Excel Psychiatric Associates, PA
10225 Hickorywood Hill Ave., Suite B
Huntersville, NC 28078
P: 704.457.9292 F: 704.274.5783

PATIENT REGISTRATION PAPERWORK

Name:_____ DOB: _____ Gender: _____

Address:_____

City, State, ZIP: _____

SSN: _____ Mobile Phone: _____

E-mail: _____ Other Phone: _____

MEDICAL AND REFERRAL INFORMATION

How did you find our practice? _____

Name of Primary Care Provider & Practice: _____

Other Medical Specialists (e.g. Neurologist, Cardiologist): _____

Pharmacy Name, Street, and ZIP Code: _____

EMERGENCY CONTACT

Who should we contact in case of an emergency? _____

Relationship to you: _____Contact Information: _____

CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to providers of Excel Psychiatric Associates, PA (EPA) to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, fax, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations. I am aware that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination, and that initial consultation does not necessarily create a doctor-patient relationship. I consent for EPA to obtain my prescription history

Patient Signature: _____ **Date:** _____

If Patient is a **Minor or unable to sign**, authorization is given on the patient's behalf:

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

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At Excel Psychiatric Associates, we deeply care about you as a whole person and want to obtain a glimpse of who you are and what your life is like. In order to get the most from our initial meeting, please take a few minutes to reflect on these questions and answer them to your best ability.

PERSONAL HISTORY: Please tell us about …

Where you grew up and your family of origin:

Your educational background: ☐High School ☐Some college ☐Associates ☐Bachelor's ☐Graduate School / Major:

Your relationships: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed

Do you have children? (Names, ages, & location – if living outside your home):

Who lives in your household besides children (names/ages, pets?):

What you enjoy doing in your free time?

What you do for a living? ☐Employed ☐Not working ☐Retired ☐Disabled (list reason for disability and year granted):

Current job title, company, and length at position:

Your total annual household income (used to calculate/estimate cost of meds & eligibility for Patient Assistance Programs for medications):
☐ $0-25,000 ☐ $25,000-50,000 ☐ $50,000-75,000 ☐ $75,000-100,000 ☐ >$100,000

If you consider yourself a spiritual/religious person? ☐Yes ☐No
Affiliation/Preferences:_____

If you have a military service background (list branch, length of service, position, date/type of discharge):

If you have been arrested, convicted of a crime, or incarcerated? ☐Yes ☐No

PSYCHIATRIC HISTORY: Please share with us …

Do you have any previous diagnoses?

☐Depression	☐Autism	☐OCD	☐Gender dysphoria
☐Anxiety	☐Bipolar	☐Personality disorder	☐Dementia
☐Panic attacks	☐Schizophrenia	☐Eating disorder	☐Other:
☐ADHD	☐Schizoaffective disorder	☐Insomnia	
☐Learning disorder	☐PTSD	☐Narcolepsy	

The name of your former psychiatrist: ☐None
_____

The name of your current therapist/counselor: ☐None
_____

Information about prior psychiatric hospitalizations (when/where/why?): ☐None
_____

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Many of our patients struggle with very personal, private issues. Please let us know if you …

Struggle with thoughts of suicide: ☐Yes ☐No ☐Sometimes
Have had any prior suicide attempts (when/how?): _____ ☐None

Have been hurt by someone else:
☐Physical abuse ☐Mental/emotional abuse ☐Sexual abuse ☐Neglect ☐Bullying ☐Discrimination

Have ever used any of the following substances:

☐Tobacco (cigs/vape/e-cig)	☐CBD	☐Opioids	☐Prescription drug overuse
☐Alcohol	☐Cocaine	☐LSD/Mushrooms/Ecstasy	☐Other _____
☐Marijuana	☐Methamphetamine	☐Intravenous use of any drug	☐Caffeine. If so, how much? _____

Are you currently concerned about alcohol or drug consumption? ☐Yes ☐No
Are others concerned about alcohol or drug consumption about you? ☐Yes ☐No
History of alcohol or drug issues in the past? ☐Yes ☐No
Prior treatment for alcohol/drug consumption? ☐Yes ☐No

