IMPACT CAROLINA SERVICES, INC
FACE SHEET

Referral Date: _____ Referral Source: _____ Referral Telephone #_____

Assessment Date: _____ Admission Date: _____ Discharge Date: _____

PATIENT INFORMATION

Last Name:	First Name:		Middle Int.:	Maiden
Social Security Number:	Date of Birth/ Age:	Gender:	County Residency:	Record Number:
Address:	City:	State:	Zip Code:	Telephone Number:
Cell Phone::	Marital Status::	Race/Ethnicity:	Education Level:	Religious Affiliation
Employer:	Occupation	Telephone#	PCP #:	Primary Care Physician:
Legal Guardian:		Address:		
Home telephone #	Work telephone #	Cellular telephone #		

EMERGENCY CONTACT INFORMATION

Emergency Contact**:**	Address:	
Home telephone #	Work telephone #	Cellular telephone #
Emergency Physician/Hospital	Address	Telephone

FAMILY BACKGROUND INFORMATION

Father's name:	Address:	
Home telephone #	Occupation/Work telephone #	Cellular telephone #
Mother's name:	Address:	
Home telephone #	Occupation/Work telephone #	Cellular telephone #
Siblings/Children: _____ Age: _____ _____ Age: _____ _____ Age: _____		
Significant Others:	Address:	
Home telephone #	Work telephone #	Cellular telephone #

Rev: 03/10/2017

Insurance Information

Primary Insurance: Medicaid Medicare Insurance Self-Pay
Name of Insured: Last: _____ First: _____MI: ____
If Different than Patient: Spouse Child
Name on Card: Last: _____ First: _____
Insurance Company: _____ Telephone# _____
Address: _____
Policy #: _____ Group#_____

Please be sure to provide office with a copy of Insurance card so that your benefits & eligibility can be confirmed.

Secondary Insurance (If Applicable): Medicaid Medicare Insurance
Name of Insured: Last: _____ First: _____MI: ____
If Different than Patient: Spouse Child
Name on Card: Last: _____ First: _____
Insurance Company: _____ Telephone# _____
Address: _____
Policy #: _____ Group#_____

Please be sure to provide office with a copy of Insurance card so that your benefits & eligibility can be confirmed.

Responsible Party (Complete ONLY if someone other than patient is responsible for payment of services)
First Name: _____ Last Name: _____
Mailing address: _____
_____
Telephone Number: (___) _____ Alternate/Cellular (___) _____
Relationship to patient: _____ Marital Status: _____
Social Security # _____ DOB: _____ Age: _____
Employer: _____ Telephone # (____) _____

History of Previous Doctors and Pharmacies

List all doctors you have seen in the last six months. (Include family doctor, therapist, other specialist and etc.)
_____
_____
_____
_____
_____

List any Hospital stays in the last six months.
_____
_____
_____
_____

List All Pharmacies used in the past six months.
_____
_____
_____
_____
_____

CONSENT FORM

ACKNOWLEDGEMENT STATEMENTS

☐ I have received the Patient Confidentiality handout which has been explained to me and I understand the contents to be released, the need for information and that there are statutes and regulations protecting the confidentiality of information. I understand that Impact Carolina Services is required by law to release my protected health information without my consent if at any time I become a danger to myself or to others.

☐ I further acknowledge that I have received the HIPPA Notice of Privacy statement and understand information contained in the document and this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

☐ I have received the Patient Rights Handout which explains my rights as a consumer and I understand the contents.

REQUIRED REPORTING

Our group is required by state and federal regulations to report non-identifying patient information for the purpose of evaluation and funding purposes. It will also be necessary for Impact Carolina Services to use and disclose certain information about myself in order to carry out treatment, payment and health care operations.

REPORTING OF SUSPECTED ABUSE/NEGLECT

Our group is required by state laws to report suspected abuse or neglect to the appropriate authorities. If you have any questions about this, please feel free to ask for a better understanding before you sign this document. Your signature below acknowledges receipt of this information.

