

New Patient Checklist

(Please call 919-636-5695 if you have any questions about the registration forms and /or policies.)

_____ ***New Patient Information Form***

_____ ***Authorization for Treatment***

If prior authorization (PA) is required, and you do not obtain PA you, will be liable for the cost of the appointments. (See CHPA Policies and Procedures for important information regarding your financial liability for unpaid charges.)

_____ ***Authorization to Obtain and Use Protected Health Information***

_____ ***CHPA Policies and Procedures***

This contains important information about cancelled/failed appointments, charges not covered by insurance, issues of confidentiality and other important policies.

_____ ***New Patient History***

_____ ***Cardiac Screen, Screening for risk of long QTc...***

Give to receptionist:

- Registration paperwork**
- Insurance Card** If you have insurance but do not bring your insurance card, you will have to pay for your appointment.
- Photo id** – personal ID for adults, parent ID for a child

Note: Copays, deductibles and self-pay fees are collected at the time of the appointment.

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____
Address _____ City: _____
State: _____ Zip: _____ Date of Birth: _____ Sex: F M

Preferred phone (messages/courtesy appointment reminders) (Home Cell Work): _____
Alt. phone: _____ **Email address**** _____
Emergency Contact: _____ Relation: _____ Telephone: _____

***Email will be used for appointment reminders and for invitations to our patient portal.*

All copays, deductibles, estimated co-insurance, and other charges must be paid at each check in

Address to which statements should be mailed: Please check box if same address as above.
Name: _____ Relationship to patient: _____
Address _____ City: _____
State: _____ Zip: _____ Preferred Telephone: _____

If the person assuming financial responsibility for treatment will not be present at the appointment, the patient must bring the payment to the appointment.

Insurance Information: (We must make a copy of your card(s) in order to have all of the information needed to manage your claim submission. If you do not bring the card(s), you will be required to pay the full estimated cost of the appointment(s) at check-in.)

Name of primary insurance: _____

Name of secondary insurance, if applicable: _____

REQUIRED: When does your plan year start? _____ (mo/yr) What is your deductible? _____

If you do not know this information please contact your insurance customer service. Without correct information we must assume you have an active, unmet deductible and collect the estimated cost of the appointment. Incorrect information will incur a \$20 service fee and require immediate full payment of the outstanding balance.

****Prior Authorization:** see prior authorization page. Please obtain any needed prior authorization(s). Claims that are denied because you did not obtain a needed prior authorization will be billed to you. _____ **Initials**

I authorize the release of all medical records to clinicians involved in my treatment and to my insurance company. I further authorize insurance payments to be made directly to CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA.

I understand co-payments, deductibles, self-pay charges are due at time of service. Charges for services not covered by insurance are due at the next appointment or when billed, whichever occurs first.

Signature of patient or parent/guardian for minors _____ **Date** _____

AUTHORIZATION FOR TREATMENT

In order to utilize your mental health benefits, it is likely that your insurance carrier requires you to obtain an authorization for treatment within **24 hours of your first appointment**. In order to bill the insurance on your behalf, Chapel Hill Psychiatric Associates ask that you contact your insurance carrier and obtain the following information. When completed, please provide the front desk staff with the completed information or fax to us at 919.442.1105.

NAME OF CLIENT: _____ DOB: _____

NAME OF INSURANCE: _____

PLEASE CALL PHONE NUMBER FOR MENTAL HEALTH COVERAGE (ON BACK OF CARD) AND GET THE FOLLOWING INFORMATION:

BILLING ADDRESS FOR BEHAVIORAL HEALTH CLAIMS:

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION NUMBER: _____

EFFECTIVE DATE OF AUTHORIZATION: _____ EXPIRATION DATE: _____

NUMBER OF VISITS: _____

PROVIDER: Kathleen Transue, ANP Tracy Ware, MD Lizzette Potthoff, LCSW
 Pat Roos, PhD Elizabeth Parker, LCSW Brad Prinzhorn, PsyD

SERVICE CODE(S):

Dr. Ware & K. Transue	99205 or 90792	New Patient Evaluation and Management
	99213	Med Management
	99214	Med Management
	99215	Med Management
	90833	Add on code for Med Provider
	90836	Add on code for Med Provider

Therapists	90791	Intake Evaluation Therapist
	90834	45 Minute Psychotherapy
	90837	60 Minute Psychotherapy
	90847	Family Therapy
	Other: _____	

WAIVER:

I understand that if for any reason my insurance denies payment for services provided by CHPA that I will be responsible for payment of any and all charges incurred.

Signature of client _____ Date: _____

Chapel Hill Psychiatric Associates, PA

Authorization to Obtain and Use Protected Health Information

This authorization implements the requirements for client authorization to use and disclose health information protected by the Health Privacy Law (45 CFR, Parts 160,164) HIPAA; the federal drug and alcohol confidentiality law (42 CFR Part 2) and the NC state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 112C).

Patient Name: _____ Date of Birth: ____/____/____

Information to be released to from:

Information to be released to from:

Chapel Hill Psychiatric Associates, PA
610 Jones Ferry Road, Suite 208
Carrboro, NC 27510
Tel: (919) 636-5695
Fax: (919) 442-1105

Dates of Treatment: ____/____ to ____/____

Purpose of Release: Continuity of Care Legal Representation Primary Care Provider
 Request of the Individual Other: _____

Information to be released:

- History and Physical Exams Diagnostic test Results Psychological Assessments
- Psychotherapy Notes Admission Information Discharge Summary
- Psychiatric Evaluations Medication Records Substance Use/Treatment
- Progress Update/ Verbal Treatment Plans AIDS/HIV Status
- Educational Testing and Grades Other: **All records including secondary records from outside evaluations and hospitalizations** _____ - Initialed by patient or representative

Important Rights You Should Know:

-1- This authorization shall expire 1 year from the date of signature below unless revoked prior to that date by submitting a written revocation to Chapel Hill Psychiatric Associates. If you revoke this authorization, it will not apply to information that has already been used or disclosed. The information disclosed based on this authorization may be used or re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

-2- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure. You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

-3- If you refuse to sign this authorization, Chapel Hill Psychiatric Associates will not deny or refuse to provide you treatment. However, our inability to obtain pertinent information or to coordinate care may alter the risk benefit analysis of your treatment options and therefore which treatments are recommended.

Please document your permission or refusal by checking and initialing the appropriate section below..

I am: the individual signing below

Signature of Client _____ Date (required) _____

a personal and legal representative because the patient is a minor, incapacitated, or deceased

Signature _____

Relationship to the Client: _____ Date (required) _____

Refusing consent to release information as requested. Please Initial here: _____

Witness: _____ Date: _____

New Patient History

Name _____ Date _____

Name of person completing form if different from patient _____

Referred by _____

Reason for appointment _____

Name and phone number for any current mental health provider _____

Previous Treatments (Please list therapists, psychiatrists, medications, hospitalizations and approximate dates. Include substance abuse treatment.) _____

(Please have records forwarded to our office.)

Current Medications (prescription and over the counter):

<u>Name</u>	<u>Dose</u>	<u>When started</u>	<u>Side Effects</u>	<u>Prescribed by</u>
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Medication Allergies _____

New Patient History continued

Primary Care Provider (name, address, phone, fax) _____

For women only – Please inform your provider if there is any chance you are, or will become pregnant, now or at any time during treatment. Psychiatric meds are not proven safe in pregnancy. Abruptly discontinuing medication and/or psychiatric illness may also pose a risk to a pregnancy.

I am not pregnant and, if sexually active, am using reliable birth control to prevent pregnancy. I will contact my mental health provider and advise them of any pregnancy or plan to become pregnant so that risks and benefits may be discussed. **Initials** _____

Medical and Neurologic History (Please list any significant illnesses or injury.) _____

Substance Use History

Alcohol - How much do you drink? _____

Do you have, or have you had, a problem with alcohol? _____

Have family or friends ever been concerned about your use of alcohol? _____

Caffeine – How much caffeine do you have on an average day? _____

Cigarettes – Do you smoke and if so how much? _____

Street Drugs – Do you or have you used any street drugs? (Please state what and how much.) _____

Over the counter and prescription medications - Do you, or have you, ever used more than the prescribed dosage or for longer than recommended? _____

Developmental History (Please list any problems, complications or delays in development from pre-birth through early childhood.) _____

Education History (Please list any problems you had in school and your highest level of education.) _____

New Patient History continued

Work History (Please list your current or most recent employment and any employment problems that may be related to mental health concerns.) _____

Psychosocial History (Please list recurrent or current interpersonal problems, marriage history and any history of verbal, physical or emotional abuse.) _____

Family and Family Psychiatric History (Please list first names, ages and medical or mental health history of family members.

Please indicate if there is any adoption history including your own.)

Spouse _____

Children _____

Parents _____

Extended Family Members (if relevant) _____

Other information you would like us to know _____

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen

Screening for risk of long QTc and “sudden death”

All patients of Dr. Ware and Ms. Transue are requested to complete the first section of this packet and return it to your medication provider or the front desk.

The rest of the packet is yours to keep and contains extremely important safety information. Please read it, keep it for reference, and address any questions to your medication provider.

Name of patient: _____ Date of Birth _____

Patient sees: _____ Ms. Transue _____ Dr. Ware

Name of person filling out the form, if different: _____

Relationship to patient: _____

I have received the “Important Information on Prolonged QTc...” handout.

X _____ Date: _____

Please read the handout “Important Information on Prolonged Qtc...”

Please answer the following screening questions.

Does the patient have a history of heart disease or heart problems? _____

Does the patient have a history of fainting? _____

Has anyone in the patient’s biological family died suddenly before age 40? _____

If yes, what was the cause of death? _____

Does the patient have a history of an abnormal EKG or long QTc? _____

Does the patient have a very slow heart rate (less than 50 beats per minute)? _____

Does the patient have a history of low potassium, magnesium or calcium in the blood?
(circle which was low) _____

Does the patient take any of the medications listed on the next two pages, either routinely or when needed? Please circle the medication(s) the patient is taking currently. Please also circle any medications that are taken occasionally and write “prn” next to the medication. Prn means “as needed.” *Please note the same medications are listed on both pages. The first page is alphabetical by brand name. The second page is alphabetical by generic name.*

