TRIAD PSYCHIATRIC AND COUNSELING CENTER, PA

Name: First ______________________ M.I. _______ Last ____________________

Date of Birth : ___________________ Sex : Male/Female Marital Status: _____

Social Security # : ___________________________

Street Address: ____

City: ____________________________ State: _______________ Zip: _________

PLEASE CIRCLE THE PHONE NUMBER YOU PREFER US TO CALL FOR APPT REMINDERS

Phone # : Home ________________ Cell _________________ Work ___________

Emergency Contact : _____________________________ Phone # : _____________

Relationship to Patient : ____

IF PATIENT IS A MINOR:

Mother's Name: ____

SS# (if Insurance Card Holder): ____

Phone # and Address (if different from above) : _____________________________

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Father's Name: ____

SS# (if Insurance Card Holder): ____

Phone # and Address (if different from above) : _____________________________

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Primary Care Provider: _______________________ Location: _______________

Specialists: ___________________________________ Location: _______________

Therapist/ Counselor: __________________________Location: _______________

Current Medication: (include over the counter) :

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____

Current Local Pharmacy: _______________________ Location: _______________

Mail-In Pharmacy: ____

Medication Allergies:

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____

Food Allergies:

____

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Date: _______________________

Triad Psychiatric and Counseling Center, P.A.

- 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.

Signature:_______________________________ Date:____________________

Compliance Assurance Notification For Our Patients

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 appoints 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:

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____
____
____

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: _______________________________ Date:____________________

Triad Psychiatric and Counseling Center, PA

Client Rights Information

Please read and initial each line, 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. If, at any time, they are not satisfied with the outcome, modifications, or changes made regarding their complaint or concern, they are encouraged to notify the practice owner. In the event that there still has not been satisfactory resolution to their complaint's 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 Medicaine 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

___ The patient has the right to be informed that there may be instances, pursuant to General Statute 130A-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/Patient Guardian Date

Triad Psychiatric and Counseling Center, PA
Office Policy Regarding Urine Drug Screens

THIS NOTIFICATION IS FOR CLIENT INFORMATIONAL PURPOSES ONLY:

TPCC will be implementing 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 present 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 comorbid 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 you insurance carrier by the participating lab. You may be responsible for any portion of the claim that is not covered by you insurance carrier. The laboratory can help with those who have documented financial hardship. Please go to the following link for details on financial assistance: www.avutox.com/lab-resources/for-patients.

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Signature of Patient/Patient Guardian Date