PATIENT INFORMATION

Please Print

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: _____ GENDER IDENTITY: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

RACE (OPTIONAL): ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER RACE

ETHNICITY (OPTIONAL): ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

PHONE:_____ WORK PHONE: _____ CELL PHONE: _____

PREFERRED PHONE (circle one): H W C SOCIAL SECURITY #:_____ DATE OF BIRTH: _____

WHO REFERRED YOU TO CAROLINA PARTNERS? _____

PATIENT EMPLOYER INFORMATION: ☐ EMPLOYED ☐ STUDENT ☐ OTHER

COMPANY: _____ EMPLOYER PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____
(OPTIONAL)

☐ YES, I'D LIKE TO OPT IN TO THE CPMH MAILING LIST FOR OCCASSIONAL NEWS AND COUPONS

RESPONSIBLE PARTY INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: _____ GENDER IDENTITY: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

PHONE:_____ WORK PHONE: _____

SOCIAL SECURITY #:_____ DATE OF BIRTH: _____

RELATIONSHIP TO THE PATIENT: _____

RESPONSIBLE PARTY EMPLOYER INFORMATION: ☐ EMPLOYED ☐ STUDENT ☐ OTHER

COMPANY: _____ EMPLOYER PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT'S PRIMARY CARE DOCTOR

DOCTOR: _____ NAME OF PRACTICE: _____

PHONE:_____ ADDRESS: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ INSURANCE ID NUMBER OF THE **PATIENT:** _____

INSURANCE ADDRESS:_____CITY: _____ STATE: _____ ZIP: _____

INSURANCE CO PHONE:_____ GROUP NAME OR NUMBER:_____

POLICY DATES: FROM: _____ TO: _____ EMPLOYER PLAN: ☐ YES ☐ NO

INSURED PARTY NAME: _____

INSURED PARTY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED PARTY PHONE: _____

INSURED PARTY SOCIAL SECURITY NUMBER: _____ **INSURED PARTY** DATE OF BIRTH: _____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____

I hereby authorize payment directly to the physician of the surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient or Responsible Party Signature: **DATE:**

PLEASE READ CAREFULLY AND COMPLETE

I have read the Policy and Procedures and understand and accept the policies described above. I would rather:

☐ Pay each visit in full (and file my own insurance).

☐ Pay my insurance co-payment and other fees each session and have my insurance filed for me.

☐ Make an alternative plan that must be specific and accepted by Carolina Partners in Mental HealthCare, P.L.L.C. This option needs to be discussed with your clinician and approved in order to take effect.

Patient Name Printed: _____

Patient or Responsible Party Signature:_____ Date:_____

Clinician's Signature:_____ Date:_____

Witness:_____ Date:_____

INSURANCE AUTHORIZATION

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM.

☐ I authorize use of this form on all my insurance submissions.

☐ I authorize release of information to all my insurance carriers.

☐ I understand that I am responsible for my bill.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

☐ I authorize payment directly to my doctor or other health care provider, and hereby assign my right to reimbursement for services rendered to Carolina Partners in Mental HealthCare, P.L.L.C.

☐ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Signature:_____ Date:_____

FINANCIAL ACCEPTANCE FORM

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICE. THANK YOU.

We will make your payment as easy and convenient as possible. You may pay by cash, check, credit card, or debit card. Please read the following and sign at the bottom to accept these terms.

I _____, agree to pay my co-pay, deductible, co-insurance, and any past-due balance on my account at the time of service.

Patient or Responsible Party Signature:_____ Date:_____

I would like to pay on a monthly basis with the following card information **(Optional):**

_____ Debit Card # _____ Expiration Date_____

Name on Card _____

_____ Credit Card # _____ Expiration Date _____

Name on Card _____ Type of Card _____

I authorize Carolina Partners in Mental HealthCare, PLLC to charge any past due balances on my account to the above credit or debit card number on a monthly basis.

Patient or Responsible Party Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

This **ACKNOWLEDGEMENT** THAT WE HAVE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR "NOTICE OF PRIVACY PRACTICES" is required by federal law. Thank you for your cooperation.

I, _____ , acknowledge that I have received from
Patient Name Printed

Carolina Partners in Mental HealthCare, PLLC the "Notice of Privacy Practices" and have had adequate opportunity to read and review the document.

CONSENT TO TREATMENT

I, _____ , agree to receive treatment from Carolina
Patient Name Printed

Partners in Mental HealthCare, PLLC. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

Patient or Responsible Party Signature:_____ Date:_____