**Generic Name
(Brand Name)**

Albuterol (Ventolin®)

Albuterol (Proventil®)

Alfuzosin
(Uroxatral®)Amantadine
(Symmetrel®)Amiodarone
(Pacerone®)Amiodarone
(Cordarone®)

Amitriptyline (Elavil®)

Amphetamine
(Dexedrine®)Amphetamine
(Adderall®)Arsenic trioxide
(Trisenox®)Astemizole
(Hismanal®)Atazanavir
(Reyataz®)Atomoxetine
(Strattera®)Azithromycin
(Zithromax®)

Bepidil (Vasacor®)

Chloral hydrate
(Noctec®)Chloroquine
(Aralen®)Chlorpromazine
(Thorazine®)Ciprofloxacin
(Cipro®)Cisapride
(Propulsid®)

Citalopram (Celexa®)

Clarithromycin
(Biaxin®)Clomipramine
(Anafranil®)

Clozapine (Clozaril®)

Desipramine
(Pertofrane®)Dexmethylphenidate
(Focalin®)Diphenhydramine
(Benadryl®)Diphenhydramine
(Nytol®)Disopyramide
(Norpace®)Dobutamine
(Dobutrex®)

Dofetilide (Tikosyn®)

Dolasetron
(Anzemet®)Domperidone
(Motilium®)Dopamine
(Intropine®)

Doxepin (Sinequan®)

Dronedarone
(Multaq®)Droperidol
(Inapsine®)Ephedrine
(Rynatuss®)Ephedrine
(Broncholate®)Epinephrine
(Bronkaid®)Epinephrine
(Primatene®)Erythromycin
(Erythrocin®)Erythromycin
(E. E. S.®)Escitalopram
(Lexapro®)Escitalopram
(Cipralax®)Felbamate
(Felbatrol®)Fenfluramine
(Pondimin®)Flecainide
(Tambocor®)Fluconazole
(Diflucan®)

Fluoxetine (Prozac®)

Foscarnet
(Foscavir®)Fosphenytoin
(Cerebyx®)Galantamine
(Reminyl®)Gatifloxacin
(Tequin®)Gemifloxacin
(Factive®)

Granisetron (Kytril®)

Halofantrine

(Halfan®)

Haloperidol (Haldol®)

Ibutilide (Corvert®)

Imipramine
(Norfranil®)

Indapamide (Lozol®)

Isoproterenol
(Medihaler-Iso®)Isoproterenol
(Isupres®)Isradipine
(Dynacirc®)Itraconazole
(Sporanox®)Ketoconazole
(Nizoral®)

Lapatinib (Tykerb®)

Lapatinib (Tyverb®)

Levalbuterol
(Xopenex®)Levofloxacin
(Levaquin®)Levomethadyl
(Orlaam®)Lisdexamfetamine
(Vyvanse®)

Lithium (Lithobid®)

Lithium (Eskalith®)

Mesoridazine
(Serentil®)Metaproterenol
(Metaprel®)Metaproterenol
(Alupent®)Methadone
(Methadose®)Methadone
(Dolophine®)Methylphenidate
(Ritalin®)Methylphenidate
(Concerta®)

Mexiletine (Mexitol®)

Midodrine
(ProAmatine®)Moexipril/HCTZ
(Uniretic®)Moxifloxacin
(Avelox®)Nicardipine
(Cardene®)

Nilotinib (Tasigna®)

Norepinephrine
(Levophed®)Nortriptyline
(Pamelor®)Octreotide
(Sandostatin®)

Ofloxacin (Floxin®)

Ondansetron
(Zofran®)

Oxytocin (Pitocin®)

Paliperidone
(Invega®)

Paroxetine (Paxil®)

Pentamidine
(NebuPent®)Pentamidine
(Pentam®)Perflutren lipid
microspheres
(Definity®)Phentermine
(Fastin®)Phentermine
(Adipex®)Phenylephrine
(Neosynephrine®)Phenylpropanolamine
(Dexatrim®)Phenylpropanolamine
(Acutrim®)

Pimozide (Orap®)

Probucol (Lorelco®)

Procainamide
(Pronestyl®)Procainamide
(Procan®)Protriptyline
(Vivactil®)Pseudoephedrine
(PediaCare®)Pseudoephedrine
(Sudafed®)Quetiapine
(Seroquel®)Quinidine
(Quinaglute®)Quinidine
(Cardioquin®)Ranolazine
(Ranexa®)Risperidone
(Risperdal®)

Ritodrine (Yutopar®)

Ritonavir (Norvir®)

Roxithromycin*
(Rulide®)Salmeterol
(Serevent®)

Sertindole (Serlect®)

Sertindole
(Serdolect®)

Sertraline (Zoloft®)

Sibutramine
(Meridia®)Solifenacin
(VESIcare®)

Sotalol (Betapace®)

Sparfloxacin
(Zagam®)

Sunitinib (Sutent®)

Tacrolimus
(Prograf®)Tamoxifen
(Nolvadex®)Telithromycin
(Ketek®)Terbutaline
(Brethine®)Terfenadine
(Seldane®)Thioridazine
(Mellaril®)Tizanidine
(Zanaflex®)

Tolterodine (Detrol®)

Tolterodine (Detrol
LA®)Trazodone
(Desyrel®)Trimethoprim-Sulfa
(Sulfa®)Trimethoprim-Sulfa
(Bactrim®)Trimipramine
(Surmontil®)

Vardenafil (Levitra®)

Venlafaxine
(Effexor®)

Voriconazole (VFend®)

Ziprasidone
(Geodon®)

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen – Patient Education

Home Reference

Important Information on Prolonged QTc Risk for Sudden Cardiac Death

X

The electrical system that controls when and how the heart beats can be disrupted by medications. In extreme cases, this change in electrical activity may cause the heart to stop beating normally. A person experiencing Prolonged QTc may feel **short of breath, dizzy, or may lose consciousness without warning (“syncope”)**. In extreme cases they may die suddenly.

