients are unable to provide a sample, controlled medications, may not be prescribed.

If a drug screen is failed, the provider has no obligation to send in controlled medication. In this case or in the case of discharge, the policy is based on the situation. The provider has the following options; to not send in any medication if their medications are not in the patient's system, provide a taper down dose to wean the patient off of medications or send in medication for 2 weeks to 1 month in order to provide patients with time to find a new provider.

Conduct:

Psychiatric Services of Carolinas expects all of our patients to conduct themselves appropriately. This includes no cursing, no yelling, no violence, no harassment and no sexual remarks or actions. This includes actions to other patients or staff.

Failure to comply with any of these policies may result in discharge from our facility.

Patient Name:_____ Date:_____

Patient Signature:_____