Patient Name:_______________________________________

Date of Birth:_______________________________________

Carolinas Psychiatry & Behavioral Wellness

DEMOGRAPHIC INFORMATION

Patient Legal Name:		Social Security #:
Gender:	Age:	Date of Birth:
Address:		
City, State, Zip:		
Phone:	Email:	

Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact:____________________________________
Relationship:______________________________

Phone:____________________________________

EMPLOYMENT AND INSURANCE

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Employer Name:___________________________________Occupation:_______________________________

Employer Address:____

Insurance #1 (Primary)

Policy Holder Name:___________________________________ Policy Holder's Number:_________________

Name of Plan:___________________________________ Policy #____________________________________

Insurance Company:______________________________ Insurance Company Phone: ____________________

Insurance # (Secondary)

Policy Holder Name:___________________________________ Policy Holder's Number:_________________

Name of Plan:___________________________________ Policy #____________________________________

Insurance Company:______________________________ Insurance Company Phone: ____________________

Responsible Party Information (complete if other than patient):

Name of Responsible Party: ____

Relationship to Patient: ____

Address: ____ City:________________ State:____ Zip:_______

Home Phone: ________________ Work Phone: ___________________ Cell Phone: ______________________

Social Security #: __________________________ Employer Name: ________________________________

Employer Address:____

City: ____ State: __________ Zip:___________________

Atrium Health

Carolinas Psychiatry & Behavioral Wellness

*Patient Name:*____________________________________

*Date of Birth:*____________________________________

CURRENT HOUSEHOLD SITUATION

Name	Relationship	Date of Birth or Age
1.		
2.		
3.		
4.		
5.		

REASON FOR YOUR VISIT/ CONCERNS

Please list your reason for you visit:

Have you ever been seen by a Psychiatrist or Counselor Before? ☐Yes ☐No If Yes, please list:

Have you ever had a problem with Drugs or Alcohol? ☐Yes ☐No If Yes, please explain:

Have you ever been in a treatment facility for substance abuse? ☐Yes ☐No If Yes, please list of the dates of treatment:

MEDICAL INFORMATION (current/past)

Current and Past Medical Illnesses:

Past Psychiatric Treatment (if any):

Please list any history of inpatient mental health treatment (if any):

Please list any allergies to medication/food/environment:

Carolinas Psychiatry & Behavioral Wellness

*Patient Name:*______________________________________

*Date of Birth:*______________________________________

Current Medications: ☐No ☐Yes, please list:

Are you concerned about any of your current medications? ☐No ☐Yes, please explain:

SIGNIFICANT FAMILY HISTORY

Please check all that apply:

☐Anxiety

☐Depression

☐Bipolar

☐Schizophrenia

☐ADHD

☐Suicide

☐Drug and Alcohol

☐General Medical

ADDITIONAL COMMENTS

Carolinas Psychiatry & Behavioral Wellness

Ongoing Communication Authorization

Patient Name:______________________________DOB: ____________________________

Preferred Phone:____________________________Okay to Leave a Message? Yes No

Primary Care Provider:________________________ Phone: ____________________________

How did you hear about our practice? ____

Please list any family, friends, providers or any other individuals that you would like for us to be able to have ongoing communication with regarding your care.

Name:__________________________Phone:___________________Relationship:______________

Name:__________________________Phone:___________________Relationship: ______________

Name:__________________________Phone:___________________Relationship: ______________

Name:__________________________Phone:___________________Relationship: ______________

Are you currently seeing any other behavioral health professionals? If so, please list:

Name:__________________________Office:___________________Phone: ______________

Name:__________________________Office:___________________Phone: ______________

Name:__________________________Office:___________________Phone: ______________

_____________________________________ _______________

Patient, Parent or Legal Guardian Signature Date

____

Patient, Parent or Legal Guardian Print Name

Carolinas Psychiatry & Behavioral Wellness

Dear Carolinas Psychiatry & Behavioral Wellness Patient/Caregiver,

Thank-you for choosing Carolinas Psychiatry & Behavioral Wellness as your healthcare provider. We are glad to work with you for a healthier you.

