Robin Casey MD, PLLC

117 Hidden Valley Dr, Chapel Hill, NC 27516
Ph: (919) 998-6463 Fax: (844) 433-3838
robincaseymd.com

Patient Information

Please print legibly (circle answers or fill in blanks) Today's Date: _____

Patient: _____
First Middle Initial Last

Street: _____

City, State, Zip: _____

Home: (____)_____ Work: (____)_____

Cell: (____)_____

Best # to leave a confidential voicemail: Home Work Cell

Email: _____

Patient Occupation: _____

Name of Employer: _____

Date of Birth: _____ Age: _____

Sex: M F Social Security #:_____-_____-_____

Marital Status:
Single Married Separated Widowed Divorced x_____

Reason for Appointment: _____

_____

Referred by: _____

Emergency Contact: _____

Relation: Parent Guardian Spouse Other: _____

Home: (____)_____ Cell: (____)_____

Emergency Contact #2: _____
(in case of minor, both parents must be listed)

Relation: Parent Guardian Spouse Other: _____

Home: (____)_____ Cell: (____)_____

Address to send statements: _____

_____

_____

Pharmacy: _____

Street:_____

City, State, Zip: _____

Phone: (____)_____ Fax: (____)_____

Email and Text Appointment Reminders

Email: _____ Cell number: _____ (our system only allows for one email address and cell number per patient) By signing this section you understand that this is not a guaranteed service and is a courtesy to our patients. **OUR MISSED APPOINTMENT POLICY REMAINS IN EFFECT.** Do not reply to notifications via e-mail or text. To change or cancel an appointment, call the office. You understand that we cannot guarantee the confidentiality of email or text. We will not be liable for improper disclosure of confidential information.

Signature: _____ Date: _____

1) **PCP Name:** _____
Clinic name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

2) _____
Clinic name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

3) **Therapist (if applicable):** _____
Clinic name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____Fax: (____)_____

4) **Attorney (if applicable):** _____
Firm name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____Fax: (____)_____

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POLICIES & PATIENT AGREEMENT – Page 1 of 2

Please initial each section and provide your signature at the end of the form.

_____ ***Appointments:*** Due to the sensitive nature of matters discussed and in order for us to give our full attention to the person being evaluated, children may not come to the appointment, unless he/she is the one being evaluated. For patients under the age of 18, all persons with legal, medical decision-making authority should be present for the initial and any following visits. Scheduled appointments are the patient's responsibility to keep track of. Please note that email appointment reminders are a courtesy to our patients and are NOT guaranteed.

_____ ***General information on prescription refills:*** Typically, Dr Casey writes prescriptions for the amount of medication needed until your next scheduled appointment.

Please provide at least **FIVE** business days notice when a refill is needed. We comply with all state and federal laws. Prescription refills for stimulants can only be written every 30 days. We cannot post-date prescriptions. If you use a mail-order pharmacy that is something other than CVS/Caremark or Cigna (they accept electronic prescriptions), please note it is your responsibility to fax in the prescription we provide to you. When requesting a refill, please provide the medication name and dosage as well as the name, full address, and telephone number to your pharmacy. If you are an existing patient and need an emergency refill sooner than five business day, please ask your pharmacy for a refill or ask them for an emergency supply.

_____ ***Conditions NOT suitable for our clinic:*** Adult /Adolescent patients with the following conditions/ situations may not be able to be treated by our clinic and thus may be referred elsewhere for proper care: significant acting out behavior including violence, anger or aggression, to include illegal or criminal behaviors; psychiatric evaluations as required by probation, courts or work-related assessments; patients needing monitoring of injectable medications; any other condition not appropriate as deemed by the physician.

_____ ***Cell phones, Email Reminders, and Messages:*** It may be necessary at times for our office to leave you a message at the phone numbers you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers. By providing your email, you give us permission to contact you in this manner for appointment reminders or general communications. If you are using a cell phone or email while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call or phone/email messages.

_____ ***Emergencies:*** We try to service our patients during a crisis situation whenever possible; however, we are not equipped as a 24-hour emergency facility. In case of an emergency, if you are unable to meet with your provider, call 911 or go to the nearest emergency room.

