Raleigh Psychiatric Associates, P. A.

4700 Homewood Court, Ste 220 Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

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PATIENT INFORMATION

PATIENT NAME_____
LAST FIRST M

ADDRESS_____
STREET CITY STATE ZIP CODE

EMAIL **SEX: M** ☐ **F** ☐ **AGE**____ **DATE OF BIRTH**_____

OCCUPATION_____ **EMPLOYER**_____

HOME PHONE:_____ **CELL:** _____

SINGLE ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **OTHER**_____

SPOUSE, PARENT, SIGNIFICANT OTHER (circle one) NAME:_____

ADDRESS: (if different)_____ **PHONE:**_____

INSURED'S NAME_____ **DATE OF BIRTH**_____

CHILDREN OR SIBLINGS (circle one) NAME & AGES_____

PRIMARY PHARMACY:_____ **PHONE:**_____

REFERRED BY:_____ **PRIMARY PHYSICIAN:**_____

I GRANT PERMISSION TO SEND LETTERS & SPEAK TO REFERRING CLINICIAN, REQUEST PRIOR TREAMENT RECORDS & COORDINATE CARE: YES: ☐ **NO:** ☐

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OTHER CONTACTS WITH PSYCHIATRIST, PSYCHOLOGISTS, SOCIAL WORKER, MENTAL HEALTH COUNSELORS OR HOSPITALIZATIONS:_____

_____

_____

PERSON RESPONSIBLE FOR BILL IF OTHER THAN PATIENT:

NAME:_____RELATIONSHIP:_____

STREET ADDRESS CITY STATE

PHONE

NAME OF HEALTH INSURANCE_____

NAME OF POLICY HOLDER: _____POLICY HOLDER DOB_____

SUBSCRIBER ID #_____GROUP #_____EFECTIVE DATE_____

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I agree I am responsible for all medical expenses I incur at RPA regardless of what my insurance carrier decides or reimburses. If any overpayment of my account, a refund will be issued or credit to future visits.

I authorize the physician/therapist to provide treatment as is necessary. I authorize release of medical information to my primary physician. I authorize the release of medical information to my insurance carriers.

I understand RPA is an interdisciplinary group practice where clinicians share medical records and on-call responsibilities. I understand my clinicians may recommend the services of another RPA clinician to collaborate, consult, and/or coordinate my care.

I understand that in so doing, clinicians need to share information about me. The clinicians and staff at RPA do not, as a routine, accept e-mail. Each clinician may choose to make exceptions. Should this occur, then this agreement acknowledges this arrangement and will be a part of the clinical record as will copies of all the e-mails. All phone calls are part of the record.

I understand that I must give a 24 **Hour Notice** for cancellation of appointment weekdays and Friday by 12:00 noon for Monday or I will be charged a regular fee. I have read and understand and so indicate.

_____ _____

Patient (or authorized agent) Signature Date

I authorize my insurance benefits to be paid directly to the designated physician or therapists if they are participating and in network.

_____ _____

Patient (or authorized agent) Signature Da

RALEIGH PSYCHIATRIC ASSOCIATES, P.A.
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FINANCIAL POLICY

Office Services:
Fees are determined by (1) the type of service scheduled, and (2) if applicable, in accordance with criteria set forth by Medicare.

Payment is due in full at the time of service. Cash, personal check, Visa and Mastercard are acceptable.

Cancellations or appointment changes are subject to 24-hour notice or a cancellation fee (up to full fee) may be charged, subject to review with the clinician at the patient's next appointment.

If you request, we may provide a reminder call as a courtesy two business days prior to your appointment. Problems such as your phone being busy, no answer etc may interfere with such reminders. You are responsible to be at your appointment at the agreed time.

Insurance will be filed as a courtesy and all benefits will be paid directly to you unless prior arrangements have been made with insurance carriers RPA has contracts with.

FEES FOR NON-SESSION ACTIVITES

Forms: A reasonable fee will be charged for the completion of disability forms, etc, or for generating financial reports.

