

Patient/Client Registration

Robin Casey MD, PLLC
117 Hidden Valley Dr
Chapel Hill, NC 27516
phone/fax 844-345-2256

Legal Name First Middle Last names		Today's Date
Preferred name:		Preferred pronouns:
Legal Sex (please check one)* <input type="checkbox"/> Female <input type="checkbox"/> Male <small>*While Robin Casey MD, PLLC recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.</small>		
Date of Birth <i>Month Day Year</i>	Social Security #	State ID # or License #
/ /		

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone () -	Cell Phone () -	Work Phone () -	Best number to use: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Local Address	City	State	ZIP
Billing Address (if different from above)	City	State	ZIP
Email addresses:			
List any phone number/emails/addresses at which it is NOT okay to contact you or to leave a message:			
Occupation	Employer/School Name	Are you covered under school or employer's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact's Name	Phone Number	Relationship to you	
<small>If you are under 18, we require that you provide parent/guardian contact information.</small>			
Parent/Guardian Name	Phone Number(s) and email	Relationship to the patient	
May Robin Casey MD, PLLC Health send mail to your local address (check one)? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>This question only refers to mail for purposes other than billing. Payment is expected at the time of your visit.</small>			

This information is for demographic purposes only and will not affect your care.

1.) Which of the categories best describes your current annual income? Please check the correct category: <input type="checkbox"/> < \$10,000 <input type="checkbox"/> \$10,000 - 14,999 <input type="checkbox"/> \$15,000 - 19,999 <input type="checkbox"/> \$20,000 - 29,999 <input type="checkbox"/> \$30,000 - 49,999 <input type="checkbox"/> \$50,000 - 79,999 <input type="checkbox"/> Over \$80,000	2.) Employment Status <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	3.) Racial Group(s) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi racial <input type="checkbox"/> Native American / Alaskan Native / Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	4.) Ethnicity <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino/Latina 5.) Country of Birth <input type="checkbox"/> USA <input type="checkbox"/> Other _____
6.) Language(s) <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Français <input type="checkbox"/> Português <input type="checkbox"/> Русский <input type="checkbox"/> Other _____	7.) Do you think of yourself as <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know	8.) Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____ 9.) Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran	10.) Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Friend or Family Member <input type="checkbox"/> Health Provider <input type="checkbox"/> Hospital/Emergency Room <input type="checkbox"/> Internet search <input type="checkbox"/> Other _____
11.) What is your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or not exclusively male or female	12.) What was your sex at birth? <input type="checkbox"/> Female <input type="checkbox"/> Male	13.) Do you identify as transgender or transsexual? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Please turn over 

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, it is preferred that children do not accompany the patient 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. Keeping up with scheduled appointments are the patient's responsibility - appointment reminders are a courtesy to our patients and are NOT guaranteed. OUR MISSED APPOINTMENT POLICY REMAINS IN EFFECT. To change or cancel an appointment, call the office.

_____ **General information on prescription refills:** Typically, Dr Casey writes prescriptions for the amount of medication needed until your next scheduled appointment unless otherwise discussed. 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 for 30 days per script. We cannot post-date prescriptions. 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 in the case our office is unable to accomodate your request in time.

_____ **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 and email addresses, you authorize us to contact you and/or to leave messages for you at those number /emails, unless explicitly stated otherwise and in writing. 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/ text messages. If you have confidential or personal information to communicate, you agree to use the HIPAA secure patient portal provided through Robin Casey MD, PLLC's medical records system. We will not be liable for improper disclosure of confidential information. To change or cancel an appointment, call the office.

_____ **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 9-1-1 or go to the nearest emergency room.

_____ **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.

_____ **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 a minimum of 24 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, "no show" appointments could result in treatment termination.

_____ **Insurance Verification:** The information you receive when calling your insurance company is not a 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.

Patient Name: _____

Patient Date of Birth: _____

Robin Casey MD, PLLC 117 Hidden Valley Dr, Chapel Hill, NC 27516 Phone/fax 844-345-2256 robincaseymd.com

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. See HIPAA policies for further detail.

