

TRIAD PSYCHIATRIC & COUNSELING CENTER, PA

NAME: FIRST: _____ M.I.: _____ LAST: _____

DATE OF BIRTH: ____/____/____ GENDER IDENTITY: _____ PREFERRED PRONOUNS: _____

SOCIAL SECURITY #: ____ - ____ - ____ MARITAL STATUS: _____ PREFERRED NICKNAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CHECK ONE AS YOUR PREFERRED CONTACT NUMBER: HOME CELL WORK

I CONSENT TO TEXT/EMAIL REMINDER COMMUNICATIONS: YES NO

PHONE #: HOME: _____ CELL: _____ WORK: _____

EMERGENCY CONTACT: _____ NAME: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PROVIDER: _____ LOCATION: _____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER): _____

CURRENT PHARMACY: _____ LOCATION: _____

MEDICATION ALLERGIES: _____

OTHER ALLERGIES: _____

IF PATIENT IS A MINOR

****PLEASE SUBMIT ANY CURRENT/UPDATED COURT ORDERS AND/OR SPECIAL CUSTODY AGREEMENTS FOR PATIENT TO ADHERE TO PRACTICE COMPLIANCE AND HIPAA GUIDELINES****

ARE THERE ANY COURT ORDERS/CUSTODY AGREEMENTS IN PLACE: YES NO

GUARDIAN NAME: _____

SS# (IF INSURANCE CARD HOLDER): ____ - ____ - ____ RELATIONSHIP TO PATIENT: _____

PHONE # AND ADDRESS (IF DIFFERENT FROM ABOVE): _____

GUARDIAN NAME: _____

SS# (IF INSURANCE CARD HOLDER): ____ - ____ - ____ RELATIONSHIP TO PATIENT: _____

PHONE # AND ADDRESS (IF DIFFERENT FROM ABOVE): _____

SIGNATURE: _____ NAME: _____ DATE: _____

Compliance Assurance Notification For Our Patients

- I authorize the release of any medical or other necessary information to process my insurance claims to my insurance company.
- I request payment of any government benefits to be paid to myself or to the party who is accepting assignment for those benefits.
- I authorize payment of medical benefits be paid to my physician for services rendered.

Our staff at TPCC, including providers and counselors, continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with HIPAA. We are required by law to maintain the privacy of our patients and to provide individuals with the notice of our legal duties and privacy practices with respect to PHI, including HIV and Substance Abuse status. Therefore, pursuant to General Statute (GS) 130A-143, HIPAA Regulation 164.512 and Policies 42CFR and 45CFR, we have implemented a Compliance Program that will help prevent any inappropriate use of PHI. Copies of these Statutes and Policies are available upon request as are our Notice of Privacy Practices. Any questions regarding this policy may be directed to the Compliance Officer.

Do we have your consent:

- To contact you at the phone numbers you have provided? YES NO
- To leave a message regarding appointments and/or prescriptions? YES NO
- To discuss your Personal Health Information with any other persons? YES NO

If YES, please list their names and their relationship to you: _____

By signing below, you have acknowledged that you have read and been made aware of our Notice of Privacy Practices and have given your consent for disclosure of the above. Patients have the right to withdraw any of the above consents and may submit that request to our office at any time.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Client Rights Information

Please read and Sign, thereby acknowledging you have read and understand:

- The patient has a right to receive information about our company's services, practitioners, clinical guidelines, and patient rights and responsibilities regarding their care.
- The patient has a right to reasonable access to care regardless of race, religion, gender, sexual orientation, ethnic, age, or disability.
- The patient has a right to participate in an informed way in the decision making process regarding their treatment planning.
- The patient has a right to be informed of all potential risks, benefits of treatment, and has the right to refuse treatment.
- The patient has a right to discuss with their provider the medically necessary treatment options of their condition regardless of cost or benefit coverage.
- The patient has a right to individualized treatment including a) adequate and humane services regardless of the source of financial support, b) provisions of services within the least restrictive environment possible, c) an individualized treatment or program plan, d) competent clinical staff to supervise and carry out the treatment.
- The patient has a right to the consideration of ethical issues that arise in the provision of care and services including resolving conflict and withholding resuscitative services.
- The patient has a right to designate a surrogate decision maker if the patient is incapable of understanding a proposed treatment or is unable to communicate their wishes.
- The patient has a right to be treated with personal dignity and respect.
- The patient has a right to care that is considerate and respects the patient's values and beliefs.
- The patient has a right to personal privacy and confidentiality of information.
- The patient has a right to voice their complaints or appeals regarding TPCC or their managed care provider to the office manager.
- In the event that there still has not been satisfactory resolution to their complaints or concerns, the patient has the right to contact the following: The Division of Mental Health 919-715-3197, The Disabilities Rights of NC 800-821-6922, and The NC Board of Medicine 800-253-9653 or www.ncmedboard.org.
- The patient has a right to make recommendations regarding the Patient rights and Policies at TPCC.
- The patient has a right to be informed of rules and regulations regarding the patient's conduct.

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- The patient has the right to be informed that there may be instances, pursuant to General Statute 13oA-143, HIPAA Regulation 165.512, Policies 42CFR and 45CFR, that we are legally mandated to release their Personal Health Information (PHI) without their signed consent. Copies of these regulations and policies are available upon request.
- The patient has the responsibility to give TPCC and their provider information needed in order to receive care.
- The patient has the responsibility to follow the agreed upon treatment plan and instructions for care.
- The patient has the responsibility to participate in understanding their behavioral health problems and in developing along with their provider a mutually agreed upon treatment goal.

By signing below, the patient hereby consents to treatment by their managed care provider following the above expressed guidelines. Any patient who wished to withdraw consent for treatment may do so by submitting their decision in writing to their provider.