☒ EMERGENCY TREATMENT / EMERGENCY INFORMATION / EMERGENCY RESTRICTIVE INTERVENTION

In case of sudden illness/accident/emergency, I hereby give permission to Impact Carolina Services and staff to seek emergency treatment on behalf of the below named patient should the need arise. It is understood that this treatment will be provided by a qualified medical professional, physician, and/or hospital emergency room personnel. In addition, a copy of current medications and known medical conditions and allergies may be released. Efforts will be made to contact the identified emergency contact person prior to treatment, should this be possible. I also will hold harmless Impact Carolina Services any liability caused by their taking of any emergency procedures and/or contacts. Impact Carolina Services will be available for **URGENT / EMERGENCY** visits for existing patients within a 48 hour time frame. The after-hours emergency number for the practice is **704-732-2006**. This number is for after hour emergencies **ONLY**. Issues regarding scheduling of appointments, medication refills, or other issues that can wait until the office reopens will not be addressed by the provider on call.

☐ I agree to the emergency procedures as outlined above.

☐ I will assume the full responsibility of all incurred emergency treatment expenses.

☐ Emergency restrictive interventions will only be utilized when a consumer presents an imminent danger to him/herself or others or when substantial property damage is occurring. Whenever possible, less restrictive interventions will be used prior to the use of restrictive intervention.

CONSENT FOR SERVICES

☒ I agree to participate in the treatment, services and support that are provided by Impact Carolina Services as outlined in the patient's service plan. I have been informed of the services in terms that I can understand. I have also been informed of the alleged benefits, potential risks and possible alternative methods of treatment. I understand that I may ask my provider for a copy of my treatment plan at any time and one will be provided at no cost to me. I understand that I am free to refuse treatment or services at any time.

I agree to accept the following checked services from Impact Carolina Services:

☒ Individual/ Family/ Group Therapy
☒ Family Therapy w/patient
☒ Comprehensive Clinical Assessment
☒ Medication Management
☒ Medication Management w/ Therapy
☒ Psychiatric Evaluation

The above consents have been read by me or to me and explained to me by an employee of Impact Carolina Services in simple non-technical language, that all questions have been answered to my satisfaction and that I understand my rights.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

PATIENT NAME:	**PATIENT NUMBER:**

Rev: 03/10/2017

Patient Rights

Each patient of Impact Carolina Services shall be treated with respect to the basic human rights of dignity, privacy and humane care. An individual shall at all times retain the right to:

- Seek treatment without regard to age, race, disability, religious affiliation, ethnicity, nationality, or sexual orientation.
- The individual is informed of the rights to treatment including access to medical care and habilitation regardless of age, or degree of MH/IDD/SA disability.
- Make wishes about future treatment known.
- Confidentiality (as spelled out in Policy, a copy of which is available upon request).
- Be informed of the qualifications of the professionals rendering services
- Exercise all civic rights.
- A copy of an individualized, service plan which includes the anticipated goals, as well as services to be provided in order to achieve these goals will be provided.
- Be free from unnecessary or excessive medication. Medications shall be administered in accordance with accepted medical standards and only upon order of a physician as documented in the record.
- Refuse medications.
- Be informed of experimental or nonstandard forms of service.
- Expect reasonable continuity of care, i.e. to know in advance, what appointment times and clinicians are available and where.
- Be free from influences in my decision of services and providers.
- Be informed of cost of service.
- Be considered of estimated length of service.
- Be considered legally competent unless there has been a court decision of incompetency.
- Refuse service or institute due process to terminate relations with Impact Carolina Services
- Free from searches or personal belongings except under critical circumstances.
- Expect special instructions and other requests to be honored when possible.
- Contact Disability Rights of NC (1-877-235-4210).This is the agency designated under federal and state law to protect and advocate the rights of persons with disabilities.

For further clarification of rights, I will ask Impact Carolina Services or other staff members. As a patient, I am aware that I have the right to request a different clinician/therapist/case manager at any time. I need to discuss this with my clinician/therapist/case manager or the Psychiatrist. For questions about availability of another provider in the network call 1-800-898-5898. If I believe that my rights may have been violated, I can file a grievance and appeal, if I am not satisfied with the resolution. Any practice employee may assist me in doing this.