_____ ***Missed, Late, Canceled and "No Show" appointments:*** As scheduled appointment times are reserved especially for you, all appointments are subject to charge, whether missed, unattended or canceled, unless there has been notice given. In order to avoid being charged $100 you must call to cancel 24 hours hours in advance from the scheduled time of your appointment. Insurance companies do not pay for cancellation fees, and therefore, these charges will be your responsibility. **At our discretion, repeated "no show" appointments could result in treatment termination for non-compliance.**

_____ ***Insurance Verification:*** The information you receive when calling your insurance company is not guarantee of payment and your insurance company may or may not pay for services. Once charges are submitted, the insurance company may determine benefits differently that they initially indicated. At any time during treatment should you become ineligible for insurance coverage or should your insurance coverage change you must notify Robin Casey MD, PLLC as soon as possible and prior to your next appointment. You are responsible for payment in full of all services rendered, including services denied or not covered by insurance, or due to failure to obtain pre-authorization of a visit.

(continued on the next page)

POLICIES & PATIENT AGREEMENT – Page 2 of 2

_____ ***Limits of Confidentiality Statement:*** All information between practitioner and patient is strictly confidential. There are legal exceptions to this: (1) The patient authorizes a release of information with a signature. (2) The patient's mental condition becomes an issue in a lawsuit. (3) The patient presents as a physical danger to self or others. (4) Child or Elder abuse and/or neglect is suspected. (5) Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms). In the case of (3) or (4) above, our office is required by law to inform potential victims and legal authorities so that protective measures can be taken.

_____ ***Consent for Treatment:*** I authorize and request my practitioner to carry out evaluations and treatment which now or during the course of my treatment, become advisable. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotheraputic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

_____ ***Right to Withdraw Consent:*** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

_____ ***Termination of Care by Providers:*** I understand that my provider also has the right to terminate care with me. Should my provider choose to terminate care with me, I will be notified in writing or verbally in person or by phone. I understand my provider and/or Robin Casey MD, PLLC / Chatham North Psychiatry will assist me, within reason, in finding a new provider. I understand that if I have have not been seen as a patient for a period of two or more years, I will automatically be considered 'terminated'; in this situation I understand I am welcome to reestablish care should I desire to restart care/services.

_____ ***HIPPA Privacy Practice Notice:*** I understand Robin Casey MD, PLLC follows privacy guidelines which are outline in the Notice of Privacy Practices, which has been presented to me and is available at our office at my request.

_____ ***Payment Responsibility:*** Please note if you have a deductible to meet, it is our office policy to collect in full for your appointments until your deductible is met. Any portion of your responsibility of payment (copays/ coinsurance/ deductible) is collected at the time services are rendered. Charges for services which are not benefits of the insurance plan are the patient's responsibility. These may include, but not be limited to: telephone calls to a patient for consultation or medical management; telemedicine (video) appointments; missed appointment fees; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; completion of disability paperwork; medical records.

I understand that I am responsible for payments of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that Robin Casey MD, PLLC will submit any in-network insurance claims for me, including those with or without a co-payment agreement. I understand that if my insurance company denies payment or does not reimburse Robin Casey MD, PLLC for services rendered, or reimburses Robin Casey MD, PLLC differently than they initially indicated, I will be personally responsible for payment.

By signing below, I certify that I have read and understand these policies and agreements and have full knowledge of its meaning and effect.

_____ _____

Patient or Parent/Guardian Signature Date/Time

_____

Patient or Parent/Guardian Printed Name(s) and relationship to the patient

Thank you for taking the time to complete this document. This history form is designed to give you an opportunity to provide us with a wide variety of background information. Please read the questions carefully and answer them as frankly as possible. The information will help us to help you. Completion of this form is considered the first step in the evaluation and treatment process. By answering these questions in advance, our staff will be able to spend more time during the initial interview discussing the issues that are most important to you, as you begin mental health treatment.