FAMILY HISTORY: We'd like to learn more about people in your immediate family …

With medical illness?:	☐Yes ☐No	With psychiatric illness?:	☐Yes ☐No
☐Neurologic conditions	☐Dementia	Who struggle with alcohol/drug use?	☐Yes ☐No
☐Seizure disorders	☐Genetic disorders	Who have attempted or died by suicide?	☐Yes ☐No

Describe the illness and which family member it affects:

MEDICAL (NON-PSYCHIATRIC) HISTORY: Let us know if you've been treated for …

Medical Health Problems, such as:

☐Obstructive Sleep Apnea	☐Migraines	☐Kidney disease
☐Traumatic Brain Injury (concussion/black out)	☐Thyroid disorder	☐Liver disease
☐Stroke	☐Chronic pain	
	☐Seizures	

List Others:

Current Height: _____ Weight: _____ ☐Recent weight changes

Previous surgeries and approximate year: ☐Gastric bypass ☐Other_____

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It is very important that we know about the various remedies you are using to maintain your health.

Medication Allergies: _____ ☐None

Please use this space to list all your **current medications**:

Medication Name	Dose	How often taken?	What is it for?

FEMALES ONLY – which birth control method do you use?

☐Pill ☐IUD ☐Hysterectomy ☐Post-menopausal ☐Other:

Please list all **vitamins, supplements, and herbs** that you take:

Supplement Name	Dose	How often taken?	What is it for?

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Please check off any medication you have ever taken

- ☐ Marplan (isocarboxazid)
- ☐ Nardil (phenelzine)
- ☐ Parnate (tranylcypromine)
- ☐ Emsam patch (Selegiline)

- ☐ Tofranil (imipramine)
- ☐ Elavil (amitriptyline)
- ☐ Vivactil (protriptyline)
- ☐ Pamelor (nortriptyline)
- ☐ Anafranil (clomipramine)
- ☐ Norpramin (desipramine)
- ☐ Sinequan / Silenor (doxepin)
- ☐ Surmontil (trimipramine)
- ☐ Ludiomil (maprotiline)

- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Paxil [☐CR] (paroxetine)
- ☐ Luvox [☐CR] (fluvoxamine)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)

- ☐ Effexor XR (venlafaxine ER)
- ☐ Cymbalta (duloxetine DR)
- ☐ Pristiq (desvenlafaxine ER)
- ☐ Savella (milnacipran)
- ☐ Fetzima (levomilnacipran ER)

- ☐ Wellbutrin/Aplenzin/Zyban (bupropion)
- ☐ Serzone (nefazodone)
- ☐ Remeron (mirtazapine)
- ☐ Symbyax (fluoxetine+olanzepine)

- ☐ Viibyrd (vilazodone)
- ☐ Trintellix / Brintellix (vortioxetine)

- ☐ Ketamine (IV/IM)
- ☐ Spravato (intranasal esketamine)
- ☐ Zulresso (brexanolone)

- ☐ Ambien [☐CR] (zolpidem)
- ☐ Belsomra (suvorexant)
- ☐ Dayvigo (lemborexant)
- ☐ Doral (quazepam)
- ☐ Hetlioz (tasimelteon)
- ☐ Lunesta (eszopiclone)
- ☐ Prazosin (Minipress)
- ☐ Restoril (temazepam)
- ☐ Rozerem (ramelteon)
- ☐ Sonata (zaleplon)
- ☐ Trazodone

- ☐ Haldol (haloperidol)
- ☐ Loxitane (loxapine)
- ☐ Navane (thiothixene)
- ☐ Prolixin (fluphenazine)
- ☐ Stelazine (trifluoperazine)
- ☐ Thorazine (chlorpromazine)
- ☐ Trilafon (perphenazine)

- ☐ Clozaril (clozapine)
- ☐ Fanapt (iloperidone)
- ☐ Geodon (ziprasidone)
- ☐ Invega (paliperidone)
- ☐ Latuda (lurasidone)
- ☐ Risperdal (risperidone)
- ☐ Saphris (asenapine)
- ☐ Seroquel [☐XR] (quetiapine)
- ☐ Zyprexa (olanzepine)

- ☐ Abilify (aripiprazole)
- ☐ Rexulti (brexpiprazole)
- ☐ Vraylar (cariprazine)
- ☐ Caplyta (lumateperone)

- ☐ Nuplazid (pimvanserin)

- ☐ Haldol Decanoate (haloperidol)
- ☐ Prolixin Decanoate (fluphenazine)
- ☐ Zyprexa Relprevv (olanzepine)
- ☐ Abilify Maintena (aripiprazole)
- ☐ Aristada (aripiprazole lauroxil)
- ☐ Risperdal Consta (risperidone)
- ☐ Invega Sustenna (paliperidone 1 mo)
- ☐ Invega Trinza (paliperidone 3 month)
- ☐ Perseris (subcutaneous risperidone)

- ☐ Benadryl ☐Tylenol PM ☐Zzquil
- ☐ Unisom ☐Melatonin ☐Valerian
- ☐ CBD ☐St John's Wort ☐SAMe

- ☐ Ativan (lorazepam)
- ☐ BuSpar (buspirone)
- ☐ Inderal [☐LA] (propranolol)
- ☐ Klonopin (clonazepam)
- ☐ Librium (chlordiazepoxide)
- ☐ Valium (diazepam)
- ☐ Vistaril / Atarax (hydroxyzine)
- ☐ Xanax (alprazolam)

- ☐ Depakene (valproic acid)
- ☐ Depakote [☐ER] (divalproex)
- ☐ Dilantin (phenytoin)
- ☐ Keppra (levetiracetam)
- ☐ Lamictal [☐XR] (lamotrigine)
- ☐ Lithium [☐CR] / Lithobid
- ☐ Neurontin (gabapentin)
- ☐ Phenobarbital
- ☐ Tegretol [☐XR] (carbamazepine)
- ☐ Topamax (topiramate)
- ☐ Trileptal (oxcarbazepine)
- ☐ Zonegran (zonisamide)

Amphetamine Family

- ☐ Adderall (not XR)
- ☐ Evekeo (☐ODT)
- ☐ Procentra (liquid)
- ☐ Zenzedi

- ☐ Adderall XR
- ☐ Adzenys ER (liquid)
- ☐ Adzenys XR-ODT
- ☐ Dexedrine Spansule
- ☐ Dyanavel XR (liquid)
- ☐ Mydayis
- ☐ Vyvanse

Methylphenidate Family

- ☐ Ritalin (not XR)
- ☐ Focalin (not XR)

- ☐ Adhansia XR
- ☐ Aptensio XR
- ☐ Concerta
- ☐ Cotempla XR-ODT
- ☐ Daytrana (patch)
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Metadate CD
- ☐ Metadate ER
- ☐ Ritalin LA
- ☐ Quillichew ER
- ☐ Quillivant XR (liquid)

Non-Stimulants

- ☐ Catapres (clonidine)
- ☐ Intuniv (guanfacine ER)
- ☐ Kapvay (clonidine ER)
- ☐ Strattera (atomoxetine)
- ☐ Tenex (guanfacine)

(continued on opposite side)

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Please check off any medication you have ever taken

- ☐ Artane (trihexyphenidyl)
- ☐ Austedo (deutetrabenazine)
- ☐ Cogentin (benztropine)
- ☐ Gralise (gabapentin once daily)
- ☐ Horizant (gabapentin enacarbil)
- ☐ Ingrezza (valbenazine)
- ☐ Primidone
- ☐ Symmetrel / Osmolex (amantadine)
- ☐ Xenazine (tetrabenzene)

- ☐ Compazine (prochlorperazine)
- ☐ Phenergan (promethazine)
- ☐ Reglan (metoclopramide)
- ☐ Zofran (ondansetron)

- ☐ Aricept (donepezil)
- ☐ Exelon patch (rivastigmine)
- ☐ Namenda [☐XR] (memantine)
- ☐ Namzaric (donepezil/memantine)
- ☐ Razadyne ER (galantamine)

- ☐ Apokyn (apomorphine)
- ☐ Azilect (rasagiline)
- ☐ Comtan (entacapone)
- ☐ Gocovri (amantadine ER)
- ☐ Mirapex [☐ER] (pramipexole)
- ☐ Neupro patch (rotigone)
- ☐ Northera (droxidopa)
- ☐ Nourianz (istradefylline)
- ☐ Requip [☐XL] (ropinirole)
- ☐ Rytary (carbidopa/levodopa ER)
- ☐ Sinemet [☐CR] (carbidopa/levodopa)
- ☐ Xadago (safinamide)

- ☐ Nuedexta (dextromethoprhan&quinidine)
- ☐ Provigil (modafinil)
- ☐ Nuvigil (armodafinil)
- ☐ Sunosi (solriamfetol)
- ☐ Wakix (pitolisant)
- ☐ Xyrem (sodium oxybate)

- ☐ Addyi (flibanserin)
- ☐ Vyleesi (bremelanotide)

- ☐ Belviq [☐XR] (Lorcaserin)
- ☐ Chantix (varenicline)
- ☐ Contrave (bupropion/naltrexone)
- ☐ Phentermine (Adipex)
- ☐ Qsymia (phentermine/topamax)
- ☐ Saxenda / ☐Victoza (liraglutide)

- ☐ Antabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Lyrica [☐CR] (pregabalin)
- ☐ Methadone
- ☐ Nucynta [☐ER] (tapentadol)
- ☐ Suboxone/subutex (buprenorphine)
- ☐ Tramadol (Ultram)
- ☐ Vivitrol injection (naltrexone)

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Fee Schedules: Effective May 25, 2021

•Dr. Craig Chepke, MD:
Initial Consultation: 60-75 min $400
Standard Follow-up appt: 45 - 50 minutes $300
Brief Follow-up appt: 20 - 25 minutes $200

•Cameryn Duni, PA-C:
Initial Consultation: 60-75 min $250
Standard Follow-up appt: 45 - 50 minutes $200
Brief Follow-up appt: 20 - 25 minutes $100

•Resident Physician Clinic (MD)
Initial Consultation: 60-75 min $250
Standard Follow-up appt: 45 - 50 minutes $200
Brief Follow-up appt: 20 - 25 minutes $100

Pharmacogenomic Testing for non-consulting patients $55 (fee from laboratory billed separately)
No personal checks or cash accepted for any appointment type.

Prescription refill service outside of appointment: non-controlled substances $40*, Controlled substances $85*
Applies to any medications phoned, faxed, sent electronically, or mailed outside of an appt.

Dr. Chepke-Miscellaneous physician services, per 15 minutes: $80*
Cameryn Duni, PA-C-Miscellaneous clinician services, per 15 minutes: $50*
Resident Physician Clinic (MD)-Miscellaneous physician services, per 15 minutes: $60*
Staff- Miscellaneous admin fee, per 15 minutes: $20*
Ex: includes completion of paperwork or letters, multiple clinical phone calls or emails, multiple appeal of prescription benefits. *All services provided outside of standard business hours (9AM – 4PM Mon-Fri) could be billed at twice the standard rate.

•Tiffany Chepke, LCSW:
Integrative Health and Wellness Coaching/Therapy sessions:

Packages: (**10% discount for all packages paid in full prior to 1st session)**
Creating Change: 1 free consultation, 1 introduction session, 3 intermediate sessions, 1 closing session $700
Optional Email access: $50

Investing In Yourself: 1 free consultation, 1 introduction session, 4 intermediate sessions, 1 closing session and complementary email access $850

Making It Last: 1 free consultation, 1 introduction session, 7 intermediate sessions, 1 closing session and complementary email access $1000

Individual sessions:
Initial Consultation 60 minutes: $200
Individual Follow-up 45 minutes: $150

Couples/Family sessions:
Initial Consultation 60-90 minutes: $250
Couples/Family Follow-up 60 minutes: $200

