Fayetteville Psychiatric Associates
2587 Ravenhill Dr.
Fayetteville, NC 28303
Office (910) 323-1543, Fax (910) 485-1257

Fayetteville Psychiatric Associates of Lumberton
4828 Fayetteville Road
Lumberton, NC 28358
Office (910) 739-6621, Fax (910) 739-6631

Fayetteville Psychiatric Associates of Fuquay Varina
600 Stelleta Drive
Fuquay Varina, NC 27526
Office (919) 567-0684 Fax (919) 567-0692

REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's last name: First: Middle: Parent/Guardian name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )	Cell Phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Primary insurance :	Subscriber's name:	Subscriber's SSN #.:	Group no.:
		Subscriber's D.O.B.	Policy no.:
Name of Secondary insurance:	Subscriber's name:	Subscriber's SSN#.:	Group no.:
		Subscriber's D.O.B.	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell/ Work phone# ( )

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MEDICAL INFORMATION

Primary Physician: Date of last visit:	Address: Phone #:
Medical Issues:	
Allergies:	

PREVIOUS COUNSELING/TREATMENT

Who:

Where:

Results:

Who:

Where:

Results:

Nature of Current Problems:

_____

_____

_____

_____

Current Medications (Include dosage and length of use):

_____

_____

_____

_____

Adverse Reactions to Medications:

_____

_____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance that is not covered by my insurance company. Where required, I also request payment of government benefits to the party who accepts assignment. I also authorize Fayetteville Psychiatric Associates or insurance company to release any information required to process my claims.

Patient/Parent/Guardian signature *Date*

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CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE

Patient Name: _____

I understand that Fayetteville Psychiatric Associates may disclose my protected health information to a family member, relative, friend or other person that I identify who is directly involved in my care, or payment of my care, provided that I have an opportunity to agree to, or object to, such disclosure.

Therefore, I hereby consent, agree, and authorize Fayetteville Psychiatric Associates to disclose my protected health information to the following individual(s) who is or are directly involved in my care, or in the payment of my care:

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

I understand that by consenting to the disclosure of my protected health information to the individual(s) identified above, all my personal information relevant to my care and treatment may be disclosed, including but not limited to, my medical history, my medical condition, diagnostic tests performed, laboratory results, prescriptions, surgical procedures, and other personal information given to, or discussed with Fayetteville Psychiatric Associates.
Please note, that **ONLY** the patient can pick up prescriptions that are controlled substances. For patients under the age of 18: **ONLY** the parent can pick up prescriptions that are controlled substances.

This consent to disclose my protected health information applies to:
☐ This visit only: Date:_____

☐ All visits at which the individual(s) identified is or are present

☐ All communications with the individual(s) identified above, including information provided in person, by telephone, or by mail.

This consent is immediately effective and shall remain effective for 365 days. I understand that I have the right to revoke this consent at any time by providing written notice to Fayetteville Psychiatric Associates.

I understand that I am not required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to Fayetteville Psychiatric Associates disclosure of my protected health information to the individuals identified above.

Patient/Parent/Guardian Signature: _____ Date: _____
Description Guardian: _____

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PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of Fayetteville Psychiatric Associates, PC's Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the notice.

Patient's signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature:_____ Date:_____

Printed Name of Representative: _____

Please describe the Representative's authority to act on behalf of the patient (initial one)

(Initial)_____: The guardian is the parent/foster parent/therapeutic foster parent of the patient

(Initial)_____: The guardian is a family member of the patient.
Description:_____(grandparent, aunt, cousin, etc.)

(Initial)_____: The representative is the guardian of the patient, who has been adjudicated incompetent.

(Initial)_____: The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Fayetteville Psychiatric Associates, PC personnel.