CONFIDENTIAL

FOR PROFESSIONAL USE ONLY

Date / Time you are completing this form: _____

NAME: _____ DATE OF BIRTH ___ / ___ / ___

SPOUSE'S/PARTNER'S NAME: _____ DATE OF BIRTH ___ / ___ / ___

ADDRESS:_____
(Number, Street, Apt. #) (City, State) (Zip Code)

PHONE:Home _____ Work _____ Other _____

Okay to leave a message at the phone numbers? Yes_____ No _____

CURRENT AGE: _____ E-mail: _____

SEX: Male _____ Female _____ MAIDEN NAME (if applicable) _____

SOCIAL SECURITY #: _____ CITIZENSHIP: _____

EMPLOYER'S NAME (S) & ADDRESS (ES): (Also include all other sources of income)

ESTIMATED ANNUAL FAMILY INCOME: _____

Do you currently have trouble affording your medications? Yes _____ No _____

MEDICAL INSURANCE (S): (Fill in company names and policy numbers, if you have them handy)
Skip this if you have provided this information previously

What mental health or psychiatric conditions have you been diagnosed with in the past (list diagnosis and date you were first diagnosed):

Briefly describe the mental health reason(s) that brought you to our clinic today. The details of what has brought you in will be discussed with your clinician, so if possible, please attempt to summarize.

How long has this been a problem or when did it worsen?

How did you hear about our clinic? _____

If you have **a current** Psychiatrist and/or Counselor / Therapist, please list below:

Psychiatrist: location and phone number:

Therapist: location and phone number:

If you have ever seen a psychiatrist, psychologist, social worker, counselor, member of the clergy, family doctor, etc., for this, or for similar problems, please list the following:

Professional's Name/Address	Dates seen (from _____/to _____)	Problem
1.		
2.		
3.		
4.		
5.		

If you have ever been **hospitalized** for psychiatric or medical conditions, please list the following:

Hospital's Name/Address Dates seen (from _____/to _____) Problem

1.

2.

3.

4.

If you have had prior mental health treatment, what type of therapy, services, and/or medications did you find to be the **most helpful**?

What new approaches or services do you feel would be of the most help to you, if those services are available? (specific therapies, respite care, support groups, drop-in-center, intensive case management, outpatient therapy, etc.)

Please list all medications (prescriptions, over-the-counter, herbals or supplements) you are using now**, including dosages and times** you take the medications:

If you have any **ALLERGIES** or have had bad reactions to any medications, please list them here and describe the reaction:

If you have ever used or tried any medications for mental health related problems (anxiety, depression, bipolar, psychosis, or others), please list them here and comment on the reason they were discontinued:

MEDICAL HISTORY

Please check all of these that you have now and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

Pres.	Past	Age		Pres.	Past	Age	
_____	_____	_____	crying spells	_____	_____	_____	arthritis
_____	_____	_____	head injury	_____	_____	_____	asthma
_____	_____	_____	headaches	_____	_____	_____	back problems
_____	_____	_____	fainting / dizziness	_____	_____	_____	bed-wetting / soiling
_____	_____	_____	seizures	_____	_____	_____	bladder problems
_____	_____	_____	unconsciousness	_____	_____	_____	bowel problems
_____	_____	_____	loss of appetite	_____	_____	_____	cancer
_____	_____	_____	weight gain / loss	_____	_____	_____	diabetes
_____	_____	_____	high fevers	_____	_____	_____	heart trouble
_____	_____	_____	hives / rashes	_____	_____	_____	hepatitis / jaundice
_____	_____	_____	blood pressure (high / low)	_____	_____	_____	kidney trouble
_____	_____	_____	chest pain / pressure	_____	_____	_____	liver trouble
_____	_____	_____	shortness of breath	_____	_____	_____	rheumatic fever
_____	_____	_____	gynecological problem	_____	_____	_____	stomach problems
_____	_____	_____	premenstrual syndrome	_____	_____	_____	stroke
_____	_____	_____	nightmares	_____	_____	_____	thyroid problems
_____	_____	_____	night sweats	_____	_____	_____	tuberculosis
_____	_____	_____	pos. test for AIDS antibody	_____	_____	_____	unusual bleeding
_____	_____	_____	sexual dysfunction	_____	_____	_____	other _____
_____	_____	_____	skin problems	_____	_____	_____	other _____

Please use this area to comment on any of the items listed above, and on any other serious accidents, operations, or illnesses:

Please check the following if it applies to you and describe details in the space provided:

_____ Sleep Difficulties — Details:
- _____ can't fall asleep
- _____ can't stay asleep through the night
- _____ wake up too early
- _____ sleeping too much

_____ Eating Difficulties — Details:
- _____ eating too much
- _____ eating too little
- _____ binge eating and/or purging

_____ Difficulties maintaining a daily routine — Details:

Please list the name(s), address(es), and phone numbers of your **primary care provider(s)** or clinic(s) you use most often:

Please list the names and addresses of **any other doctors you are seeing/have seen**:

1.