It is important for you to know the policies:

1) **Cancel/No-show Policy**:
   a. Patients must call the office at 704-801-9200 at least the day before your appointment if you will not be able to come. This allows the provider to have another patient scheduled in his/her time slot.
   b. Patients who do not show up for a scheduled appointment will be considered a "no-show."
   c. Patients with 3 or more "no-show" appointments may not be able to continue to receive services at Carolinas Psychiatry & Behavioral Wellness.

2) **Late Policy**:
   a. Patients who show up after their scheduled appointment time will be considered late.
   b. If a patient is late for their appointment, they may have to reschedule for another date/time. It is up to your healthcare team to determine if you can be seen when arriving late.

3) **Co-Payment & Deductible:**
   Depending upon the type of insurance a patient has, a co-payment or deductible is usually due at the time of your appointment. **If you have to pay a co-pay or deductible, that payment is expected at the time of check-in,** before you see the provider. Please make a plan to bring your co-pay or deductible with you for your appointment. If you do not have this at check-in, you may not be seen by the provider.

We look forward to partnering with you for your healthcare.

______________________________________ ____________________
Patient, Parent or Legal Guardian Signature Date

____
Patient, Parent or Legal Guardian Print Name

______________________________________ ____________________
Patient Name (If different than above) Date of Birth

Carolinas Psychiatry & Behavioral Wellness

Controlled Substances Policy

At Carolinas Psychiatry & Behavioral Wellness, we will do our best to ensure you receive the safest and most effective care available. Our practice standards are as follows.

Benzodiazepine medication (clonazepam and similar drugs), "sedatives", sleep aides and other anti-anxiety treatments have the potential to cause physical dependence, psychological dependence and misuse or over prescribing can lead to adverse events such as seizures, accidents, poor decision making and in rare cases death can result. The use of such treatment will be limited to short term management whenever possible.

Stimulant medication (methylphenidate and similar drugs) can be used to treat problems with attention, mood, appetite and daytime somnolence. Misuse of stimulant medication can lead to dependence, addiction, cardiac toxicity and in rare cases death can result.

Coordinated care will be required for prescribing controlled substances. A release of information and records from your primary care doctor and any specialists will be obtained to ensure your safety.

Medication can be taken only as prescribed and cannot be used in combination with alcohol or other recreational/illicit drugs.

Periodic monitoring with a urine drug screen may be necessary to ensure your safety.

Periodic monitoring of DEA controlled substance registries will verify your history for filling prescriptions of controlled substances.

The clinic will need at least two business days to respond to refill requests. Refills of controlled substances will not be offered after regular business hours, on weekends or on holidays.

Early refills of controlled substances will not be offered for misuse, overuse or for convenience.

If you perceive that you have a life-threatening emergency or otherwise severe and urgent condition related to side effects, overdose or withdrawal seek immediate assistance from 911 emergency services.

Emergency rooms and urgent care clinics will be advised to evaluate your condition for imminent danger and potential withdrawal and refer you back to our clinic for routine concerns such as refills and continuing care.

To ensure public safety you agree to report all lost or stolen prescriptions and medication pills to

Patient Name:

Date of Birth: Patient Identifier

Medical Record #:

local law enforcement.

By signing this agreement, I agree to the following conditions:

1. I will participate in **other treatments** that are recommended and will be ready to wean off or stop the opioid medication as other effective treatments become available.

2. I will take my medications exactly **as prescribed** and will not change the medication dosage or schedule without approval. If changing medicine, I will bring unused pills to my provider for proper disposal.