There is a great deal of controversy and debate over how frequently this happens and how best to minimize the risk to people who might benefit from the medications.

Some organizations and publications have called for routine EKG's, but only for a few of the many medications associated with an increased risk of Prolonged QTc (*American Heart Association, New England Journal of Medicine*).

Others have endorsed screening for risk before ordering an EKG (*World Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, Society for Developmental and Behavioral Pediatrics, National Initiative for Children's Healthcare Quality, National Association of Pediatric Nurse Practitioners, Children and Adults with Attention Deficit/Hyperactivity Disorder*).

Chapel Hill Psychiatric Associates, PA recognizes the validity and complexity of this debate while respecting the right of the patient, parent and/or guardian to be part of the decision-making process.

Our policy is based on an expansion of the screening questions recommended by the World Psychiatric Association and our commitment to educating our patients regarding this complex issue. Neither the screening questions nor an EKG can guarantee that each person who is at risk can be identified. There will always be some, we hope very limited, risk of abnormal heartbeat and death when these and many other medications are used.

The following is a copy of the screening questionnaire you completed. These questions are used to establish a relative baseline risk. If your answer to any of these questions changes, please advise us as soon as possible.

Does the patient have a history of heart disease or heart problems? _____

Does the patient have a history of fainting without explanation and possibly without warning? _____

Has anyone in the patient's biological family died suddenly before age 40? _____

If yes, what was the cause of death? _____

Does the patient have a history of an abnormal EKG or long QTc? _____

Does the patient have a history of having a very slow heart rate (less than 50 beats per minute)? _____

Does the patient have a history of low potassium, magnesium or calcium in the blood? (circle which was low) _____

Estimating risk also requires a recognition of relative risk among medications.

There are three levels of risk for medications that we prescribe.

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Cardiac Screen – Patient Education

The first level includes medications known to cause Prolonged QTc. (**Haldol, Thorazine, Mellaril, Orap**)

The evidence for the second level is less clear. (**Lithium, Effexor, Geodon, Seroquel, Amantadine, Risperdal, Invega**)

The third level includes medications believed to be safe at normal doses as long as the person does not have another major risk factor. (**Stimulants, Strattera, Celexa, Prozac, Zoloft, Paxil, Anafranil, Imipramine, Nortriptyline, Amitriptyline, Desipramine, Reminyl, Sinequan, Surmontil, Vivactyl**)

Risk also increases with each additional medication that is associated with possible Prolonged QTc.

For a current list of medications that may cause prolonged QTc please go to www.azcert.org

The issue of risk is complex. **Besides the risks already reviewed, the risk of Prolonged QTc is increased by taking a medication that increases the blood level of the medication that may cause Prolonged QTc.** If you are taking one of the medications listed below in bold, you should not take any of the medications or food listed in the corresponding subparagraph without contacting your medication provider. Depending on the medication and the patient's other risk factors, we can usually adjust the dose. If we are prescribing both medications, we will already have been adjusting the dose clinically, but please contact us if you have any concerns.

1. Amitriptyline (Elavil), Chlomipramine (Anafranil)

Fluvoxamine, ciprofloxacin, fluconazole, amiodarone, Wellbutrin (bupropion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil.

2. Haldol (haloperidol)

Fluvoxamine, ciprofloxacin, amiodarone, Wellbutrin (bupropion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem.

3. Antidepressants: desipramine, imipramine, nortriptyline, paroxetine (Paxil), venlafaxine (Effexor)

Antipsychotics: Mellaril (thioridazine), Thorazine (chlorpromazine)

Other: Strattera (atomoxetine), Amphetamines (Adderall, Dexedrine etc...

Wellbutrin (bupropion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline).

4. Geodon (ziprasidone), Seroquel (quetiapine), Orap (Pimozide)

Indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem, Tagamet (cimetidine).

5. Risperdal (risperidone), Invega (Paliperidone)

Wellbutrin (bupropion), Prozac (fluoxetine), Paxil (paroxetine), quinidine, Cymbalta (duloxetine), Tagamet (cimetidine), Zoloft (sertraline), indinavir, nelfinavir, ritonavir, amiodarone, cimetidine, clarithromycin, diltiazem, erythromycin, Luvox (fluvoxamine), grapefruit juice, itraconazole, ketoconazole, mibefradil, troleandomycin, verapamil, diltiazem, Tagamet (cimetidine).