The above rights have been read by me or to me and explained to me by an employee of Impact Carolina Services

_____ _____

Patient/Legally Responsible Person Signature Date

Patient Name	Patient Number **Date**

Patient Choice of Services and Providers

Impact Carolina Services is committed to ensuring that patients have the right to choose the application of the service they qualify for, to decide the provider of the services they qualify for, and to select, if they desire, a change in services and/or providers.

By signing this form, you are stating you understand that you, as the patient, have the right to choose relevant services and which provider delivers those services and that you have been provided with that choice. Further, you acknowledge that Impact Carolina Services nor any employees have, in any way, advertently or inadvertently influenced your choice of services or providers.

Service	Chosen Provider	Service	Chosen Provider
Individual/Family/Group Therapy	Dr. Joseph Adedokun	**Comprehensive Clinical Assessments**	Dr. Joseph Adedokun
Developmental Therapy		**CAP (specify services)**	
Intensive In-Home Services		**Multisystemic Therapy(MST)**	
Psychosocial Rehab		**Child and Adolescent Day Treatment**	
Partial Hospitalization		**Assertive Community Treatment Team(ACTT)**	
Substance Abuse Comprehensive Outpatient Treatment(SACOT)		**Substance Abuse Intensive Outpatient Program(SAIOP)**	
Family Type Residential Treatment Level I		**Family Type Residential Treatment Level II**	
Residential Treatment-High Level III		**Residential Treatment Secure Level IV**	
Medication Management	Impact Carolina Services	**Psychiatric Evaluation**	Impact Carolina Services

***I understand that no affiliate of** Impact Carolina Services*
has not influenced my decision in any way.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

Patient Name	Medicaid Identification	Patient Number

Benzodiazepine and Controlled Substance Policy

You have been prescribed a medication called a benzodiazepine which has the potential to become habit forming. It is important that you understand the risks and safety issues related to use of these medications. For this reason, we have instituted a ***Benzodiazepine and Controlled Substance Policy****. Please read the following information and sign below.*

In the event that my treatment requires the use of the controlled substances, I WILL ADHERE to the following:

- I am reading and making the agreement while in full possession of my faculties and not under the influence of any controlled substances that might impair my judgment.
- I will not obtain any controlled medication from another medical provider (including referrals from this office) without informing Impact Carolina Services of the circumstances involved. This includes pain pills, muscle relaxers, anti-anxiety, or stimulant medications.
- I will notify my provider of any new health concerns I may have even if not obviously related to my treatment.
- I will not be involved in the sale, transport, sharing of any controlled substance or medication.
- **I will safeguard my medication from loss of theft. If I lose them, for whatever reason, I <u>will not ask</u> for early refills or for prescriptions to be called in.**
- **I will not ask for early refills for any reason.**
- I will carry only the amount of the medication I need, in the prescription bottle for the time away from home, leaving the rest in a safe place.
- I will not take larger or more frequent doses than that written on the prescription bottles.
- **I understand that I need to see the provider on a monthly or on a scheduled basis in order to get my prescription. I will not request for my medications to be called in without seeing the provider.**
- I will bring all medication and bottles to the office for every appointment.
- I give my prescribing provider permission to discuss all diagnostic and treatment details (including prescription history) with dispensing pharmacists or other professionals who provide or have provided my health care for the purpose of maintaining accountability.
- I understand and agree that I am subject to random unannounced drug test. Presence of unauthorized substances may result in my discharge from the practice. Refusal to take a drug test may also result in my discharge from the practice.
- In the event that I am arrested or incarcerated related to the legal or illegal drugs, refills on controlled substances will not be given and the provider will discharge me be immediate for alleged criminal behavior.
- **(FOR FEMALES)** I also understand that if I become pregnant, or if I am suspicious that I am pregnant, **I will notify my provider immediately**.
- Under no circumstances will any patient get more than one month supply of medication.
- **I agree to use only one pharmacy for obtaining controlled medications. This practice must be notified of any pharmacy changes at least three (3) days prior to refill request.**

I have read this document and agree to the guidelines. If I have had any difficulty understanding the content I have asked for clarification. If my prescription(s) is not helping improve daily function it may be discontinued. A copy of this agreement is being provided to me. I understand that if this agreement is not followed, I may be discharged from the practice.

