New Hope Psychiatric Services of the Carolinas, PLLC
1558-A Union Rd, Gastonia, NC 28054
704-810-7418

Today's Date_____ Referred by _____

Name_____

Date of Birth _____ Social Security Number _____ - _____ - _____

Home Address_____
Street City State Zip

Home/Cell Phone_____ Email Address _____

Age _____ Education (yrs) _____ Marital Status _____

Current type employment and hours per week _____

Employer and Address _____Work Phone_____

Medical Insurance Co. _____ Certif/Policy # _____

Name of Spouse or Parent_____ Phone_____

Notify in case of emergency _____Phone _____

Personal physician(s)_____ Phone _____

Pharmacy: _____ Phone _____

Please describe your current major symptoms, problems, worries and/or concerns. Include information about when they began and under what circumstances:

Have you been treated for these problems before or ever seen a psychiatrist, psychologist or counselor? If so, when, whom and for what?

Do you have any physical symptoms such as headaches, an upset stomach, loss of appetite, fatigue, trouble sleeping, etc.? If so, list your symptoms and time of onset:

Do you have a physical disease now and/or are you presently under the care of a physician?

If you are currently taking any medicine(s) or pills or vitamins or herbs, then please list by name and dose schedule:

If you have allergies to medications, please list them:

Please describe your personal habits, such as smoking, drinking, or using drugs. How much do you smoke, drink and/or use drugs now?

Have you or any blood relatives ever experienced any of the following?

			Who?
Depression	Yes	No	
Suicide	Yes	No	
Drug addiction	Yes	No	
Excessive drinking	Yes	No	
Convulsions or Epilepsy	Yes	No	
Fainting spells	Yes	No	
Nervous breakdown	Yes	No	
Psychiatric hospitalization	Yes	No	
Counseling and/or psychotherapy	Yes	No	

Have you ever had any physical sicknesses requiring hospitalization or any operations or fractures, etc.? Please list them with appox. dates.

Have you ever had a head injury? _____ When?_____
Were you knocked unconscious? _____ For how long? _____

Where were you born?_____
Where did you live during most of your childhood?_____

As a child or adolescent, were you ever physically or sexually abused?_____
If so, at what age and by whom?_____

Were your parents separated by divorce, illness, death, etc., before your 18th birthday?
If so, give your age at the time and describe what happened:

At what age and why did you leave home? (e.g. 18 y.o. for college)
_____

Where do you presently live?_____ For how long?_____

Parents' religion_____ Your religion_____
How often do you attend church or temple? (once a week, etc.) _____

Have you been in military service?_____
If so, which branch & what dates? _____

Have you ever been arrested or in jail?_____ If so, when and for what?

FATHER (or step-father or other man who raised you when you were a child)

Age:____ If deceased, date and cause of death:_____
Highest level of education: _____ Most recent occupation: _____
Has he retired?_____ Where does he live now? _____

Describe his involvement in church/temple/religion:

Briefly describe your father's personality:

How did you and your father get along with each other while you were growing up? Give some examples of the things you did together and the feelings you had.

MOTHER (or step-mother or other woman who raised you when you were a child)

Age:_____ If deceased, date and cause of death:_____
Highest level of education: _____ Most recent occupation: _____
Has she retired? _____ Where does she live now? _____

Describe her involvement in church/temple/religion:

Briefly describe your mother's personality:

How did you and your mother get along with each other while you were growing up? Give some examples of the things you did together and the feelings you had.

How did your mother and father get along with each other? What were some of their major disagreements about?

List all of your brothers and sisters in order of birth. Include yourself in the list where you belong:

First Name Sex Present Age Educational Level Marital Status Occupation

_____
_____
_____
_____
_____
_____
_____
_____

Age of onset of puberty _____ Major source of sex education_____

Age when started dating _____ Age when became sexually active _____

If you have had any homosexual contacts, then at what age? _____

If you have concerns about sexual issues that you would like to discuss, what are they?

How many abortions have you or your partners had? _____

List all marriage(s), separation(s), divorce(s), and partner(s)

Name Began Dating Year Married # Children Year Separated/ Divorced/Widowed

_____
_____
_____
_____
_____

Current Spouse's age _____ Educational level _____ Occupation _____

Do you have concerns about your current marital relationship you would like to discuss? If so, what are they?

List your children and their age(s) by order of birth:

_____ _____
_____ _____
_____ _____

Do you have any concerns about any of your children that you would like to discuss? If so, what are they?

****

Please finish each sentence with the first ending you can think of.