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Please ensure the accuracy of the following information, as it greatly affects the availability of treatment options :

Do you have a deductible for prescription meds?
☐ No ☐ Yes
I*f yes, how much per year?* $ _____
If yes, amount met this year: $_____

I have verified with my insurance company that I do / I do not (circle one) have a deductible for prescription medications
Signature:_____ Date:_____

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES (required)

Name on account (exactly as it appears on credit card):_____

Billing address for credit card: _____

Credit card number: _____

Exp. Date:_____ 3 Digit security code (on back of card)_____

1. I authorize Excel Psychiatric Associates, PA ("EPA") to charge the above credit card for professional services provided by EPA to me, or if applicable to the following EPA client(s):

Signature of cardholder:_____ Date:_____

2. Payment for late cancellation or no show: I authorize EPA to charge my credit card the full rate for any missed appointment or for cancelling appointment without at least 24 business hr notice

Signature of cardholder:_____ Date:_____

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CLIENT SERVICES AGREEMENT

Welcome to Excel Psychiatric Associates PA. We are honored that you have chosen us as your mental health providers and look forward to working with you. The mental health system can be confusing, and we expect that you may have questions on our services, so we hope this document will help to answer your questions. This Client Services Agreement contains important information about the services that we provide and your rights and responsibilities while undergoing psychiatric treatment with us. lt is very important that you read this Agreement carefully. By signing this Agreement, you are entering into a binding agreement with us. We can discuss any questions you have about this Agreement or our office procedures upon your request.

APPOINTMENTS

Your provider conducts an evaluation that lasts from 1 to 3 sessions. During this time, both parties can decide if EPA is best suited to provide you the services you need to meet your treatment goals. **Once an appointment is scheduled, you agree to pay for it unless you provide 24 business hours (Monday-Friday) advanced notice of cancellation.** Please note insurance companies do not provide reimbursement for cancelled sessions.

*****On-Time Appointment/Late Arrivals***

Other practices often book multiple patients per time slot, and your wait time can be long. We do not do that at Excel Psychiatric Associates. Patients are seen by appointment. lf you arrive late, the appointment must end as scheduled and you will be charged for the full amount of your scheduled visit. This will allow your provider to see each patient when they are scheduled. Therefore, plan to arrive before the time scheduled to allow for any unforeseen delays. At EPA we pride ourselves on our on-time appointments, and this late arrival policy helps us see you on time.

*****Rescheduling Appointments***

If you need to cancel or reschedule your appointment, please call us during regular business hours. One of our administrative team will answer your call in person and assist you right away.
We DO NOT double book provider appointments, so the provider will reserve your appointment time for you. We ask that you give us ***24 business hours notification*** to cancel or reschedule your appointment so that your time is used effectively, and to offer it to someone else who may need to see the provider. All cancellations made with ***less than 24 business hours notice*** will result in an immediate charge to your credit card on file for the amount of the appointment.

_____ Please initial that you have read, understand and agree to the above described appointment cancellation, rescheduling, no show or missed appointment agreement.

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Same-Day/Next Day Urgent Appointments :

Please contact our office if you feel you have an immediate need to see or speak to a provider. Same day urgent visits may be available, based off the clinician's availability. Also if you are scheduled for a brief appointment but feel you are in crisis, please call the office to let us know so we can book you a longer appointment. In some cases, we can offer video appointments and/or to see another clinician if needed. Additional fees could be applied for longer/urgent/same day appointments.

PROFESSIONAL FEES

Fees are available on our website www.excelpsychiatric.com. We also provide detailed fee information before your first appointment. ln addition to office appointments, you agree to pay an hourly rate for additional professional services provided to you, broken down for periods of less than one hour. Other services include report writing, telephone calls, emails, consulting with other professionals with permission if needed, preparation of records or treatment summaries, and time performing other services you may request. lf you become involved in legal proceedings that require participation of your provider, you agree to pay for all of your provider's professional time, including preparation and transportation, even if your provider is called to testify by another party.