Patient signature_____ **Date**_____

ESSENTIAL MEDICATION RELATED INFORMATION FOR PATIENTS/ RESPONSIBLE GUARDIANS

1. The physician will explain expected actions, usual side effects, and possible adverse affects of the medication.

2. Additional medication related information is available from both your physician and your pharmacist. In any case, when a prescription is filled at the pharmacy you are asked whether you would like for the pharmacist to go over the medication with you, and also a print out of the effects and side effects of each of your specific medications are included with your prescriptions.

3. A patient's lost, misplaced, or stolen medication will only be refilled earlier that the next date that it is due to be filled once in a lifetime. **No controlled medications will be replaced.** As such, please keep all your medications under lock and key, keep only what you need for the day on you at one time, and use only as directed. Only the provider can increase your medications; please do not take this upon yourself.

4. If a change in your medication was made by the physician at your last appointment, and a new prescription was not given at that time, then please have your pharmacy call us for updating your medication related orders.

5. If a refill is due before your next appointment you will need to call us at least 2 days before the medication is going to run out. Please note however, if you are running out of medications due to you not attending your appointment, no medications will be called in for you. When calling please make sure include the following information:
    1. Name of medication
    2. Dose (milligrams) and directions of the medication
    3. Date the medication was last filled
    4. Quantity that was given when the medication was filled last
    5. How many pills you have at the time you call
    6. Pharmacy where you had the medication filled
    7. Telephone number of the pharmacy

6. Frequently changing your pharmacy is discouraged.

Thank you for your cooperation.

_____ _____

Patient's Signature Date

_____ _____

Witness Physician's Signature

AUTHORIZATION TO PAY

PATIENT'S NAME: _____

RESPONSIBLE PARTY: _____

ADDRESS: _____

RELATIONSHIP TO THE PATIENT: _____

DOCTOR'S NAME: _____

To the above named doctor:

I authorize payment of medical benefits to the provider, or supplier of services, named above for the services rendered.

This authorization shall remain valid for any services provided pursuant to said arrangements. You agree that you are the responsible party on this account.

The patient is entitled to receive a copy of the authorization upon request. A photocopy of this signed form shall be as valid as the signed original. I authorize the release of any information to the insurance companies needed to process any claims, filed by this office, for the above named patient.

I do understand that it is my responsibility to pay the account in full. Insurance will be filed as a courtesy. I also understand that my insurance may, or may not, pay the charges incurred.

Insurance company name: _____

Identification number: _____

Group number: _____

Do you have more than one insurance carrier? If so:

Insurance company name: _____

Identification number: _____

Group number: _____

_____ _____

Date **Patient's Signature**

_____ _____

Date **Parent or Guardian Signature if the patient is a minor**

_____ _____

Date **Responsible Party**

_____ _____

Date **Witness**

FINANCIAL POLICY

1) PAYMENT is expected at the time of your visit, unless prior arrangements have been made. We accept cash, debit, credit cards, and money orders. After you have become established as a patient, personal checks may be accepted at the discretion of the provider.

2) INSURANCE CLAIMS- as a courtesy to our patients, we will file your primary insurance policy. Please remember insurance coverage is a contract between the patient and the insurance company. We expect the patient to be responsible for the payment in full**.**

HMO's, PPO's, and MANAGED CARE- We belong to a number of managed care plans. It will be important that you check with your insurance company to verify whether you need authorization for psychiatric outpatient treatment. The initial authorization must be obtained by the patient; otherwise, you will be responsible for payment. Upon initial authorization, you will be responsible for the co-payment.

MEDICARE- This office accepts Medicare assignment. Mental Health is covered at 62.5%. You will be expected to pay your percentage of what Medicare does not cover if you have met your deductible. **You will be expected to pay in full if your deductible has not been met.**

MEDICARE & MEDICAID- Medicare and Medicaid do not cover Medicare approved psychiatric charges at 100%. Combined they pay 62.5% of the approved charges. The patient is responsible for the 37.5% co-pay.

3) NO INSURANCE- Patients who do not have insurance are expected to pay for treatment in full at the time of service.

4) MINOR CHILDREN- It is the responsibility of the accompanying parent to see that payment is made in full, at the time of service.

