

PATIENT INFORMATION

Please Print

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

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

GENDER: MALE FEMALE EMPLOYMENT: EMPLOYED STUDENT OTHER

PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

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

MARITAL STATUS: _____ WHO REFERRED YOU TO CAROLINA PARTNERS? _____

SINGLE MARRIED OTHER

PT EMPLOYER INFORMATION

COMPANY: _____ EMPLOYER PHONE #: _____

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

RESPONSIBLE PARTY INFORMATION

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

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

GENDER: MALE FEMALE EMPLOYMENT: EMPLOYED STUDENT OTHER

HOME PHONE: _____

WORK PHONE: _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

MARITAL STATUS: _____

SINGLE MARRIED OTHER

RESPONSIBLE PARTY EMPLOYER INFORMATION

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/pr 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.

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.

Client's Name: _____

Client's 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.

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.

Signed _____ Date _____

I would like to pay on a monthly basis with the following card information:

_____ 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.

Signed _____ 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
Client 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
Client 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.

Signature _____ Date _____