INSURANCE FAQS

Q : I understand that you are out of network providers. How does that work?

A: 1) You pay us at the time of your appointment in full.

2) Claims cannot be sent to the traditional Medicare program, you can submit to Medicare Supplemental plans. We have directions on how to do that. All patients with Medicare must sign an opt-out/private contract every 2 years. You must contact your insurance company for the appropriate form to file an Out of Network claim.

3) You will receive an Explanation of Benefits (EOB) from your insurer in the mail. lf reimbursement is due, the insurer will include a check to you in this statement.

Q . What are the out-of-network reimbursement benefits I get after seeing Excel Psychiatric Associates with my insurance?

A : Each insurance carrier (e.g. Blue Cross, Aetna, etc) has hundreds of different plans, each of which has different benefits. You must call your insurance directly for this answer.

Q : What reimbursements can patients expect to see for out-of-network benefits?

A : Reimbursements are highly variable—some patients get 100% of their appointment covered and others get nothing covered. Typically, about 50-80% of short appointments, and about 50% of long appts are covered once your Out-of-Network deductible has been met.

BILLING AND PAYMENTS

You agree to pay for each session at the time it is held, and to pay EPA for any additional fees for professional services that EPA provides to you, including the fees described in the Professional Fees paragraph. All fees are due to EPA at the time the services are provided.

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INSURANCE REIMBURSEMENT

Your health insurance policy may provide some coverage for mental health treatment. You (not your insurance company) are responsible for full payment of fees to EPA. lt is important that you find out exactly what mental health services your policy covers. EPA is not in network with any insurance company, and you will need to file the EPA billing receipt with your insurance company to use your out-of-network benefits. You should carefully read the section in your insurance coverage booklet that describes mental health services. lf you have questions about the coverage, call your plan administrator.

PSYCHIATRIC SERVICES

Psychotherapy is not easily described in general statements— it varies depending on the personalities of the psychiatric provider and the patient, and the particular concerns you are experiencing. There are many different methods EPA may use to deal with the concerns that you hope to address. Psychotherapy calls for an active effort on your part. ln order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Because of the importance of proper and safe management of medications, you agree to provide all clinical information related to medical history (including family history) and physical symptoms. This allows for the current psychiatric presentation to be evaluated for a physical component or cause and for the selection of the most tolerable and safest medications in treating your condition. lt is extremely important that your primary care doctor and all other clinicians providing you medical care are aware of the diagnoses and treatments that you have been given by each member of your treatment team (both physical and mental health providers), and that you keep an open dialogue with your doctors regarding how you are tolerating medications so that appropriate interventions, if needed, can occur in a timely fashion. You agree to keep all scheduled appointments with your provider and to take medications exactly as they are prescribed. Your provider may not provide medication management to anyone who repeatedly does not take medications as agreed upon and prescribed.

CONTACTING US

Phone calls: lf you have a non-clinical question (for example, billing, rescheduling, etc) you can get assistance from our administrative staff M-F 8AM-4PM. lf you have a question for your provider, please speak with our administrative staff first. lf they are able to answer your question they will do, but if not, they will schedule a phone call with your provider. This will allow your provider to answer your question without rushing and while they have full access to your medical record. Depending on the nature of the call, your provider will charge you for the phone call at the rate specified at excelpsychiatric.com

Emails:

You can email the office at frontdesk@excelpsychiatric.com. Similar to phone calls, our admin team will help you M-F 8AM-4PM if they can. lf they cannot answer your questions, they will forward the email to your provider. Depending on the situation, your provider may request the admin schedule a phone call to discuss. Depending on the nature of the email, your provider will charge you for the time reading and responding to the email at the rate specified at excelpsychiatric.com.

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Prescription Refills:
In our experience, refill requests generated by pharmacies are often inaccurate in terms of dose or quantity, so we do not respond to these, and your provider will provide refills scheduled in accordance with appointments during your regularly scheduled appointment. As such, it is necessary for you to keep track of what medications will need refills in order to request them from your provider at the appointment. If you need a prescription refill outside of your appointment time and have not attended scheduled appointments as scheduled, an administrative fee applies as per the fees section. To get the refill, just call our office and your provider will review the request, and if appropriate, we will send the prescription to your pharmacy within two business day. Urgent same day requests will have an additional/higher fee.