3. I will keep **regular appointments** at Carolinas Psychiatry & Behavioral Wellness

4. If I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates or stimulants); or if I am **hospitalized** for any reason, I will inform the clinic within **one business day.**

5. I understand that lost or stolen prescriptions will **not be replaced**, and I will not request early refills.

6. I understand that the use of any **illegal and recreational drugs or excessive alcohol use may lead to cancellation of this agreement.**

7. I am responsible for keeping track of the medication left and plan ahead for arranging office visit appointments in a timely manner so that I will not run out of medication.
    - Refills will only be given during a face-to-face office visit with my primary care provider or another physician in the practice if he/she is unavailable.
    - Refills will be made only during regular office hours. Refills will not be made at night, on weekends or during holidays.

8. I will not give/sell my medications to anyone else.

Failure to adhere to these conditions may result in stopping the medication and/or discharge from the practice.

Patient Name (print):____DOB:________________

Patient Signature:____Date:________________

Guardian/Parent Name (print):____

Guardian/Parent Signature:____Date:________________

Provider Signature:____Date:________________

Patient Name:

Date of Birth: Patient Identifier

Medical Record #:

Conditions for Successful Psychotherapy

Thank you for asking to work with one of our skilled therapists. Therapy alone, or when combined with medication, is often effective in helping reduce anxiety, depression, relationship/family conflict and school/work problems. Most people experience improvement within 6 to 10 sessions.

Like all relationships, the relationship between a client and his/her therapist requires mutual trust, commitment, and respect. Your therapist will work to help you learn healthy ways to cope with whatever led you to seek treatment. For therapy to be effective, it often requires you to confront difficult "truths" about your life. This can lead to feeling temporarily uncomfortable or even frustrated with therapy. Yet, it can be very healthy to talk about such feelings with your therapist.

For therapy to have a reasonable chance of being helpful to you, both you and your therapist need to agree to accept common sense responsibilities important in all relationships. These include:

- Honesty
- Willingness to participate in the most effective treatment interventions recommended including consistent completion of therapeutic assignments ("homework"), to be linked with community resources to complement therapy, if suggested by your therapist and/or participate in individual, family or group therapy.

Successful therapy also includes addressing concerns/questions about your therapist with your therapist. If you rather not address the concern with your therapist, you can ask to speak to the Director of Operations at 704-801-9200.

Consistent Attendance

Clients who attend therapy sessions in an inconsistent manner ("NO SHOW") are unlikely to benefit from therapy. Inconsistent attendance is defined as missing three (3) or more scheduled sessions in a six (6) month period. Should you have to miss a session, please call at least 24 hours before the scheduled appointment to allow the counselor time to schedule another client. Calling less than 24 hours will be considered a NO SHOW. Clients with 3 or more NO SHOWS within a 6-month period, could be discharge discharged from therapy services.

Client Progress

Your therapist will review and update your treatment goals as your clinical needs require. Treatment updates will record your progress since beginning services. If there is evidence that you are not benefitting from therapy, your counselor will attempt to modify his/her treatment interventions to provide you with opportunities for therapeutic gain. Should you continue to show you are not benefitting from services, your counselor will explore other treatment options which could include referring you to a higher level of care, i.e. partial hospitalization or a referral to another Atrium Health counselor or outside agency.

Please review the agreement below and feel free to ask your therapist questions. If you choose not to sign this agreement, it will indicate that therapy is unlikely to be helpful at this time. If you still wish to obtain therapy, your therapist will provide you with a referral to another agency.

As client, I agree to follow the conditions described above. I understand that failing to uphold any of these conditions will likely result in my case being closed. I understand that I may request therapy from Carolinas Psychiatry & Behavioral Wellness - Davidson in the future by asking for a referral from my psychiatrist or by calling the Appointment line at 704-801-9200. I also understand that emergency services are always available from the BH-C Emergency Department my local Emergency Department, or by calling the Behavior Health Call Center at 704-444-2400.

______________________________	____________________	_________	__________
Client's/Guardian's Signature	Relationship to Client	Date	Time

As your therapist, I agree to schedule and keep regular appointments that accommodate your schedule when possible. I agree to directly discuss any attendance problems, incomplete therapeutic work or when you or I believe that maximum gain from therapy has been reached.

______________________________	________________________	________________
Therapist's Signature/Credential	Date	Time

Patient Label