If you experience any of the warning signs of Prolonged QTc, including dizziness and shortness of breath, you should contact your medication provider or primary care provider as soon as possible. If you have experienced loss of consciousness or "fainting" you should call 911 for transportation to an emergency room.

Welcome to our practice!

This Agreement contains important information about our professional services and business policies, and information required by the Health Insurance Portability and Accountability Act (HIPAA).

Please read this document carefully and address any concerns or questions to your clinician(s).

When you sign the [signature page](#), it will represent an agreement between you and Chapel Hill Psychiatric Associates, PA.

This agreement has important information including:

- EVALUATIONS AND TREATMENT
- OVERVIEW OF SERVICES
- CANCELLATIONS
- CONTACTING YOUR PROVIDER DURING AND OUTSIDE OF BUSINESS HOURS
- TERMINATION OF TREATMENT
- PROFESSIONAL FEES, INCLUDING FOR PRESCRIPTIONS
- CONFIDENTIALITY LIMITATIONS
- RECORDS
- PATIENT RIGHTS
- PRIVACY RIGHTS FOR MINORS
- BILLING & INSURANCE REIMBURSEMENT
- COMPLAINT PROCEDURES

EVALUATIONS AND TREATMENT

Evaluations

The first step of treatment is the initial evaluation. This evaluation may require multiple sessions to establish what the goals of treatment are (your treatment plan). One of the goals of these initial sessions is for you and your provider to decide if this is a good pairing to provide the services you need. Thus, completing an initial evaluation is not a guarantee of continued treatment with this provider. If continuing treatment at CHPA is not recommended, the clinician completing the evaluation will discuss the reasons and options for treatment.

There are also a number of circumstances in which a patient may be referred to another provider in CHPA including a need for additional services, a second opinion, or a transfer of care. If there is a referral to a different provider at CHPA, that first appointment will be scheduled as an evaluation, and a new assessment will be done.

Follow-up Appointments

After the initial treatment evaluation(s), there are typically two different kinds of appointments. If medications are recommended, medication management appointments typically lasting 20 to 40 minutes will be scheduled to monitor your clinical status and response to treatment. If you have begun psychotherapy, those appointments typically last 45 to 60 minutes. Attending appointments and following through on recommendations is vital for you to have your best outcome.

OVERVIEW OF PSYCHIATRIC SERVICES

Psychiatric treatment involves diagnostic assessments, education, medication management, and supportive and educational therapy. The initial assessment is usually completed in the first or second appointment and serves to guide treatment

recommendations. On occasion, it may not be possible to complete the intake until outside records or additional specific evaluations are obtained. Upon completion of the assessment, the clinician will explain the recommendations and answer any questions.

Your medication provider will recommend the time frame for follow-up appointments based on your specific treatment and clinical concerns. This time frame reflects the frequency of assessment required to provide appropriate care. Thus if you need to cancel an appointment, it will be important to reschedule in a timely manner. If your medication provider determines that there has been insufficient follow-up to safely continue the current medications, she may decline to renew a medication or provide only a partial refill pending attending an appointment.

OVERVIEW OF PSYCHOLOGICAL SERVICES

Psychotherapy service recommendations are similarly based on your therapist's initial assessment. Appointments are usually 45 to 60 minutes and occur at a frequency agreed to by you and your therapist. In order for the therapy to be most successful, you will be working on your concerns both during your sessions and at home. Since therapy often involves discussing problematic aspects of your life, you may experience challenging feelings such as sadness, guilt, anger, frustration, loneliness and hopelessness. However, psychotherapy has been shown to have many benefits including better relationships, solutions to specific problems, and significant reductions in feelings of distress. In addition, research suggests that coordinating the use of medications, should they be needed, with psychotherapies leads to better and more enduring outcomes. In our practice, we coordinate your care in order to meet that goal wherever possible.

CANCELLATIONS

We request that you provide at least **48 business-day hours** advance notice of cancellation. Late cancellations, failure to cancel, or *arriving more than 15 minutes late* may result in a charge to your account that will not be covered by insurance. There is usually a courtesy reminder call two business days ahead. However, the reminder calls are not guaranteed and do not alter your responsibility to attend, or cancel appointments you have made.

You may have more than one follow-up appointments scheduled. If you change ONE appointment, please do not assume we will cancel any other appointments. Cancellations occur only following a specific request. Please understand that our clinicians usually have very full schedules and it may be difficult to reschedule your appointment at a time that is convenient for you.

PARTICIPATION IN LEGAL PROCEEDINGS

CHPA providers reserve the right not to participate in legal proceedings. If a provider agrees to participate, the specific limitations and fees will be established in writing in advance of providing the service.

CONTACTING PROVIDERS

Emergencies

If you think that your concern poses any risk to you that is time sensitive, including a medication reaction, or if you think you might require urgent psychiatric inpatient assistance or hospitalization, please do not wait for a response from your clinician or the clinician on-call. **Call 911** for transportation to your local emergency room. You can also call the Response Service at Holly Hill Hospital at 1.800.447.1800 for an emergency consultation 24 hours a day.

During business hours

Non-urgent messages should be left on your provider's voicemail, which is listed on your appointment card and on our website.

Urgent concerns during business hours may be recorded on your provider's voicemail, but they should also be directed to the administrative staff at 919.636.5695, so that they can ensure the urgency of the issue is communicated.