_____ Please initial that you have read, understand and agree to the above described Prescription Refill Service.

Urgent clinical issues:
If you have an urgent clinical need which cannot wait until business hours, please see the below resources:
Contact your primary care doctor or another mental health professional if you have one (psychotherapist, etc)
Call the Mecklenburg County Crisis Center at 704.566.3410
Call Novant Health Huntersville Medical Center 704.316.4000
Call CHS-University 704.863.300 or CHS-Northeast 704.403.3000
In the event of an emergency call 911 or go to your nearest emergency room

Please be aware that email is not a secure form of communication, and EPA cannot protect against the possibility that information you send over email might be intercepted by unwanted parties. As a general rule, refrain from disclosing any sensitive personal information over email. Your provider might not respond to emails of a personal nature. If your provider feels that email is not appropriate for your needs, they may suggest that you schedule an appointment or a phone call to answer your question(s).

CONFIDENTIALITY
The law protects the privacy of communications between a patient and a provider. Any confidential information you disclose to us during treatment, or any other confidential information we obtain while attending to you professionally, shall be held in confidence unless you permit us to disclose such information or where we are required to disclose such information by law. By signing this contract, you are agreeing to the disclosure of confidential information to other physicians and therapists familiar with your case, where your provider decides it is clinically necessary or appropriate to do so. Please tell us in advance if you want certain information withheld.

_____ Please initial that you have read, understand and agree to the above described HIPAA/Confidentiality agreement.

Excel Psychiatric Associates, PA
10225 Hickorywood Hill Ave., Suite B
Huntersville, NC 28078
P: 704.457.9292 F: 704.274.5783

TERMINATION

You are under no obligation to continue services with EPA. However, EPA strongly encourages that you notify your provider in person so that any issues can be discussed openly. lf you terminate your relationship with EPA, you are responsible to pay any fees incurred prior to termination. EPA also reserves the right to terminate services with a patient if any, but not limited to, such behaviors should occur: calling the office repeatedly about the same issue(s) more than 2x day, contacting EPA staff about clinical matters other than via offie telephone or through the patient portal, showing up in the EPA office with or without a scheduled appointment and refusing to leave the premises after being asked and being rude/disrespectful or inappropriate when talking to EPA staff.

NOTICE OF PRIVACY RIGHTS

I, _____, agree that I have read and understoof the Notice of Privacy Practices (provided separately).

Legally responsible party signature: _____ Date: _____

COMPLAINTS

EPA will take reasonable precautions to minimize risks, ensure your safety, and provide you with a positive experience. lf at any time you believe that we have not been diligent in performing services, or if you believe that your privacy rights have been violated, please bring it to the attention of EPA staff so that we can discuss the matter. lf you believe that we have not provided services in accordance with professional obligations, you may contact the NC Medical Board or the NC Psychiatric Association. lf you believe we have violated your privacy rights, you may also contact the Secretary of U.S. Department of Health and Human Services. EPA will not retaliate against you for filing a complaint.

By signing, printing and dating this document you are acknowledging that you have read, understood and agreed to the policies & procedures of Excel Psychiatric Associates, P.A.

Signature _____

Date: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Date of Birth_____

I hereby authorize Excel Psychiatric Associates, PA ("EPA") to use and disclose individually identifiable health information relating to me as described below. Specific types of information to be used or disclosed including dates of service related to such information (information below will be called "Authorized Information" throughout the rest of this form):

- I acknowledge that the Authorized Information may include alcohol or drug abuse records about me, and I authorize EPA to use or disclose such information.
- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider, or otherwise covered by the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder ("HIPAA"), the Authorized Information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I also understand that additional protections apply to alcohol and drug abuse records. If the Authorized Information includes alcohol or drug abuse records, the recipients may only disclose such information as authorized by 42 C.F.R. Part 2 and applicable state law.
- I understand that I may revoke this authorization at any time by notifying EPA in writing except to the extent EPA or the person who is to make the disclosure has already acted in reliance on my authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