Returned checks: There will be a few for all returned checks.

Phone calls: will be returned as soon as possible. Due to patient appointments, emergencies, etc phone calls may be delayed. If a life-threatening emergency exists, call 911. Phone calls with clinician may be charged.

Medications: Patients are asked to work with the physicians to ensure that prescriptions are written to last until the next session. **PLEASE REQUEST REFILLS FROM YOUR PHARMACY FIRST.**

GENERAL INFORMATION APPLICABLE TO ALL PATIENT SERVICES:

Accounts are considered delinquent if payment or financial arrangement does not occur within 30 days of the initial billing.

Confidentiality is waived in the event we file with your insurance. If any bill is 90 days past due and patient has not negotiated a financial contract with the therapist, confidentiality is also waived to allow referral to a collection agency or legal proceedings regarding collection fees.

Questions concerning these policies may be directed to your clinician and the administrative staff at 919-787-7125

I have reviewed and read the above conditions. I am the responsible payer.

_____	_____	_____
Print Name	Signature	Date

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PATIENT CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Raleigh Psychiatric Associates to use and disclose protected health information. (PHI) about me to carry out treatment, payment and healthcare operations. (TPO) RPA's "Notice of Privacy Practices" provides a more complete description of such uses and disclosures.

I have the right to review and receive the "Notice of Privacy Practices" prior to signing this consent. RPA reserves the right to revise its Notice of Privacy Practices anytime. A revised copy may be obtained by forwarding a written request to the above address.

With this consent, RPA may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, or payment and healthcare operations. This includes, but not limited to appointments, reminders, insurance items, and labs.

With this consent, RPA may mail to my home or other location, any items that assist the practice in carrying out my care.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to RPA by my Protected Health Info (PHI) to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, RPA may decline to provide treatment.

Upon request from patient, "Notice of Privacy Practices" will be provided.

Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian
Print Name	Date

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MEDICATION HISTORY

PATIENT NAME: _____ DATE: _____

For our records, please list: 1) Any known allergies, 2) all medications, both over-the-counter and physician prescribed, you are taking now or have taken during the last six months, and 3) any psychiatric medications (antianxiety, antidepressant, antimanic, antipsychotic, tranquilizer) you **have ever** taken.

ALLERGIES: _____

_____

MEDICATION	STRENGTH (mg)	DOSAGE & FREQUENCY	M.D. WHO PRESCRIBED	DATES TAKEN FROM	TO	REASON FOR TAKING	EFFECTIVENESS

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MEDICAL AND SURGICAL HISTORY FORM

_____ _____

Please list all medical illnesses:

_____

_____

_____

_____

_____

_____

Please list all surgeries including the year surgery was performed:

_____

_____

_____

_____

Please list medical and psychiatric illnesses in your family including the family connection:

_____

_____

REVIEW OF SYSTEMS

Constitutional: fever weight gain weight loss appetite change night sweats fatigue chills

Eyes: blurry double vision vision loss tearing redness pain sensitivity to light glaucoma

Ears, Nose, Mouth, Throat: hearing loss ringing ears ear pain nasal congestion nasal drainage nosebleeds mouth/throat irritation tooth problem

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling high/low blood pressure

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or vomitus heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency urinary hesitancy pain impotence sexual problem infection urinary retention

Musculoskeletal: pain stiffness joint redness/warmth arthritis back pain weakness muscle wasting sprain/fracture

Neuro: headache weakness dizziness change in voice change in taste change in vision change in hearing loss/change sensation trouble walking balance problem coordination problem shaking speech problem

Endocrine: cold or heat intolerance blood sugar problem weight/gain loss missed periods hot flashes/sweats change in body hair change in libido increased thirst increased urination

Heme/Lymph: swelling bleeding problem anemia bruising enlarged lymph node

Allergic/Immunologic: itch post nasal drip watery/itchy eyes nasal drainage immunosuppressed