PATIENT INFORMATION (Please Print using Black or Blue Ink)

LAST NAME: _____ **FIRST NAME**: _____ **MIDDLE INITIAL**: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____ **ZIP**: _____

SEX: _____ **GENDER IDENTITY**: _____ **MARITAL STATUS**: ☐ SINGLE ☐ MARRIED ☐ OTHER

RACE (OPTIONAL): ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER RACE

ETHNICITY (OPTIONAL): ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

PHONE (REQUIRED) CELL:_____ WORK: _____ OTHER: _____ TYPE: _____

PREFERRED PHONE (CIRCLE ONE): C W O

EMAIL: _____

SOCIAL SECURITY #:_____ **DATE OF BIRTH**: _____

HOW DID YOU FIND OUT ABOUT US? ____ _____ _____

PATIENT EMPLOYER INFORMATION: ☐ EMPLOYED ☐ STUDENT ☐ OTHER

COMPANY: _____ EMPLOYER PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

LAST NAME: _____ FIRST NAME:_____ MIDDLE INITIAL: ____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

PHONE:_____ TYPE: _____

SOCIAL SECURITY #:_____ DATE OF BIRTH: _____

RELATIONSHIP TO THE PATIENT: _____

RESPONSIBLE PARTY EMPLOYER INFORMATION: ☐ EMPLOYED ☐ STUDENT ☐ OTHER

COMPANY: _____ EMPLOYER PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PATIENT'S PRIMARY CARE DOCTOR

DOCTOR: _____ NAME OF PRACTICE: _____

PHONE:_____ ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

I hereby authorize payment directly to the physician of the surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient or Responsible Party Signature: **DATE:**

PLEASE READ CAREFULLY AND COMPLETE

I have read the Policy and Procedures and understand and accept the policies described above. I agree to pay my insurance co-payment or deductible/co-insurance, and balance due prior to each session.

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ **INSURANCE ID NUMBER** OF THE **PATIENT:** _____

INSURANCE ADDRESS:_____CITY: _____ STATE: _____ ZIP: _____

INSURANCE CO PHONE:_____ **GROUP NAME** OR **NUMBER**:_____

POLICY DATES: FROM: _____ TO: _____ EMPLOYER PLAN: ☐ YES ☐ NO

INSURED PARTY NAME: _____

INSURED PARTY ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

INSURED PARTY PHONE: _____

INSURED PARTY SOCIAL SECURITY NUMBER: _____ **INSURED PARTY** DATE OF BIRTH: _____

EMERGENCY CONTACT **NAME**: _____ PHONE **NUMBER**: _____

INSURANCE AUTHORIZATION

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM.

☐ I authorize use of this form on all my insurance submissions.

☐ I authorize release of information to all my insurance carriers.

☐ I understand that I am responsible for my bill.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

☐ I authorize payment directly to my doctor or other health care provider, and hereby assign my right to reimbursement for services rendered to MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC

☐ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Printed Name:_____

Patient or Responsible Party Signature:_____ **Date**:_____

FINANCIAL ACCEPTANCE FORM

We make your payment as easy and convenient as possible. You may pay by cash, check, credit or debit card.

For outstanding balances, you may pay on our website: CarolinaPartners.com

You may pay past due balances by the following method. Provide us with a credit or debit card.

_____ Debit Card # _____ Expiration Date_____

Name on Card _____

_____ Credit Card # _____ Expiration Date _____

Name on Card _____ Type of Card _____

I authorize MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC to charge any past due balances on my account to the above credit or debit card number on a monthly basis.

Patient or Responsible Party Signature:_____ **Date**:_____

MINDPATH CLINICAL RESEARCH INSTITUTE

You may be contacted by us, a clinician, or an agent of the practice with information about clinical trials that might be of benefit to you or someone for whom you are authorized to make medical decisions. Whether or not you choose to participate in a particular study as a study subject will be voluntary and subject to the circumstances of each trial.

Would you occasionally like to be notified to undergo the screening process for the opportunity to participate in a clinical trial? ☐ Yes ☐ No

May we email/text you about – and during – a research study?

Email: ☐ Yes ☐ No Text: ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

This **ACKNOWLEDGEMENT** THAT WE HAVE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR "NOTICE OF PRIVACY PRACTICES" is required by federal law. Thank you for your cooperation.

I, _____ , acknowledge that I have received from
Patient Name Printed

MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC the "Notice of Privacy Practices" and have had adequate opportunity to read and review the document.

MEDICAL RECORDS CONSENT

I, _____ , understand that if I am referred to another
Patient Name Printed

provider outside of MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC, notes about substance abuse may be shared with the provider to whom I am referred.

CONSENT TO TREATMENT

I, _____ , agree to receive treatment from MindPath Care
Patient Name Printed

Centers at Carolina Partners in Mental HealthCare, PLLC. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

Patient or Responsible Party Signature:_____ **Date**:_____

Patient Fees

PLEASE BE AWARE that when you make an appointment that time is especially made for you. We really look forward to seeing you at your scheduled appointment. However, our goal is that all patients are seen in a timely manner; therefore, the following will be followed:

Cancellation (**with** - 24 Hour Notice)	No Charge
Cancellation (**without** - 24 Hour Notice)	$60
No Call / No Show	$60

***** Patterns of cancellations will be discussed with your provider. *****

You will not be rescheduled for another appointment beyond these parameters without permission from your provider.

Insurance does not pay for Cancelled or No Show appointments. The above fees will be an out of pocket expense for you as an individual.

If you have any questions or concerns about this, please discuss them with your provider.

I have read and understand this policy. I agree to pay according to the above guidelines.

_____ _____

Patient or Responsible Party Signature **Date**