1. What to disclose

☐ I authorize exchange of any/all of my authorized information and/or records (please send whole patient file)
☐ I authorize release of only the following of my authorized information: _____

2. Who can disclose

☐ I authorize two-way disclosure of my authorized authorization between Excel Psychiatric and the individual/groups named here:
1. _____
2. _____
3. _____

< OR >

One-Way Only
☐ I authorize Excel Psychiatric to communicate authorized information to these individual/groups:_____
_____
☐ I authorize Excel Psychiatric to receive authorized information from:_____

3. For How Long

☐ This authorization expires two (2) years from the date of this authorization
☐ OR the date the following event occurs:_____

4. Signature

Signature of Patient or Personal Representative :_____
Relationship: _____Date:_____

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Private Contract - Provider Opt-Out of Medicare

Provider Name: Craig Chepke, MD; Tiffany Chepke- LCSW, Cameryn Duni, PA-C, Excel Psychiatric Associates, PA

Provider Address: 10225 Hickorywood Hill Ave. Suite B

City: Huntersville State: NC Zip Code: 28078

Beneficiary Name:

Legal Representative (if applicable):

Beneficiary Medicare Number:

This private contract agreement is between the physician and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician above has informed the beneficiary or his/her legal representative they have opted-out of the Medicare Program. The current Medicare opt-out period is from 1/1/2020 to 1/1/2022 . The physician noted above is not excluded from participating in Medicare Part B under §§1128, 1156 or 1892 of the Act.

The beneficiary or his/her legal representative has read and agree to the following terms of the private contract by placing their initials by the items below:

- ☐ I, or my legal representative, accept full responsibility for payment of the physician's or practitioner's charge for all services furnished by this physician/practitioner;
- ☐ I, or my legal representative, understands that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner;
- ☐ I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare;
- ☐ I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period; which is 1-1-2020 to 1-1-2022 ;
- ☐ I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
- ☐ I, or my legal representative, enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out;
- ☐ I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
- ☐ I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Date

Beneficiary or Legal Representative's Signature

Date

Physician's Signature

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CONTROLLED SUBSTANCE AGREEMENT

In the event that my treatment requires the use of controlled substance(s), I adhere to the following:

1. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substances that might impair my judgment.
2. I will not obtain any controlled medication from another medical provider without informing this practice, Excel Psychiatric Associates, P.A., of the circumstances involved. This includes pain pills, muscle relaxers, anti-anxiety, or stimulant medications.
3. I will notify my medical provider of any new health concerns I have even if not obviously related to my treatment.
4. I will not be involved in the sale, transport, or sharing of any controlled substance or medication.
5. I will safeguard my medication from loss or theft. I will carry only the amount of medication I need, in the prescription bottle, for the time away from home, leaving the rest in a safe place.
6. I will not take larger or more frequent doses than what is written on the prescription bottle.
7. I will not ask for early refills, this includes prescriptions lost, stolen, etc…
8. In the event that I am arrested or incarcerated related to legal or illegal drugs, I will not be given any refills of controlled substances. I understand that my involvement in such activities could result in termination of care from Excel Psychiatric Associates, P.A..
9. If I am a female, I understand that if I become pregnant, or if I am suspicious that I am pregnant, I will notify my provider immediately.
10. I agree to use only one pharmacy for obtaining controlled medications. I am to notify my provider if I wish to change pharmacies and this must be done prior to requesting any refills.
11. I understand that, Excel Psychiatric Associates, can request I complete a random/scheduled urine drug screen at any time. Failure to comply could result in discharge from our clinic.

I have read this document and agree to the guidelines. If I had any difficulty understanding the content, I have asked for clarification. If my prescription(s) is/are not helping to improve my daily life, I will report this to my provider. I understand that if this agreement is not followed, I may be discharged from this practice.

Patient Name Printed:_____Date of Birth: _____

Patient Signature: _____Date: _____