SIGNATURE OF PATIENT/GUARDIAN

DATE

CHART #: _____

Office Policy Regarding Urine Drug Screens

THIS NOTIFICATION IS FOR CLIENT INFORMATION PURPOSES ONLY

TPCC implements a Urine Drug Screen (UDS) protocol. The main purpose of this policy is to:

- Ensure patient compliance with prescribed medication
- Monitor clinical progress and improve clinical decision making
- Confirm abstinence from substances of abuse
- Aide in assessment, diagnosis, and detection of relapse to substances of abuse

Criteria for UDS Screening:

- Any patient who refuses to submit a UDS will not be prescribed any controlled substances such as Benzodiazepines, Opioids, Stimulants, or Suboxone. **This includes any patient who presents for an initial evaluation requesting prescriptions for the above mentioned medications.**
- Any patient currently on Benzodiazepines, Opioids, Stimulants, and/or Suboxone will be tested at their provider's discretion.
- Any patient that is being prescribed psychotropic medications and displays any indication of concerns for co-morbid substance use will be tested at their provider's discretion.
- Any patient that displays behavioral alterations that raise clinical suspicion of possible substance abuse will be tested at their provider's discretion.

Cost of Testing:

Urine samples will be collected at the TPCC practice location and sent to a qualified laboratory for testing. You will not be billed for sample collection. However, charges for the actual lab test will be billed to your insurance carrier by the participating lab. You may be responsible for any portion of the \$30.00 fee that is not covered by your insurance carrier. **SELF-PAY PATIENTS WILL BE RESPONSIBLE FOR THE TOTAL COST OF QUALITATIVE AND QUANTITATIVE URINE DRUG SCREEN ANALYSIS AT THEIR PROVIDER'S DISCRETION.**

SIGNATURE OF PATIENT/GUARDIAN

DATE

POLICIES AND PROCEDURES

- 1) Co-pays are a contract you and our practice have with your insurance company and are due at the time of each visit. Please be prepared to pay your co-pay when you arrive for your appointment. Failure to pay your co-pay may delay the scheduling of your next follow-up appointment.
- 2) Prior notice of any appointment you are unable to keep allows us to make use of the available appointment. Therefore, we require a cancellation notice of 24 business hours prior to your appointment. Office phone hours are 8am-5pm Monday-Friday with the exception of lunch from 1pm-2pm.
- 3) **A No-Show fee (no notification of cancellation) of \$130.00 or a Late Cancellation fee (failure to provide 24 hours notification of cancellation) of \$95.00 will be assessed accordingly to the patient's account. More than two (2) No Show and/or Late Cancellations within a twelve (12) month period will result in discharge from Triad Psychiatric & Counseling Center, PA.**

PATIENT/GUARDIAN INITIAL: _____

- 4) Patients must contact their pharmacy and request the pharmacy to notify us by FAX of any request for refills of non-stimulants/narcotics. For refills on stimulant or narcotic medications, patients must call our pharmacy coordinator line. They can be reached at (336) 553-1993. **Please allow 24-48 hours for our pharmacy coordinators to address all prescription refill requests. Prescriptions called or faxed by your pharmacy after 5:00pm on Thursday will not be filled until Monday. No refill prescriptions will be given on a walk-in basis.**
- 5) In the event you are more than 15 minutes late, your appointment may need to be rescheduled.
- 6) We require that you call our billing office prior to your appointment with any insurance changes. This allows our billing office the opportunity to obtain your benefit information.
- 7) Any request for transfer of medical records, which includes consent for release of the patient's HIV and Substance Use status, must be made in writing per HIPAA compliance regulations. Release of Information forms are available at our office or on our website at www.triadpsychiatricandcounseling.com.

The above policies have been made to help our practice serve you better by keeping down unnecessary operating costs. Thank you for your cooperation and for allowing us to participate in you care. A copy of this signed agreement will be made available to you upon request.

SIGNATURE OF PATIENT/GUARDIAN

DATE

TRIAD PSYCHIATRIC & COUNSELING CENTER, PA

The Patient and Visitor Code of Conduct is a set of values and guidelines outlining the expectations of patients and visitors within TPCC facilities.

The Triad Psychiatric & Counseling Center, PA Patient and Visitor Code of Conduct was established to help ensure our clinic is safe, considerate, inclusive not only for patients and visitors, but for our Providers, MA's, and Associates as well.

- Everyone will be treated with kindness, dignity, and respect. Offensive comments about race, religion, gender, sexual orientation, or personal traits are not acceptable, and neither is the refusal to see a clinician or associate based on these traits.
- All patients and visitors will use respectful, appropriate language and behavior. Physical or verbal threats or assaults, suggestive or explicit words, phrases, gestures, or actions will not be tolerated.
- All patients and visitors will respect patient privacy and avoid disrupting other patients' care or experiences.

If these guidelines are not followed:

- Patients may be asked to leave and for severe violations, future care at TPCC may require review. In cases of non-compliance, patients will have an opportunity to explain their perspective, which will be considered prior to any decisions regarding future care at TPCC. **Ultimately, permanent discharge from the practice may be considered as a final outcome.**
- Visitors may also be asked to leave and could be restricted from future visitation.

Every day, our Providers, MA's, and Associates are committed to providing the highest levels of care to our patients. Please show them the respect they deserve and that you expect as a patient or visitor.

Thank you for choosing Triad Psychiatric & Counseling Center, PA and joining us in our commitment to ensuring a safe, caring, and inclusive environment for us all.

PATIENT NAME:

PATIENT SIGNATURE:

OR:

GUARDIAN NAME:

GUARDIAN SIGNATURE:
