Carolina Centre
Information Form

Patient Information: Date_____________

First Name _____________________ Middle Initial _________ Last Name _______________________

Single ____ Separated ____ Married ____ Divorced ____ Under Age ____ Partnered ____

________________ ________ ____________

Birth Date Age Sex (M or F)

Street Address (Physical & PO Box):

Address ____

City_________________________________ State ___________ Zip ____________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Other Phone ____________________

May we contact you at all numbers? _______

If no, please specify which to use ________________________

Name of Employer: ____

Social Security Number _____________________ Occupation ___________________

Physician __________________________________ Phone No. ____________________

Responsible Party or Significant Other Information:

Spouse/Parent/Guardian's Name ____

Single ____ Separated ____ Married ____ Divorced ____ Partnered ____

________________ ________ ____________

Birth Date Age Sex (M or F)

Street Address (Physical and PO Box):

Address ____

City ________________________________ State _________ Zip _____________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Other Phone ____________________

May we contact you at all numbers? ________

If no, please specify which to use ________________________

Name of Employer: ____

Social Security Number _____________________ Occupation ___________________

Referred by? ____

Who is financially responsible for this bill? ____

Address ____

Health History

	Yes	No
Do you have any Chronic Health Problems?	_______	_______
Are you currently suffering from a Physical Health Problem?	_______	_______
Are you presently being treated by a Physician?	_______	_______
If yes, the Doctor's name?________________________________		
Are you presently taking any medications? (Please list all)	_______	_______

____

____

Do you have any adverse reactions to medications?	_______	_______
Do you currently drink alcohol, daily or weekly?	_______	_______
If yes, describe:____		
Do you smoke cigarettes or cigars?	_______	_______
If yes, how often:____		
Do you take recreational drugs?	_______	_______
If yes, how often:____		
Have you ever been seen by a Psychologist or Psychiatrist?	_______	_______
If yes, describe:____		
Have you ever been hospitalized?	_______	_______
If yes, describe:_________________________ Date______________		

Please check any of the following that may apply to you *currently*

___________ Difficulty falling asleep of staying asleep
___________ Over or undereating
___________ Feeling sad
___________ Feeling impatient
___________ Temper outbursts or irritability
___________ Feeling angry or resentful
___________ Restlessness, nervousness, excited
___________ Fatigue or low energy
___________ Pounding heart
___________ Anxiety
___________ Distressing recollections of a traumatic event
___________ Chronic pain
___________ Dizziness
___________ Panic
___________ Blackouts
___________ Difficulty controlling impulses
___________ Weight gain or loss
___________ Thoughts about suicide
___________ Memory loss or forgetfulness

What prompted you to seek therapy?

____

Health Insurance Information

Primary Insurance Policy

Insurance Company____

Claims Mailing Address____

Policy Holder_____________________ Social Security_____________________

Member ID #_____________________ Date of Birth______________________

Relationship to Patient_____________

Employer_________________________ Group Number_____________________

Do you know your mental health benefits under this policy?

Deductible___________ How much has been met____________

Co-payment or Co-insurance_____________

Secondary Insurance Policy

Insurance Company______________________________________

Claims Mailing Address_________________________________

Policy Holder_____________________ Social Security_____________________

Member ID#_____________________ Date of Birth_____________________

Relationship to Patient_____________

Employer________________________ Group Number_____________________

Do you know your mental health benefits under this policy?

Deductible____________ How much has been met____________

Co-payment or Co-insurance_____________

I authorize the release of any medical information necessary to process the insurance claims, and I authorize the direct payment of medical benefits to the attending doctor(s) services rendered. I certify that the above questions regarding this application have been answered accurately to the best of my knowledge. I further acknowledge that I am responsible for all charges not covered under my insurance policy.

X_______________________________________

(Signature of insured)

Carolina Centre
Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance forms before seeing the clinician.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

Regarding Insurance:
We require payment at the time of service unless other financial arrangements have been made with the business office prior to the appointment. The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form (when required). Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Any required pre-approval and/or authorizations are your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:
Adult patients are responsible for full payment at the time of service.

College students, who are considered independent, will be considered responsible for payment unless prior arrangements have been made with the parent and the Carolina Centre business office.

Minor Patients:
The adult accompanying a minor and the parents/guardians are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved payment arrangement.

Regarding minors whose parents are divorced, the parent initiating the appointment will be held financially responsible, unless other arrangements are made prior to the appointment.

Parents of college students will have to make financial arrangements with the business office prior to their child's first visit.

FOR OFFICE USE ONLY:
Patient Name:__________________________________ Acct. #: ____________

Phone Sessions, Attorney/Court Fees and Psychological Testing:
If additional time or services (such as phone sessions) are provided, a pro-rated fee based on 15-minute intervals will be charged. Attorney and court fees incurred will be the responsibility of the client and/or person responsible for the client. Psychological testing fees will vary depending on the test given, testing time, report writing and interpretation time required.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_______________________________________ _______________

Signature of Patient Date

_______________________________________ _______________

Guardian/Responsible Party Date

- -

Initial One:

________ I agree to pay my balance in full at each appointment.

OR

________ I authorize Carolina Centre to keep my signature on file and to charge the following credit card on a visit-by-visit basis.

- -

(Please Circle One) Visa MasterCard Discover

Card # ____ V-Code: __________
(Last 3 #'s on the back of the card)

Expiration Date: ________________ Billing Zip Code: _______________________

Name as printed on the card (please print) __________________________________

Signature: ______________________________ Date: ________________

FOR OFFICE USE ONLY:
Patient Name:_____________________________________ Acct. #: _________

Effective immediately, all first time "Late Cancellations" or "No Show" appointments will automatically be billed at the *usual and customary appointment rate*.

Carolina Centre takes great pride in the professional services we provide to our clients. As you know, our doctors and clinicians set aside specific appointment times scheduled by you. Carolina Centre does not overbook or double-book appointments. If you fail to make your appointment for any reason, general office costs continue and your doctor is unable to see other patients wishing to be seen, because your appointment time was scheduled exclusively for you. **You are contracted for a particular block of time, whether or not you are able to keep your appointment.**

NOTE: Remember, 24-hour prior cancellation notice refers to a 24 "business hour" cancellation. If you have an appointment at 9:00am Monday morning, you are required to call our office before 9:00am the preceding Friday to avoid the late cancellation charge.

I understand and accept the policy of Carolina Centre pertaining to "No Show" appointments and appointments I have cancelled less than 24-business hours prior to my appointment. I understand and accept that I have contracted for my doctor's or clinician's time, and I accept that I am fully responsible for all usual and customary charges. If I fail to keep my appointment or have to cancel my appointment with less than a 24-business hour cancellation notice, **regardless of cause**, I accept and understand that I am fully responsible for usual and customary charges. If I have a child being seen at Carolina Centre, I understand that I am fully responsible for any "Late Cancellations" or "No Shows" of my child, whether the appointment was scheduled by me or my child.

______________________________ ______________________

Patient Name Date

______________________________ ______________________

Guardian/Responsible Party Date

______________________________ ______________________

Office Staff Date