2.

3.

Please give the name, address, and phone number of the **pharmacy you prefer** to use:

Please describe any especially frightening or disturbing events that you have experienced, such as automobile accidents, fires, deaths, violence, crime victimization, and illnesses:

Has anyone ever physically, emotionally, or verbally abused you? Yes No

If you use tobacco, how much and what type do you use daily?

If you have ever used alcohol, when, where, how much, and what type do you (did you) drink?

If you have ever used street drugs (marijuana, cocaine, LSD, etc.) or abused prescription medications, please list the following:

Type of drug	Amount	Frequency	Most Recent Usage

If you have ever been **treated for substance abuse**, please list the name(s) and address(es) of the treatment sites(s):

Name/Address	Dates (From /to)	Problem
1.		
2.		
3.		

If you consume caffeine (in coffee, tea, colas, etc.), how much do you consume daily?

Do you have any history of aggressive behavior or legal / criminal charges related to assaults? Yes No
If so, please describe:

Do you have any history of fire setting? Yes No
If so, please describe:

If you have ever been arrested, please check all that apply:	Juvenile arrest record	Yes _____	No _____
	Adult arrest record	Yes _____	No _____
	Currently on probation	Yes _____	No _____
	Currently on parole	Yes _____	No _____

If on probation/parole, list the name, address, and phone number of the P.O.:

If applicable, please describe the arrest record here:

FAMILY HISTORY

	Name	Age	Occupation	Lives in…(city/state)
Father	_____	____	_____	_____
Mother	_____	____	_____	_____
Brothers and sisters	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____

Please use this space to comment on your family while you were growing up, noting any rough spots, such as parental separation/divorce/remarriage, and if someone other than your natural parents raised you, note the name(s):

If you have lived in any foster homes or residential placements, please list the name(s) and address(es):

Check any of the following that occurred (or are occurring now) in your family and give a brief description of those checked in the space below:

1. Physical abuse _____
2. Violent arguments/fighting _____
3. Child abuse _____
4. Sexual abuse _____
5. Chronic illness _____
6. Alcohol abuse _____
7. Drug abuse _____
8. Suicidal behavior _____
9. Involvement with a cult _____
10. Involvement with a gang _____

If any members of your family have been treated for mental or emotional problems, or substance abuse issues, please explain the circumstances here:

MARITAL AND SOCIAL HISTORY

Current Relationship Status (please circle):

Single Married Living with Someone Separated Divorced Widowed Other - _____

Please provide some information about your past and present relationships with others and note any current relationship problems you may be having:

If you have children, please list the following information:

Name	Age	Lives with…	School grade/occupation
1. _____	___	_____	_____
2. _____	___	_____	_____
3. _____	___	_____	_____
4. _____	___	_____	_____
5. _____	___	_____	_____

Please list the names, ages, and relationships to you of those currently living with you and not listed above, including all family members, friends, and so on.

Name	DOB/Age	Relationship

Please check what language(s) is (are) spoken and/or written in your home?

English: _____ spoken _____ written

Spanish: _____ spoken _____ written

Other Language(s): _____ _____ spoken _____ written

_____ _____ spoken _____ written

Do you consider yourself spiritual and/or religious? Yes No . If you are actively involved in church, temple, mosque, or other spiritual activities, please give the name of this organization and a brief description of the activities:

What do you enjoy doing in your spare time? Include hobbies, interests, and anything else that helps you relax.