Fees are usually waived for calls less than five minutes in duration. Concerns likely to require more than five minutes are usually best addressed in an appointment.

Outside of business hours

Urgent concerns: On-call is in effect Monday through Thursday from 5 pm to 8:30 am, Fridays from 12 noon to Monday 8:30 am and holidays. Afterhours calls that are not an emergency or that require more than five minutes, including any required interventions, will be billed at \$125 an hour.

Please call 919.636.5695 afterhours to obtain the name and number of the on-call clinician.

REFERRALS OR TERMINATION FROM TREATMENT

You may end or transfer treatment at any time. We encourage you to discuss this choice with your treating clinician in advance so that you can be assured of having as much pertinent information as possible when you make your decision. Please also be aware that Employee Assistance Programs may prohibit our clinicians from continuing treatment. In the latter case, we will offer referrals to assist you to find another provider who will help you continue your treatment.

Treatment referrals or termination of treatment

As previously said, an initial decision to continue treatment with the clinician who completed an evaluation is not a guarantee that clinician will be able to continue to provide services under all circumstances. If your treatment needs change, it is possible your clinician will recommend a treatment that he or she is not be able to provide. Under these circumstances, your clinician may refer you to a second provider for adjunctive treatment, or recommend your care be transferred to a clinician or practice more appropriate to your needs.

Recommendations to transfer care typically occur when the specific treatment needs are outside our areas of expertise, or because of patient non-compliance with treatment recommendations, appointments or financial obligations. Examples of treatment needs that may be outside our areas of expertise include, but are not limited to: significant substance abuse; developing medically unstable conditions; psychiatric conditions requiring frequent hospitalization; and/or emergency appointments. Non-compliance may include: not following through on agreed treatment recommendations; not coming to appointments or late canceling of appointments; misusing prescription medications; declining treatment recommendations and/or referrals for treatment.

For any of these reasons, as well as other ones that would compromise your treatment, if the decision is made to transfer or terminate CHPA treatment, your clinician will provide short-term treatment (30 days or less) while you arrange to transfer your care. Suggestions will be provided for other treatment options. Depending on the reasons for the recommendation, appointments at CHPA may be required during the transfer process. The time period of coverage during transfer may be shorter if the recommendation is considered urgent. If there is a concern that your situation is unstable and/or unsafe, it may not be appropriate to continue the previously established treatment during the transition period.

PROFESSIONAL FEES

Insurance

We are an interdisciplinary office providing integrated mental health care. Fees vary by the provider and the service rendered. The actual cost of the appointment is determined by the governing insurance company contract. Questions regarding approved fee rates should be directed to your insurance company.

If you will be asking that we bill an insurance company for your treatment, please be aware the insurance company determines your financial liability. (For reference, mental health service co-pays are often listed as "specialist" on your insurance card.) If you are not aware of your assigned co-pay, our office requires that you pay \$35 at the time of the appointment. If you have a high deductible health plan and have not met your deductible, we ask that you pay \$70 at the time of the appointment. You will be balance billed for any additional charges.

Self-pay

Our providers believe our self-pay patients should pay amounts in alignment with what insurance companies typically allow. We have established a self-pay fee schedule that reflects that understanding. If you do not have insurance, or will not be using insurance, please inform the receptionist and your provider immediately so that the correct “self-pay” charge, not the insurance charge, is applied to your account. A self-pay fee schedule is available from the office staff on request. (If you choose to be self-pay even though you have insurance, you may instruct us not to give information to your insurer.)

Services not covered by insurance

Insurance typically pays only for face to face treatment. Other services may incur charges that you will be responsible for paying. Examples of these self-pay services are report writing, completing forms, telephone conversations lasting longer than 5 minutes, afterhour’s services, consulting with other professionals, family members or school representatives, obtaining prior authorizations*, coaching, providing expedited refills or stimulant prescriptions, and preparation of records or treatment summaries. Most services are billed at a standard hourly rate. Some have a flat fee. Please direct inquiries on anticipated cost to your clinician.

(* Depending on the time required, the charge for this service is currently \$15 or \$30. Changes in this charge will be posted for a period of six months in the waiting room and are effective at the time of posting.)

Signing this agreement authorizes your CHPA clinician to provide these services on request from you, another provider, your pharmacy or any company or agency requesting completion of forms or provision of records for which consent has been signed. Your signature on the policy indicates your acknowledgment that you, or your guarantor, are financially liable for any services not covered by insurance. If you do not want these services provided you must notify our office in writing prior to incurring the charge. Please indicate which specific services you wish to decline.

Special note on prescription refills –Requests and Charges

Standard refill requests:

Please direct to your pharmacy. Refill requests are usually completed within two business days of receipt.

Stimulant refill requests:

Stimulant medications cannot be refilled, called in or faxed. You must deliver the original signed prescription to the pharmacy. Requests must be made using the stimulant refill request form located in the “Forms” section of our website www.chapelhillpa.com. Prescriptions can be mailed or left for pick-up. Please allow one week for processing and additional time for mailing if appropriate.

Requests to expedite refill(s): Requests to refill a prescription on an urgent basis, will incur a charge.

