RALEIGH PSYCHIATRIC ASSOCIATES, P.A.

4700 Homewood Court,
Suite 220 Raleigh, NC 27609

Telephone: 919-787-7125
Fax: 919-781-9952

James E Bellard, M.D.
Thomas R Spruill, M.D.
Cherry Chevy, M.D.
Rhonda H Stahl, M.D.

Alyssa Williams George, M.D.
Adam Lake, M.D.
Frank D Castlebury, PhD.

PATIENT INFORMATION (PATIENTS UNDER 18)

Date: _____

Person filling out form: _____ Relationship: _____

Patient: _____ DOB: _____
Last First MI

Age: _____ Gender: Male _____ Female_____

Address: _____

Phone: _____ Mother's cell: _____ Father's cell: _____

On which of these numbers may we leave a message?

_____

Mother's name: _____
Last First MI

Father's name: _____
Last First MI

Parents' Marital Status (circle): married separated divorced never married other

If parents are not married or if there is a non-parent guardian, what is the custody arrangement?

_____

_____

_____

Siblings (names and ages) _____

Primary Physician: _____

Raleigh Psychiatric Associates, P. A.
4700 Homewood Court, Ste 220 Raleigh, NC 27609
Telephone 919-787-7125 **Fax 919-781-9952**

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_____

Raleigh Psychiatric Associates, P. A.
4700 Homewood Court, Ste 220 Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

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.
4700 Homewood Court, Ste 220
Raleigh, NC 27609

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

RALEIGH PSYCHIATRIC ASSOCIATES, P.A.
4700 Homewood Court, Ste 220
Raleigh, NC 27609

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

Raleigh Psychiatric Associates, P. A.
4700 Homewood Court Ste 220 • Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

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

Raleigh Psychiatric Associates, P. A.
4700 Homewood Court, Suite 220, Raleigh, NC
Telephone 919-787-7125 Fax 919-787-9952

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

Supplementary Information Sheet

Child's Name_____ Birthday_____

Medical History

Were there any problems with pregnancy or delivery?_____ If so, please describe:

Was the child exposed to any drugs, toxins, or alcohol before birth? If so, please describe:

Was your child born on time?_____ Birth Weight:_____

Were any birth defects identified?

Were there any problems in the first few days of life?

Has your child had frequent ear infections?

Does your child have any illnesses for which he/she is currently being treated?

Please list any surgeries your child has had and when they were performed:

Has your child ever had a seizure, head trauma or loss of consciousness?_____ If so, please describe:

Has your child ever had a CT scan, EEG or MRI?_____ If so, please describe:

Has your child ever been hospitalized?_____ If so, please describe:

Has your child ever been seen in the Emergency Room?_____ If so, please describe:

Date of most recent physical exam:_____ Vision screening:_____ Hearing Screening:_____

Please list any medications and doses your child is taking currently, including over the counter preparations, herbal preparations, and vitamins:

Is your child allergic to any medications?_____ If so, please list:

Developmental Milestones:

At what age did your child:

Wean_____ Walk_____ Use 2 word sentences_____ toilet train_____

Were any delays in development (speech, motor), noted?

Please describe what your child was like between ages 0-4:

Educational History:

Please list all schools attended and for which grades, and any teacher comments:

.
.
.
.
.
.

Has your child ever repeated or skipped a grade?_____ If so, please describe:

Has your child ever had an IEP (Individualized Educational Plan)?_____

Please list any special services or classes your child receives (tutoring, speech/language, advanced/gifted classes):

If any expulsions or suspensions have occurred, please describe:

Has your child ever had educational testing (to identify learning problems, etc)? If so, please list where, when, and result:

.
.
.

Social History

Please list names and ages of all persons living in the home:

.
.
.
.
.
.

How well does your child do socially?

Please list:

Other cities where your child has lived:

Your child's extracurricular activities:

Any legal or custody issues:

Any stressful issues your child has had:

To coordinate care, it is customary to collaborate with the child's primary physician, particularly when medications or special services are recommended. May I have permission to communicate with your child's primary physician?

Yes, to give information_____ Yes, to receive information_____

No, please do not communicate with my child's primary physician_____

Signature_____ Date_____

Relationship to child_____

Family History
Please list any blood relative with the following:

Substance Abuse_____

Attention Deficit_____

Learning Problems or Retardation_____

Depression_____

Bipolar Disorder (manic-depression)_____

Schizophrenia_____

Autism_____

Obsessions/Compulsions_____

Panic_____

Eating Disorders_____

Suicide_____

Diabetes_____

Cancer_____

Hypertension or Heart Disease_____

Thyroid Disease_____

Liver Disease_____

Kidney Disease_____

Migraines_____

Tics_____

Genetic Syndromes_____

Neurologic Disorders (Parkinson's, Multiple Sclerosis, Alzheimer's, etc.)_____

Epilepsy_____

Previous Treatment

Name_____ Date of Birth_____

Is this your first mental health consultation?_____

If not, please list the following, where applicable:

Previous evaluations (evaluator(s), date of evaluation, recommendations):

o

o

o

Previous psychotherapy (therapist, dates of treatment):

o

o

o

Previous medication trials (name of medication, dose, how long treatment was taken): *Note: If uncertain, this information may be obtained from pharmacy where prescriptions were filled.*

o

o

o

Previous psychiatric hospitalizations (hospital, dates, treatment):

o

o

o

If possible, please contact previous providers to request that any pertinent old records be sent to Raleigh Psychiatric Associates prior to your first appointment, so they may be reviewed prior to the consultation.

Thank You. All information will remain strictly confidential.