Do you feel you make friends easily? Yes _____ No _____

Do you feel that you generally trust people fairly easily? Yes _____ No _____

Briefly describe any difficulties you may have in dealing with people:

EDUCATIONAL HISTORY

What is the furthest you have gone in school? _____ GED? Yes _____ No _____

	School Name	City, State	Degree, if one obtained	Year graduated or ended
High School				
College				
Grad School				
Other Specialized Training or Education				

If you had any trouble in school with either academic subjects or behavior, or any know learning or developmental delays/concerns please describe the problem(s) here:

If you received any special awards or honors in school, please note them here:

OCCUPATIONAL HISTORY

Present occupation & employer: _____

How long have you had this job? _____

Please describe the nature of your duties/responsibilities and note any recent changes that have been stressful (include promotions, demotions, awards, or any disciplinary actions):

If your current mental health problems or medications are interfering with job performance, please comment upon that here:

How well do you get along with fellow workers? _____

How well do you get along with supervisor(s)? _____

How many different jobs have you held in the last five years? _____

What other jobs have you held since you began working?

Please list any specialized job training you have received or skills you have mastered:

How would you describe yourself in relationship to spending, saving, and managing money?

MILITARY HISTORY

Have you ever been in the military (If no, skip to the next section)? Yes No

If yes, which branch? _____ Officer or enlisted? _____

Length of service? (month and year) From _____ To _____

If you were honored or promoted while in the service, please explain here:

If you were disciplined or demoted while in the service, please explain here:

If you were in treatment while in the service, please explain here:

Do you have a "service connected" disability? Yes _____ No _____

If yes, please explain here:

Date discharged and type of discharge rec'd:

OTHER AGENCIES INVOLVED?

If you are involved with any other agencies/services or you are trying to apply for benefits, please check them off (or add them) below and fill in the name and phone number of the contact person:

Agency/Service	Contact Person	Phone Number
_____ Adult Education (_____)	_____	_____
_____ Children & Youth Services (_____)	_____	_____
_____ CHIPPS, ICM, or RC (_____)	_____	_____
_____ Clubhouse (_____)	_____	_____
_____ Consumer Organization (_____)	_____	_____
_____ Drop-in-Center (_____)	_____	_____
_____ Drug & Alcohol (_____)	_____	_____
_____ Law Suits/Legal Action (_____)	_____	_____
_____ Mental Health Program (_____)	_____	_____
_____ Public Assistance (or Medical Assistance)	_____	_____
_____ Social Security (e.g. SSD or SSI)	_____	_____
_____ Support Group (_____)	_____	_____
_____ Veteran's Administration	_____	_____
_____ Workman's Compensation	_____	_____
_____ Other (_____)	_____	_____

Please comment on any of these issues here:

Who is aware you are beginning mental health services? (e.g. family, friends, and/or employer)

If others are aware, what is their attitude about it?

What strengths can you list that will help in resolving the issues you have noted?
(e.g., family supports, friendships, personal insights, faith, etc.)

Please explain what type(s) of transportation you use: (Do you drive, take buses, or have other transportation available?)

If someone helped you fill out this form, please write his or her name and phone number here:

Please review your answers and, if there is anything else you feel would be important, please include it here:

Thank you for taking the time to fill out this form.

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phone: 919-998-6463 fax: 844-433-3838
www.robincaseymd.com

Authorization to Obtain or Release Protected Health Information

_____ _____ _____
Patient Name (please print) Date of Birth Last 4 digits of Social Security No

I hereby freely and voluntarily authorize Robin Casey MD / Chatham North Psychiatry to:

☐ Release/disclose my protected health information to the following
☐ Obtain my protected health information from the following

Individual, Facility, or Organization Name: _____

Street: _____

City, State, Zip: _____

Phone: (_____)_____ Fax: (_____)_____

The purpose of this authorization is for:

☐ Continued treatment	☐ Progress Updates	☐ Legal reasons
☐ Discharge planning	☐ Insurance Purposes	☐ Medical treatment
☐ Other (explain): _____		

Information to be obtained or disclosed:

☐ Psychiatric evaluation	☐ Lab/X-ray results	☐ Therapy notes
☐ History & Physical	☐ Progress Report (verbal)	
☐ Medication records	☐ Physician's Orders	☐ All records
☐ Aftercare Plan	☐ Discharge summary	☐ Other (explain) _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Robin Casey MD, PLLC's Privacy Officer, except to the extent that action has already been taken in reliance on it. ***This authorization will expire in 12 months following the signing of the form, unless another date or condition is specified.***

Other date or condition specified: _____

_____ _____
Patient Signature Date / Time

_____ _____
Guardian or Legal Representative Signature Date / Time

Relationship to patient _____

_____ _____
Witness Signature Date / Time