- Urgent refills requested within 2 days during your provider’s normal business hours - \$10
- Urgent refills outside of business hours or that need to be directed to the covering provider - \$25.
- Expedited stimulant refill request charges are located on the stimulant request form.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and our medical providers and licensed psychotherapists. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA.

- **There are many exceptions to the requirement for written authorization. These include, but are not limited to:**
 - Communication with other professionals involved in your care
 - Written correspondence that is delivered to the patient rather than a third party

- Communication with family members in some circumstances
- Communication with other individuals who are involved in your treatment, either directly or financially
- Professional consultation regarding your treatment
- Administrative communication within CHPA and with our billing company
- Communication with your insurance when you have requested we bill insurance
- Phone call reminders directed to the phone number you provided
- Other actions to facilitate payment of charges not covered by insurance: This includes billing the identified guarantor, phone calls and letters to discuss billing or payment issues, and provision of information to third parties to obtain payment when requests for payment have not been addressed.
- Additional information regarding health information can be found at www.hhs.gov/ocr/privacy.

Other situations where we are permitted or required to disclose information without either your consent or Authorization:

- **Threat to safety of self or others:** If a clinician believes that a patient presents an imminent danger to the health and safety of himself or someone else, the clinician may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.
- **Abuse or neglect of a child or vulnerable adult:** North Carolina law requires that every citizen (exempting lawyer/client privilege) report suspected child or vulnerable adult abuse and/or neglect to the County Director of Social Services.
- **Court proceedings:** Release of your information for a court proceeding requires your authorization or a court order.
- **Lawsuit:** If a patient files a complaint or lawsuit against a provider, we may disclose relevant information regarding that patient in order to defend that provider(s).
- **Worker's Compensation:** If our services are being compensated through worker's compensation benefits, we must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

PROFESSIONAL RECORDS

Mental health clinicians may keep Protected Health Information (PHI) in two sets of professional records. One set constitutes your Medical/Clinical Record. If kept, the second set contains your Psychotherapy Notes. Current CHPA providers rarely maintain separate psychotherapy notes. Please ask your clinician if you have any questions.

Medical/Clinical Record

Medical records include information about your reasons for seeking evaluation/medication/therapy or other services, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that were set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone, including reports to your insurance carrier. The laws and standards of our professional providers require that we keep PHI about you in your Medical Record. Typical use of these records includes documentation of the treatment process, assistance for the provider in treatment planning and overview, or communication with a collaborating provider within CHPA. Furthermore, typical disclosure of treatment records occur with the client's written consent in order to communicate with a Primary Care Provider or another mental health professional outside CHPA.

Psychotherapy Notes

While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, analysis of those conversations and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to a provider that is not required to be included in your Clinical Record and information revealed confidentially by others such as your primary care physician. These Psychotherapy Notes are kept separate from your

Clinical Record, and receive a higher level of confidentiality protection.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; being informed of a breach of unsecured PHI, having the right to restrict certain disclosures of PHI to a health plan if the client pays out of pocket *in full* for the health care service, having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the attached Notice form. We are happy to discuss any of these rights with you.

Copying or reviewing your medical record

Except in unusual circumstances that involve danger to yourself and/or others who may be named in the record, you may examine and/or receive a copy of your Medical Record. We require that the request be made in writing, and it is our policy that you initially review them in the presence of your provider, or have them forwarded to another mental health professional so you can discuss the contents. These are professional records meant to facilitate your treatment rather than to represent a comprehensive summary of all issues you reviewed; they can be misunderstood by untrained readers. The clinician will charge a pro-rated fee for his or her time supervising the record review. If this is done as part of your treatment it may be covered by your insurance. If we refuse your request for access to your records, you have a “right of review” which your clinician will discuss with you upon request. The exceptions to this policy are contained in the attached Notice Form. Patients may also request a copy of their record in electronic form, with the associated fee not exceeding the labor costs.

HIPAA rules also require that we notify patients that they have the right to opt out of receiving fundraising and/or marketing solicitations and that we will not sell a patient’s health information without his/her express consent – however, CHPA does not send out such marketing requests or seek to sell recorded information.

Copy charges: Some copy charges are limited by North Carolina State law. Generally we charge a copying fee of \$.75 per page for the first 25 pages, \$.50 for the next 75 pages, \$.25 thereafter, and a \$10 handling fee as well as cost of mailing, if applicable.

RIGHTS OF MINORS & PARENTS

Patients under 18 years of age have the right to consent to treatment for “emotional disturbance” without the permission or notification of their parents and/or legal guardians. On a practical basis, this almost never occurs. If family members arranged appointments, attended appointments, or are paying for appointments, Federal Law recognizes that involvement as “implied” consent for communication with family members. The communication remains limited by the “minimum necessary” standard and the clinician’s professional judgment regarding the best interests of the child.

Psychiatric evaluation and medication treatment in a minor

Our clinicians may determine that standard medication treatment of a juvenile requires parental or other adult participation to assess risks and benefits of treatment, to insure treatment is properly implemented, and to assess possible therapeutic effects and side-effects. While a minor may request that treatment not be discussed with his or her parents, it is unlikely that our clinicians will consider the risks of unsupervised medication treatment of a minor to be appropriate and/or safe, and will decline to proceed. If this is the case, the reasons for this choice will be explained to the child, and non-medication options offered if appropriate. If the clinician believes that involving the parents or legal guardians in the treatment of the child is “essential to the life or health of the minor” or to the safety of others, the clinician will discuss the evaluation and treatment options without the permission of the child.