What pains me most is _____

If I could get away with it, I'd _____

The best time of my life _____

Many people don't know that I _____

I can't always control myself when

_____

What I like most about myself is

_____

The worst thing I ever did was _____

I would be happier if

Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

	Not at all [0]	Several days [1]	More than half the days [2]	Nearly every day [4]
1. Over the last 2 weeks, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things……..				
b. Feeling down, depressed or hopeless …….				
c. Trouble falling or staying asleep, or sleeping too much ….				
d. Feeling tired or having little energy ……..				
e. Poor appetite or overeating ……..				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down ……..				
g. Trouble concentrating on things, such as reading the newspaper or watching television …….				
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual ……				
f. Thoughts that you would be better off dead or of hurting yourself in some way ……				

2. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult [0]	Somewhat difficult [1]	Very difficult [2]	Extremely difficult [3]
☐	☐	☐	☐

Score _____

DSM-IV Criteria, as prepared by Robert Spitzer, M.D.; New York State Psychiatric Institute
Adapted from PRIME-MD Patient Health Questionnaire (PHQ) ® trademark of Pfizer Inc.

Mood Disorders Questionnaire

1.	Has there ever been a period of time when you were not your usual self and (while not using drugs or alcohol) ...		
	...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? *(circle yes or no for each line please)*	Yes	No
	...you were so irritable that you shouted at people or started fights or arguments?	Yes	No
	...you felt much more self-confident than usual?	Yes	No
	...you got much less sleep than usual and found you didn't really miss it?	Yes	No
	...you were much more talkative or spoke faster than usual?	Yes	No
	...thoughts raced through your head or you couldn't slow you mind down?	Yes	No
	...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
	...you had much more energy than usual?	Yes	No
	...you were much more active or did many more things than usual?	Yes	No
	...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?	Yes	No
	...you were much more interested in sex than usual?	Yes	No
	...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes	No
	...spending money got you or your family into trouble?	Yes	No

2.	If you checked YES to more than one of the above, have several of these ever happened during the *same period of time*?	Yes	No
3.	How much of a *problem* did any of these cause you -- like being unable to work; having family, money, or legal troubles; getting into arguments or fights? No Problem Minor Problem Moderate Problem Serious Problem		

4.	Draw a line connecting any (blood) relative to any problem (this doesn't have to be neat): Grandparents Parents Aunts/Uncles Brothers/Sisters Children Suicide Alcohol/drug problems Mental Hospital Depression Problems Manic or bipolar		
5.	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No

New Hope Psychiatric Services of the Carolinas, PLLC
Office: 704-810-7418 Fax: 704-810-6560 Email: newhopepsy@live.com

Patient Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of protected health information (PHI) about the patient to carry out treatment, payment, or healthcare operations.

We want you to know that we respect the privacy of your personal medical records and will do all we can to secure your PHI while taking reasonable precautions to protect your PHI. When appropriate, we provide the minimum necessary information to only those we feel in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest. The Practice from time to time may contact you for appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: telephone, email, text, and either speaking with you or leaving a message.

New Hope Psychiatric Services of the Carolinas, PLLC also wants you to know that we support appropriate access to medical records. **With your consent, we may disclose PHI for purposes of treatment, payment, or health care operations such as communication with health care professionals, third party payers, and law and insurance requirements.** However, **NO CONSENT REQUIRED** for New Hope Psychiatric Services of the Carolinas, PLLC to use and/or disclose your PHI in the following instances: **emergency situations in the purpose of rendering treatment, or to a public or private authorized agent for the purpose of coordinating your care; to disclose the fact of a client's admission or discharge to the client's next of kin using professional judgment that the disclosure is in the best interest of the client; to avert a threat to health or safety; for purposes of filing a petition for involuntary commitment of a client; de-identified information; to a business associate of the Practice (i.e. referring provider, laboratory, psychologist, hospital); to a client's personal representative or legally responsible person; in evidence of a communication barrier; public health activities; in any case of abuse, neglect or domestic violence, in health oversight activities; judicial and administrative activities; Law or Government agency purposes; Coroner or medical examiner; Organ, eye or tissue donation; Criminal activity; specialized government functions (i.e. military or veteran); Division of Adult Corrections of the Department of Public Safety; workers compensation; Research and Planning if Practice involved in research activities subject to governmental requirements.**

Other Permitted/Required Uses or Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your PHI in the following instances: you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclosed protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Client Rights and Responsibilities

You have the right to revoke any authorization and/or consent to the use or disclosure of your PHI at any time, but this must be in writing. You may also request restrictions on certain use and/or disclosure as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request. In your written request, you must inform the Practice of what information you want to

limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. You have the right to receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice. The Practice will accommodate all reasonable requests. You may inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice. You have the right to amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement. You have the right to receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. You also have the right to receive a paper copy of this Privacy Notice from the Practice upon request to the Practice however it is posted on our website. The Practice reserves the right to make changes to this notice and may make those changes via website notification, interoffice display, or mail.

You may file a complaint with our privacy officer, Tonja S. Norman, PMHNP-BC, FNP-C, at 704-810-7418 or to the Secretary of Health and Human Services at 919-856-2195, if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, for further information about the complaint process.

