Date: _____

Patient's Name: _____ SSN: _____

Address: _____

Home Phone Number: _____ Sex:_____ Age:_____ DOB:_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer: _____

Employer's Address: _____

Business Phone: _____ Occupation: _____

Who is responsible for this account? _____

Spouse's (or responsible party's) Name: _____

Spouse's (or responsible party's) Employer: _____

Business Phone: _____ Occupation: _____

SSN: _____ If Military: Rank:_____ ☐ Active ☐ Retired

Do you have medical insurance?: ☐ Yes ☐ No If no: Will you be paying by: ☐ Cash ☐ Check ☐ Credit Card

If yes: Primary Insurance:_____ Phone Number:_____

Policy #:_____ Group #:_____ Subscriber #:_____

Secondary Insurance: _____ Phone #:_____

Policy #:_____ Group #:_____ Subscriber #:_____

Medicare #:_____ Medicaid #:_____

In case of emergency, notify: Name:_____ Relationship:_____ Phone #:_____

Your pharmacy name: _____ Phone #:_____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes the physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim. I further understand that I am responsible for any co-pay and/or deductible amount as per my particular insurance coverage on my account and that although my claims are filed, it is not a guarantee of benefits.

I, _____, hereby authorize _____ to pay and hereby assign directly to Behavioral Health Care, Bordeaux and Melrose Centers all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Behavioral Health Care, Bordeaux and Melrose Centers will be credited to my account in accordance with the above said assignment.

_____ _____ _____

Authorized Signature of Subscriber Date Time

Cape Fear Valley
Behavioral Health Care
P.O. Box 2000 / Fayetteville, NC
28302 – 2000

BH0040

ASSIGNMENT OF BENEFITS

CONSENT FOR PARTICIPATION IN ASSESSMENT AND TREATMENT

On behalf of myself, or the client if a minor, I hereby consent and agree to the following conditions of participation in assessment/treatment.

1. VOLUNTARY PARTICIPATION: I voluntarily consent to participate in such psychiatric, psychological, neuropsychological care and counseling services as may be deemed necessary and appropriate by the physician and/or clinical staff of the Behavioral Health Care (BHC) Outpatient Services or Community Mental Health Center (CMHC). I understand that I will be kept informed of plans for my treatment and may withdraw my consent at any time. I am aware that the practice of medicine and counseling are not exact sciences and acknowledge that no guarantees have been made to me as to the examinations and treatment.

2. DESTRUCTION OF PROPERTY: I understand that patients are responsible for any damage or destruction of clinic property, or property belonging to others which may be located at the clinic, and I agree to accept liability for and reimburse the clinic or other owners of property which I may damage or destroy.

3. CONFIDENTIALITY: I give permission for the professional staff of BHC Outpatient Services or CMHC to provide clinical information to my insurance company or its designee, at their request, for the purpose of justifying my need for treatment/continued treatment. Other verbal or written information regarding my treatment is protected by Federal law and regulations and may be released only with my specific written consent (to qualified personnel for research, audit or evaluation purposes, when in the opinion of clinic staff there is a medical emergency and release of information would be in my behalf, aid in my treatment, or protect the safety of myself and/or others or by court order). Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

4. EMERGENCY NEEDS: In the event that I need emergency medical services, I give permission to be referred for such emergency care. (If you desire a specific emergency provider, please indicate: Name:_____ Phone #:_____. Should I need emergency psychiatric services after the normal operating hours of BHC Outpatient Services or CMHC, I can call (910) 615-3700 and be connected to the after-hours emergency service.

5. FOLLOW-UP: I agree that staff members may call or write, if I fail to keep an appointment in order to assess my need for further treatment. I also agree that staff members may contact me by telephone or by letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services I received at BHC Outpatient Services or CMHC.

Signature of Patient	Print Name of Patient	Date	Time

☐ **Parent** ☐ **Legal Guardian**

Signature	Print Name	Date	Time

If legal guardian, a copy of the legal documentation is required before the patient can be seen.

Signature of Witness	Print Name of Witness	Date	Time

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis

   _____

   _____

2. Please list the family members or others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:
   a. Name_____ Phone Number_____
   b. Name_____ Phone Number_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" ☐ Yes ☐ No

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:_____

6. I am aware that a cell phone is not a secure and private line. ☐ Yes

7. May confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voice mail? ☐ Yes ☐ No (If no, appointment reminders will not be left on voice mail.)

8. I have been given a copy of my Patient Rights and Responsibilities. ☐ Yes

9. I have been given a copy of the Joint Notice of Privacy Practices. ☐ Yes

10. Advance Directive:
    Do you have a Health Care Power of Attorney? ☐ Yes ☐ No
    Do you have a Living Will? ☐ Yes ☐ No
    Have you supplied us with a copy? ☐ Yes ☐ No

_____ _____
Patient Name Date of Birth

_____ _____ _____
Patient/Legal Guardian Signature Date Time

_____ _____ _____
Clinic Employee Witness Signature/Title Date Time

May we forward a thank you letter to the individual who referred you? If so, please write the name/address or phone number below.

☐ Yes. Please send a thank you letter to the individual who referred me that summarizes medications, diagnoses, and a plan of treatment for continuation of care. I also authorize to release portions of the record relating to substance abuse and/or communicable diseases, including HIV/AIDS.

☐ Yes. Please send a thank you letter to the individual who referred me.

☐ No. Please do not send a letter to the individual who referred me.

_____ _____

Signature of Patient Date

_____ _____

Signature of parent/legal guardian Date

_____ _____

Signature of Witness Date

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent will automatically expire 365 days from the date on which it was signed.

Name / Address / Phone Number of referral source

_____

_____

_____

_____