5) CREDIT- We can arrange a monthly budget payment plan, if credit is determined to be necessary due to hospitalization. Patients who arrange credit and who have agreed to a monthly payment plan are required to comply with all scheduled payments. A monthly rebilling fee will be charged if payment is not received within 30 days.

6) RETURNED CHECKS- A service fee of $35.00 will be applied to all returned checks. You will be asked to bring cash to our office to cover the amount of the check, plus the service charge.

7) ACCOUNTING PRINCIPLES- Payments and credits will be applied to the oldest charges first, except for the insurance proceeds, which are applied to the charges for which received.

8) NO SHOW/CANCELLATION FEE- If you must cancel or reschedule your appointment, then you must do it 24 hours before your appointment time or you will be charged a fee of $50.00, if you "no show" for your appointment, then the same fee of $50.00 will apply. (This fee is assessed to the patient and is not covered by insurance companies). However, please note that if you are a Self-Pay patient, will you will be charged the full price of the missed visit at your next visit.

"I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THE FINANCIAL POLICY."

_____ _____

SIGNATURE OF THE PATIENT OR PERSON FINANCIALLY RESPONSIBLE **DATE**

INFORMED CONSENT FOR TREATMENT OF EMOTIONAL CARE

Patient's Name: _____ Date of Birth: _____

I hereby give permission to Impact Carolina Services to provide emotional care for me and/or my child named above. I understand that my treatment may include discussion of alternative diagnosis, methods and modalities to be used in treatment and possible outcomes. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be painful and difficult. I understand that I may withdraw from treatment at any time but I agree to discuss my plan with my therapist/doctor before doing so. I further agree to comply with my treatment recommendations including taking medication as prescribed and will inform my doctor of any side effects immediately. I further acknowledge that I have read and understand Impact Carolina Services' policies and procedures. It has been clearly explained to me and I understand the limits of confidentiality regarding treatment, office policies regarding scheduling, emergency coverage, fees and billing, insurance filling, missed appointments, court appearance, copying records, phone consultations, patient rights, etc.

Patient's Name: _____

Patient's Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Record Number: _____

I, _____ have received a copy of Impact Carolina Services' Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Patient/Guardian Signature Date

For Internal Use Only

Impact Carolina Services attempted to obtain acknowledgement of receipt of Notice of Privacy Practices. Acknowledgment could not be obtained as specified below:

_____ Individual Refused to Sign

_____ An emergency situation prevented obtaining the acknowledgment. It will be obtained as soon as it is reasonably practicable to do so.

_____ Other (Please Specify)_____

_____ Individual agreed for Impact Carolina Services to mail a copy of the Notice of Privacy Practices. Record date, address and to whom the notice was mailed:

_____

_____

_____ _____
Staff Signature Date

IMPACT CAROLINA SERVICES, INC

Authorization for Use and Disclosure of Protected Health Information

I, _____ authorize _____
Consumer or Consumer's legal representative **Agency or person authorized to use/disclose the information**

_____

to use or disclose to: _____ Impact Carolina Services, Inc_____
Agency or Person to whom the requested use or disclosure will be made

_____

the following protected information: Social History, Admission/Discharge Summaries, Educational/Program Assessments, Psychological/Psychiatric Evaluations, Medical Records (including medications, evaluations; IEP's, Behavioral Plans, Referrals/Recommendations), Person Centered Plan, LOE, MH Checklist/Face Sheet, Crisis Plan, NCTOPPS

Provide specific meaningful description of the information to be used/disclosed

The purpose of this disclosure is for_____CONTINUM of CARE_____
Describe purpose of the requested use or disclosure

_____

I understand information regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describe the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Impact Carolina Services Notice of Privacy Practices, a copy of which has been provided to me.

If not revoked earlier, this authorization expires upon: _____
Not to exceed one year from date of signature

NOTICE OF VOLUNTARY AUTHORIZATION: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Impact Carolina Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

_____ _____
Signature of Consumer Date

_____
Please Print Name

_____ _____
Signature of Legally Responsible person/personal representative Date
if required. Please explain representative's authority to act on behalf of consumer: _____

Patient Name:	D.O.B.:	Medicaid #:	Patient Number