Dignity and Respect
You have the right to be treated with consideration, dignity, and respect, and the responsibility to respect the rights, property, and environment of all health care providers, employees, and other patients. You have the right to have the privacy and confidentiality of your health records maintained. You are also entitled to these rights regardless of gender, age, sexual orientation, marital status, or culture, or economic, education, or religious background.

Knowledge and Information
You have the right to receive information about your practitioner's services and any treatment recommendations. You have the right—and the responsibility—to know about and understand your health care and your coverage, including the following: participating with your practitioner in decision-making regarding your treatment planning; your clinical condition; any services and procedures involved in your recommended course of treatment; and how your health plan operates as stated in your policy.

Eligible Employee Accountability/Autonomy
As a partner in your own health care, you have the right to refuse treatment, providing you accept responsibility for the consequences of such a decision. You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and in developing mutually agreed upon treatment goals. You also have the responsibility to identify yourself and insurance coverage or changes in coverage when receiving behavioral health services. You have the responsibility to provide your current provider with previous treatment records, if requested, as well as to provide accurate and complete medical information to any other health care professionals involved in the course of your treatment. You have the responsibility to be on time for your appointments and to notify your provider as far in advance as possible if you need to cancel or reschedule an appointment. You have the responsibility to notify your behavioral health plan within 48 hours—or as soon as possible—if you are hospitalized or receive emergency care. And, you have the responsibility to pay all required co-payments and deductibles as the time you receive behavioral health care services.

New Hope Psychiatric Services of the Carolinas, PLLC
Tonja Simmons Norman, PMHNP-BC, FNP-C
1558-A Union RD, Gastonia, NC 28054
704-810-7418

NOTICE of PRIVACY PRACTICES

New Hope Psychiatric Services of the Carolinas, PLLC, treats all PHI "Protected Health Information" as confidential and privileged information. Your medical information will be used for treatment, payment and health care operations.

Examples:

- The physicians and nurses will use the information to treat you.
- The billing office will use the information to bill you and your insurance company.
- The office will use the information for business, purposes such as quality improvement and to send you information.

We will disclose medical information to family members with your permission, to other physicians during emergencies, in case of abuse and neglect, and in legal proceedings.

Your HIPAA rights:

- Right to access your medical records
- Right to request restrictions
- Right to confidential communication
- Right to amend your medical record
- Right to an accounting of disclosures

If you have any questions about HIPAA and the Privacy Rule, please contact Tonja S. Norman, PMHNP-BC, FNP-C who is the HIPAA compliance officer for New Hope Psychiatric Services of the Carolinas, PLLC.

_____ _____

Acknowledgement of receipt of Notice of Privacy Practices -Patient Signature Date

Consent for Mental Health Evaluation and/or Treatment

Version for Adult

Name:
Date of Birth:
Record #:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from **New Hope Psychiatric Services of the Carolinas, PLLC**. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of North Carolina Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or social performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. Fees are billed directly to the insurer however I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at the residing facility and New Hope Psychiatric Services of the Carolinas, PLLC. I consent to disclosure for use by New Hope Psychiatric Services of the Carolinas, PLLC, staff for the purpose of continuity of my care. Per North Carolina mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **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.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Signature of client or Legal Guardian **Date**

_____ _____
Signature of witness **Date**

New Hope Psychiatric Services of the Carolinas, PLLC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client: _____

DOB: _____

Insurance ID # _____

- Use this form to obtain client or legally responsible person/personal representative authorization for the release of information
- Form must indicate whether this is to release information, obtain information, or both.
- Form must be completely filled out before client or legally responsible person/persons representative signs
- File original form in client record. MUST GIVE COPY TO CLIENT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 C.F.R. Parts of 160; 42 C.F.R., Part 2; G.S. 122C

This form implements the requirements for client authorization to use and disclose health Information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____ **, authorize** New Hope Psychiatric Services of the Carolinas, PLLC
(Client or client's legally responsible person or personal representative) (Agency or person authorized use or disclose the information)

☐ to obtain from: ☐ to release/disclose to: _____

_____

_____

(Agency or person to whom the requested use or disclosure will be made)

The following protected information: labs, visit notes, ongoing communication, etc

_____

_____

(Ex. Psychiatric Assessment; Psychological Assessments; Progress Notes; Treatment Plan; Medication Records; Screening)

The Purpose of the disclosure is: To provide continual care

_____

_____

_____

(Describe each purpose of the requested use or disclosure)

REDISCLOSURE

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Privacy Notice describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse Alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke are explained in New Hope Psychiatric Services of the Carolinas, PLLC Privacy Notice, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon: _____
(Date or event that relates to the client or the purpose of the use or disclosure)

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that New Hope Psychiatric Services of the Carolinas, PLLC cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances, i.e. Research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

Signature: _____ **Date:** _____

Please explain authority of person signing above to act on behalf of client: _____

Signature: _____ **Date:** _____
(Minors Signature-only required if minor has a substance abuse diagnosis)