LAST NAME:		FIRST NA	AME:			_ MIDDLE INIT	IAL:
ADDRESS:							
SEX:							
RACE (OPTIONAL):	] AMERICAN INDIAN	I OR ALASKA NATIV	E 🗌 ASIAN	BLACK O	R AFRICAN AN	<b>IERICAN</b>	
C	] NATIVE HAWAIIAN	OR OTHER PACIFI	C ISLANDER	WHITE	OTHER 1	RACE	
ETHNICITY (OPTIONAL	: HISPANIC O	R LATINO 🗌 NO	T HISPANIC OR	LATINO			
PHONE:		WORK PHONE:		CELL	PHONE:		
PREFERRED PHONE (	ircle one): H W	C SOCIAL SE	CURITY #:		DATE C	)F BIRTH:	
WHO REFERRED YOU	TO CAROLINA PART	NERS?					
PATIENT EMPLOYER II	FORMATION:	EMPLOYED	STUDENT	OTHER			
COMPANY:			EMPLOY	ER PHONE #: _			
ADDRESS:			CITY:		STATE	: ZIP:	

EMAIL: (OPTIONAL)

#### **RESPONSIBLE PARTY INFORMATION**

LAST NAME:		_ FIRST NAME:		MIDDLE INITIAL:		NITIAL:
ADDRESS:		CITY:		STATE:	ZIP	:
SEX:	_ GENDER IDENTITY:		MARITAL STATUS:	SINGLE	MARRI	ED 🗌 OTHER
PHONE:	WORK P	HONE:		_		
SOCIAL SECURITY #:		DATE OF BIRTH:		_		
RELATIONSHIP TO THE PA	ATIENT:			-		
RESPONSIBLE PARTY EM	PLOYER INFORMATION:	EMPLOYED	STUDENT OTH	ER		
COMPANY:		EM	PLOYER PHONE #:			
ADDRESS:		CIT	Y:	STATE	2: ZII	P:
PATIENT'S PRIMAR	RY CARE DOCTOR					
DOCTOR:	NA	ME OF PRACTICE:				
PHONE:	ADI	ORESS:				
PRIMARY INSURAN	CE INFORMATION					
INSURANCE COMPANY:		INSURANCI	E ID NUMBER OF THI	E PATIENT: _		
INSURANCE ADDRESS:		CITY:		STATI	E: 2	ZIP:
INSURANCE CO PHONE:_		GROUP	NAME OR NUMBER:_			
POLICY DATES: FROM:	TO:		EMPL	OYER PLAN:	YES	🗌 NO
INSURED PARTY NAME:						
INSURED PARTY ADDRES	SS:	(	CITY:		STATE:	ZIP:
INSURED PARTY PHONE:						
INSURED PARTY SOCIAL	SECURITY NUMBER:		INSURED P	ARTY DATE (	OF BIRTH: _	
EMERGENCY CONTACT N	AME:		PHONE NUM	/IBER:		

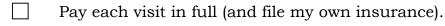
I hereby authorize payment directly to the physician of the surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of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

#### Patient or Responsible Party Signature:

LIST FOR OCCASSIONAL NEWS AND COUPONS

### PLEASE READ CAREFULLY AND COMPLETE

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



- 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.

## 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 I	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:
1 5 6	

# 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:\_\_\_\_\_