FOR <PRACTICE> USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it:

_____
_____
_____
_____
_____
_____

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CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

I understand that as a patient of **Fayetteville Psychiatric Associates** I may be eligible to receive all services that are offered**.** The goal of the assessment process is to determine the best course of treatment for me. I understand that all information shared with the clinicians at **Fayetteville Psychiatric Associates** is confidential and no information will be released without my consent. During the course of treatment at **Fayetteville Psychiatric Associates**, it may be necessary for my provider to communicate with other providers at **Fayetteville Psychiatric Associates.** While written authorization will not be requested, prior to any discussions with another **Fayetteville Psychiatric Associate provider**, I understand that in all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at **Fayetteville Psychiatric Associates,** I may discuss them with my provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by **Fayetteville Psychiatric Associates**. I understand that I may stop treatment at any time.

Patient/Parent/Guardian Signature:_____ Date_____

Witness:_____ Date_____

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AUTHORIZATIONS

ALL RECIPIENTS

Patient Name: _____

I have been informed that it is my responsibility to verify coverage of the mental health benefits with my insurance company prior to receiving treatment at **Fayetteville Psychiatric Associates.**

Fayetteville Psychiatric Associates verifies authorizations with insurance companies as a courtesy. Authorization is not a guarantee of payment. I understand that any charges not covered by my insurance company will become my responsibility.

Patient/Parent/ Guardian Signature:_____ Date_____
Guardian Description:_____
Witness:_____ Date_____

* BLUE CROSS BLUE SHIELD/ NC HEALTH CHOICE *

Patient Name: _____

Family therapy appointments without the patient present, is not a covered charge. Such services are the responsibility of the Pt.

Patient/Parent/ Guardian Signature:_____ Date_____
Guardian Decription:_____
Witness:_____ Date_____

* MEDICAID RECIPIENTS ONLY *

Patient Name: _____

I have been informed that Medicaid will only pay for 3 initial mental health evaluations in a twelve month period. I understand that if Medicaid does not cover the initial visit at Fayetteville Psychiatric Associates I will be responsible for the bill.

Patient/Parent/ Guardian Signature:_____ Date_____
Guardian Description:_____
Witness:_____ Date_____

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Advance Notice Of Medicaid Non-Coverage

Patient Name:_____

Date:_____

Medicaid patients are allowed only a certain number of unmanaged visits per calendar year (Jan through Dec) for Outpatient Mental Health Services.

Adults: 8 Visits

Children: 16 Visits

You are responsible for notifying your Mental Health Providers of how many visits you have used at other offices. If you do not notify us and we receive a denial for your claims due to visit limits exceeded you will be responsible for all services provided. If you have additional questions please feel free to contact the billing department at 910-323-1543 Option # 1.

Sign:_____

Date:_____

Have you received Mental Health Services at any other office/facility this year?
Yes ☐ No ☐

If, yes do you know how many visits you have used? #_____

Front Desk Initial_____

Date_____

The following are charges that could occur that your insurance will not cover and you will be responsible for the bill. Payment is due at the time service is rendered.

1. **Missed appointments or late cancellations:**
   There will be a charge according to the type of appointment.
   Medication check: $10 to $30 missed appointment/ late cancellation charge.
   Therapy Session $35 to $50 therapy missed appointment/ late cancellation charge.

2. **Forms:**
   To include, but not limited to: insurance forms, disability forms, assessment forms from teachers, parents or patient, and personal letters: charge of $10.00 to $25.00 depending on the complexity.

3. **Office Hours Phone Calls:**
   If you speak to the doctor or the counselor during business hours, on the phone, there is a charge that is up to the discretion of the provider.

4. **After Hours Phone Calls:**
   If you speak to the doctor or the counselor after normal operating hours there is a charge that is up to the discretion of the provider. Charges may increase depending on the complexity, length, and hour of call.

Patient/Parent/ Guardian Signature:_____ Date_____

Witness:_____ Date_____

The following are charges that could occur that your insurance will not cover and you will be responsible for the bill. Payment is due at the time service is rendered.

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PATIENT COPY