_____ **Consent for Treatment:** I authorize and request my practitioner to carry out evaluations and treatment for myself or my child 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/my child's treatment. Further, that the psychotherapeutic 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 myself/my child.

_____ **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 patient payment (copay and coinsurance) 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, knowledge of its meaning and effect. 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

Patient/Client Credit Card Pre-Authorization

Robin Casey MD, PLLC
 117 Hidden Valley Dr
 Chapel Hill, NC 27516

Phone 844-345-2256 ext 2
 Fax 844-345-2256
 Robincaseyemd.com

In an effort to better serve our patients/clients and to simplify your billing experience, our office offers credit/debit/FSA/HSA card acceptance.

I authorize Robin Casey MD, PLLC to keep a credit card on file to satisfy my financial obligations as defined by Robin Casey MD, PLLC's Patient Financial Agreement. _____ initials

Charge card information is kept filed with your confidential patient/client information and kept secure within your medical record. This information will never be released with your other medical records, even if you request your records be sent to other providers, individuals, or facilities. If you choose to utilize a third party merchant for payments, your information is stored based on their company policy and Robin Casey MD, PLLC is not liable for any mishandling on their part. _____ initials

I understand that Robin Casey MD, PLLC will automatically contact me at least 48 hours prior to using this credit card on file if my past due balance exceeds \$100. **Any past due balances under \$100 will be automatically processed without notification. I hereby authorize Robin Casey MD, PLLC to charge my credit card in agreement with this policy.** _____ initials

I understand that I can specify a different amount in which to receive prior notification, I may indicate it below on this Form, along with a valid contact phone number. If Robin Casey MD, PLLC is unable to reach me with the phone number I provide, or in the event that I am unable to satisfy my patient balance and payment arrangements are not established by me within 30 days of receipt of my first statement, Robin Casey MD, PLLC will attempt to use this credit card on file to resolve any past due balances. It is my responsibility to notify Robin Casey MD, PLLC of any updates or changes to the credit card on file associated with this agreement as soon as possible. _____ initials

PAYMENT INFORMATION	Patient/Client Name: _____	
	Patient/Client Billing Address: _____	
	Type of Card: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
	Card Number: _____	
	Expiration Date: _____ Security Code _____ Or CVV: <small>(3 digits on back of card, 4 digits on front of AMEX)</small>	
	The undersigned guarantees performance of the financial provisions of this agreement.	
	Card Holder Name: _____	
CHARGE POLICY	Signature of Card Holder: _____ Date: _____	
	____ (initial) Being the authorized cardholder, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.	
	____ (initial) Charges made for actual services performed by our office are non-refundable. In the event of pre-payment any unused funds will be refunded within <u>30</u> days.	

Patient Name: _____

Patient Date of Birth: _____

Adult New Patient Clinical Intake Form

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 or continue mental health treatment.

Date you are completing this form: _____

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:

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:

Patient Name: _____

Patient Date of Birth: _____

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.

<u>Pres.</u>	<u>Past</u>	<u>Age</u>		<u>Pres.</u>	<u>Past</u>	<u>Age</u>	
_____	_____	_____	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:

Patient Name: _____

Patient Date of Birth: _____

MENTAL HEALTH HISTORY

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

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 mental health provider in the **past** (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.)

Patient Name: _____

Patient Date of Birth: _____

Adult New Patient Clinical Intake Form

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?

What has made it better?

What has made it worse?

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 or any benefits/problems you had with them:

Patient Name: _____

Patient Date of Birth: _____

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:

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

FAMILY HISTORY

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Lives in...(city/state)</u>
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 | _____ | 6. Alcohol abuse | _____ |
| 2. Violent arguments/fighting | _____ | 7. Drug abuse | _____ |
| 3. Child abuse | _____ | 8. Suicidal behavior | _____ |
| 4. Sexual abuse | _____ | 9. Involvement with a cult | _____ |
| 5. Chronic illness | _____ | 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:

Patient Name: _____

Patient Date of Birth: _____

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

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

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:

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:

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

Patient Name: _____

Patient Date of Birth: _____

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?

Patient Name: _____

Patient Date of Birth: _____

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.