Psychotherapy with a minor

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is usually our policy to advise parents and/or legal guardians that therapy treatment of their child will be confidential unless the therapist believes that involving the parent and/or legal guardian is either “essential to the life or health of the minor” or essential to the safety of

others. The child will be provided the option of allowing the parent or legal guardian to be given general information about the progress of the child's treatment, and his/her attendance at scheduled sessions, but consent to this option is not required for treatment.

TECHNOLOGY AND CONFIDENTIALITY

- Electronic medical record – HIPAA compliant secure transmission with off-site storage.
- Paper records – Paper records are scanned into the electronic medical record. Originals are retained or shredded by policy. Retained originals are stored in locked file cabinets or offices.
- Voicemail – All CHPA voicemail is confidential.
- Fax – CHPA fax usually loads directly to our secure EMR. The fax machine is located in a locked office accessed only by CHPA employees.
- Email – Unencrypted email cannot be reasonably assumed to be confidential. Given the additional challenges of limiting access and archiving, it is CHPA policy that email is not used for clinical communication. A separate email policy applies to Cogmed Working Memory Training.
- Written correspondence – Office staff routinely open most mail. If you wish your correspondence be delivered unopened to your clinician please write “confidential” on the envelope
- Electronic billing – HIPAA compliant system
Communication with billing company – Almost all communication is by electronic HIPAA compliant system. Technical communication between our office staff and the billing company is done by fax and/or phone if the information is confidential, by email if the information is de-identified.
- CHPA Office computers – The desktop computers in the office are kept in a locked location. They are password protected and accessed only by CHPA employees trained in HIPAA compliance.
- CHPA Provider computers – Provider laptops are used to access the secure online storage. The laptops are not used for storage of clinical records.

BILLING AND PAYMENTS

As a courtesy to you, we normally accept assignment of any insurance benefits you have and we will file health care claims directly to your insurance company. Please be advised that **you will be expected to pay your co-pay, self-pay, deductible, and any outstanding patient balance at each session.** Additionally, be aware that there is a \$25 fee for returned checks.

Under circumstances of unusual and demonstrated financial hardship, we can sometimes establish payment installment plans. If an account is more than 60 days past due, without an established payment agreement, agreement may be remanded to a collections agency or small claims court. If such legal action is necessary, its costs are typically included in the claim. In these situations, we prefer to ask you to authorize us to charge your credit card for the outstanding balance more than 60 days old.

INSURANCE REIMBURSEMENT

It is very important that you find out exactly what mental health services your insurance policy covers and that you obtain the appropriate authorizations. You are responsible for full payment of any charges not covered by your insurance. Your liability for payment for services that are denied by your insurance company specifically includes, but is not limited to your failure to obtain prior authorization, re-authorization and/or failure to track of treatment coverage limitations.

Signing this agreement acknowledges your financial responsibility to pay for services rendered that are not paid for by your insurance. As a courtesy, we commonly assist with obtaining approval for treatment, and may be able to track your limitations of benefits. These services may be provided as a courtesy. They do not negate your financial liability for payment of treatment charges that are denied by your insurance.

You should also be aware that your contract with your health insurance company requires that we provide it with clinical diagnosis and often additional clinical information such as treatment plans or summaries, or copies of your Medical Record. In some cases, they may share the information with a national medical information databank. This may influence your subsequent ability to qualify for health, disability and/or life insurance. You can avoid this reporting by choosing to pay for services yourself.

GRIEVANCES

If you have difficulty with the services we are providing you, please let us know as soon as possible. Please call us with your concerns, or direct them to us in writing. Bradford Prinzhorn, PsyD is the practice president and Tracy Ware, MD is our medical director. Patricia Roos, PhD is our acting HIPAA Privacy Officer. Any of these people can be reached at this office, or in writing, at:

CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA
610 Jones Ferry Road, Suite 208
Carrboro, NC 27510-6113
Telephone: 919.636.5695
Fax: 919.442.1105

You also have the right to file a complaint with the U. S. Department of Health and Human Services at www.hhs.gov.

Thank you for the time taken to read our office policies and HIPAA policies. Your signature on the next page indicates that you have received and read the information in this document and agree to abide by its terms during our professional relationship. **Please detach and return the completed signature page to our administrative staff – the rest of this agreement should be kept for reference.**

CHAPEL HILL PSYCHIATRIC ASSOCIATES, P.A.

PLEASE READ THE [POLICIES AND PROCEDURES](#).

It contains important information regarding your financial liability for services provided.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE REVIEWED THE AGREEMENT TITLED
“**Policies and Procedures – Chapel Hill Psychiatric Associates, PA**” AND YOU AGREE TO ITS TERMS. THE
LATEST POLICY IS AVAILABLE ON OUR WEBSITE WWW.CHAPELHILLPA.COM.

YOU MAY REQUEST A PRINTED COPY OF THE POLICIES AND PROCEDURES..

Signature of Client/Patient/or Patient’s Legal Representative

Date: