Piedmont Psychiatric Associates

Patient Information Sheet / Application for Treatment

Date ____/____/____ Chart # [ ]

Name: Last _____ First _____ Middle _____

Street Address: _____ APT # _____ PO Box _____

City: _____ State _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth ____/____/____ Age: _____ SSN#: _____-_____-_____

Employer: _____ Employed: **Full Time** **Part Time** **Disabled** **Retired** **N/A**

Employer's Address: City: _____ State _____ Zip Code: _____

Sex: **Male** **Female** Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated** Student: **Full Time** **Part Time**

Primary Care Physician: _____ Phone: ( ) _____ Fax ( ) _____

Primary Care Physician's Address: City: _____ State _____ Zip Code: _____

Referring Physician: _____ Phone: ( ) _____ Fax ( ) _____

Referring Physician's Address: City: _____ State _____ Zip Code: _____

Check one: **Spouse** **Parent/ Guardian** Are you the financially responsible party? **Yes** **No**

Name: Last _____ First _____ Middle _____

Street Address: _____ APT # _____ PO Box _____

City: _____ State _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth ____/____/____ Age: _____ SSN#: _____-_____-_____

Employer: _____ Employed: **Full Time** **Part Time** **Disabled** **Retired** **N/A**

Debit/Credit Card to be kept on File: _____ Expiration Date: ____/____/____

Insurance Information

PRIMARY Insurance Carrier: _____

Insurance Carrier's Address: City: _____ State _____ Zip Code: _____

Effective Date: ____/____/____ Policy # _____

Group #: _____ Employer: _____

Guarantor Name: (***Name insurance is in***) Last _____ First _____ Middle _____

Date of Birth ____/____/____ Relationship of Patient to Guarantor: **Self** **Spouse** **Child**

SECONDARY Insurance Carrier: _____

Insurance Carrier's Address: City: _____ State _____ Zip Code: _____

Effective Date: ____/____/____ Policy # _____

Group #: _____ Employer: _____

Guarantor Name: (***Name insurance is in***) Last _____ First _____ Middle _____

Date of Birth ____/____/____ Relationship of Patient to Guarantor: **Self** **Spouse** **Child**

PLEASE COMPLETE PAGE 2 OF THIS FORM

RELEASE OF INFORMATION

I hereby authorize the release of any information in the course of my examination and/or treatment to the following:

1. My insurance company for reimbursement purposes.
2. The billing service in order to bill for services rendered.
3. My referring physician. Yes_____No_____
4. My Primary Care Physician Yes_____No_____
5. I understand that my records are protected under Federal regulations governing confidentiality of Alcohol and Substance Abuse patient records, 42 CFR Part 2, and cannot be disclosed if checked "No". I also understand that I may revoke this consent at anytime.

Primary Care Physician's Name:_____

Address:_____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name:_____

Phone:_____ **Relation:**_____

ASSIGNMENT OF BENEFITS:

I hereby authorize the payment of medical benefits to *Piedmont Psychiatric Associates*. I also understand that I will be expected to pay the co-payments and/or deductibles at time services are rendered. I further agree to pay any amounts not covered by my insurance company(s). I understand that it is my responsibility to pay any unpaid balance if payment is denied for any reason by my insurance company(s). The patient(or responsible party) remains responsible for this account, not the insurance carrier. P.P.A. must collect what is due either during the first 30 day billing cycle or by using your debit/credit card. Our goal is to avoid using a collection agency. Missed appointment charge is $80.00 and late cancellation(less than 24 hours) charge is $50.00. Charge cannot be written off if you can't provide your confirmation number given to you by our staff.

My signature below indicates my consent for treatment, release of information, assignment of benefits, and to maintain my account in good standing.

Signed:_____ **Date:**_____

PIEDMONT PSYCHIATRIC ASSOCIATES

Acknowledgement of Receipt
Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

- **I have reviewed the Notice of Privacy Practices and understand that I have received a copy for my review.**

DISABILITY

Letters, forms and paperwork will be completed *only* after we have had a chance to obtain history and begin treatment. This will require at least (3) office visits.

REFILLS

Refills can not be called in after hours. No exceptions per office policy.

_____ _____

Signature **Date**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

~PPA~

[redacted]

Name: _____ ***Date:*** _____

Age: _____ ***Date of Birth:*** _____

INSTRUCTIONS: This Well-Being Chart is a confidential document between you and your doctor. It is intended to help you and your doctor discuss your well-being openly and candidly. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.

Have you taken any medications in the last 4 weeks? Yes ____ No ____
If yes, please list: _____

_____

Drug allergies? Yes ____ No ____ Name of Drug: _____
Do you smoke cigarettes? Yes ____ No ____ Pack(s) per day ____ Other Tobacco Products _____

EYES AND EARS
___Double Vision
___Difficult in focusing vision
___Eye pain
___Sinus pain
___Increase of decrease in tearing

URINARY
___Frequent urination
___Painful urination
___Difficulty in passing urine
___Blood in urine

CARDIOVASCULAR
___Chest pain
___Chest discomfort
___Heart pounding

GASTROINTESTINAL
___Diarrhea ___Black, tarry stools
___Constipation ___Stomach pains
___Heartburn ___Food intolerance
___Rectal Bleeding ___Abdominal bloating

RESPIRATORY: NOSE/ THROAT/MOUTH
___Cold (influenza) ___Cough
___Nasal congestion ___Wheezing
___Nosebleeds ___Shortness of breath
___Hay fever ___Pain when breathing

OTHER SYMPTOMS NOT LISTED PLEASE SPECIFY:
_____

_____

SYMPTOMS LIST: *Check off any of these symptoms most bothersome or have occurred frequently during the last 4 weeks.*

___Fever
___Repetitive, senseless thoughts
___Repetitive, senseless behaviors
___Fainting
___Shakiness
___Seizures
___Easy bruising
___Skin rash
___Violent behavior
___Constant worry
___Irritability
___Tension
___Headache
___Feeling in a dreamlike state
___Fearful feelings
___Fear of losing control
___Jumpiness
___Restlessness
___Worthless feelings
___Hopeless feelings
___Sleeping too much
___Memory problems
___Sweating
___Dizziness/lightheadedness
___Keyed up or on edge
___Agitation
___Nervousness
___Trouble concentrating
___Insomnia/trouble sleeping
___Decrease in sex drive
___Trouble making decisions
___Sad/depressed/down in the dumps
___Lack of/loss of interest in things
___Helpless feelings
___Fatigue-lack of energy
___Weakness
___Increase or decrease in appetite
___Increase or decrease in weight
___Frequent crying or weeping
___Frequent thoughts of death or suicide
___Excessive feelings of guilt
___Feeling life is not worth living
___Frequent negative thinking
___Fear of doing something uncontrollable
___Fear of dying
___Chills
___Fear of going crazy
___Seeing of hearing things not real
___History of abuse

5. In the event that a crime occurs on the premises of the practice
6. Medical emergency (not on the Practice's premises) and it is likely that a crime has occurred

Coroner, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel:

1. For activities deemed necessary by appropriate military command authorities.
2. For the purpose of a determination by the Department of Veterans Affairs of eligibility for benefits.

We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President of The United States or others legally authorized.

Workers Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Inmates: We may use or disclose protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

4. YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; **(1) *psychotherapy notes*** (2) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access to your records may be made if such access might be harmful to you as a patient, or we may provide a summary of the information in your record upon your agreement. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

If you request copies, we will charge you $ 1.75 for each page copied and postage if you want the copies mailed to you.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operation. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this *Notice of Privacy Practices.* Your request must state specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to the restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction with your physician. You may request a restriction by submitting, in writing, a letter describing the restriction and signed to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking for information as to how payment will be handled or specification of alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending you protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us: Upon request, even if you have agreed to accept this notice electronically.

5. COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact at (336) 766-0505 for further information about the complaint process.

PPA
PIEDMONT PSYCHIATRIC ASSOCIATES

NOTICE OF PRIVACY PRACTICES

PHONE 336-766-0505

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION *(PROTECTED HEALTH INFORMATION)* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

The privacy of your medical information *(protected health information)* is important to us. We understand that your protected health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your protected health information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this Notice at any time provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the terms of our notice effective for all protected health information that we keep, including previously created or received before the changes

3. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

The following section describes different ways that we use and disclose protected health information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose protected health information. We will not use or disclose your protected health information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT:
We may use and disclose your *protected health information* to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. *For example*, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. *For example*, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

FOR PAYMENT:
Your *protected health information* will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, review of pre-existing condition, and undertaking utilization review activities. *For example*, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for the hospital admission.

FOR HEALTHCARE OPERATIONS:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. We may use your protected health information to contact you about your account.

For example, we may disclose your protected health information to a new employee in the process of training. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose protected health information, as necessary, to contact you to remind you of your appointment or contact you about test or other activities regarding your health. This communication may be by mail, email, fax, telephone or telephone answering machine. *For example*, we may call to remind you of an appointment and if we are unable to reach you, we may leave a message with another member of the household or on your voice mail.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription, computer services) for the practice. Whenever an arrangement between our office and a "business associate" involves the use and disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for marketing activities. *For example*, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services what we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. You may contact our Privacy Contact to request that these materials not be sent to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION.
Other uses and disclosures of your protected health information will be made only with written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT.

We may use or disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only protected health information that is relevant to your health care will be disclosed.

Others involved in your healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use or disclose protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT.

We may use or disclose protected health information in the following situations without your consent or authorization. These situations include:

Required by law: We may use or disclose protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track problems; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include:

1. Legal process and otherwise required by law
2. Limited information request for identification and location purposes
3. Pertaining to victims of a crime
4. Suspicion that death has occurred as a result of criminal conduct