Ellison & Associates of Raleigh, PC

Office Policies

Thank you for choosing Ellison & Associates of Raleigh, PC for your behavioral health needs! Your time is important, and we feel that your awareness of the information found below will help your interactions with our office to be as efficient as possible. We want to make your experience positive and rewarding. Please review the following:

ARRIVAL TIME

Please arrive at least 5 minutes early for your appointment with our office to sign-in and complete any necessary changes. (demographics, insurance, etc.)

PAYMENTS

All co-pays, deductibles, and account balances will be due at time of service. We make every effort to verify your benefits accurately. Should you make an overpayment, we will either write you a check quarterly or you have the option of an account credit. **We do not accept checks.** We accept Cash, Visa, Discover, and Mastercard. If you are unable to pay the amount in full, your appointment will be rescheduled to a later date. A legal parent or guardian is required to accompany all patients under 18 years of age for psychiatric evaluation and medication monitoring follow-up appointments.

PHONE CALLS

Please remember that the providers are seeing scheduled patients throughout the day and it may take some time before a return call can be made. **Your call will be returned within 48 hours** or during the course of the day as our schedule allows. The office functions with a timely and efficient message system, so it is not necessary to make repeat phone calls to the office during the course of the day. After-Hours phone calls: Physician phone call responses after-hours (weekends/closed Fridays/holidays) will incur a $50 charge/15 minutes. **Clinical phone calls** from providers (MD or LCSW) during office hours to patients will cost $25/ 10 minutes and **are not** covered by insurance.

APPOINTMENTS

If you have several questions or concerns that need to be discussed, it is best to schedule an appointment. As a courtesy reminder, you will receive a confirmation phone call prior to your scheduled appointment. However, it is your responsibility to keep track of your appointment dates and times. There will be no charge for rescheduled appointments that are initiated by our office and **30 day** interim medication for active patients will be provided.

Our office requires a **24 hour advance notice** for the cancellation or rescheduling of an appointment. (This will allow us to offer that time to another patient.) Please be advised, you will be charged a missed appointment fee ($50 for follow-up therapy appointment, $75 for medication management appointment/new patient appointment/new patient parent appointment) if a 24 hour advance notice is not given. Repeated failure to keep your scheduled appointments may result in termination from our practice.

PRESCRIPTIONS

Please maintain your follow-up appointments so that you don't run out of medication. There will be a $20 charge for any refills outside of appointments. All current insurance plans require face-to-face appointments

and do not cover telephone medication changes. We will be happy to provide you with 90-day prescriptions to be processed through mail-in pharmacy. However, we require that this be completed during the appointment.

FORMS

If you have FMLA, disability, work/school forms that need completion, you will need to schedule an appointment to ensure that these forms are completed accurately and completely. Please be advised, there is a charge for form completion. If a patient requests a letter citing mental health for missing school/work, we must have had a face-to-face appointment within three days of the date of absence. (FMLA/Disability forms-$25-$50, Work/School forms/Letters-$10-$15)

MEDICAL RECORDS

Please allow 3 business days to complete requests for medical records. If you do not have a current signed release on file, you will be asked to sign one when picking up your records. There will be a $10 charge for records that are provided. There is no charge for medical records being faxed to or requested from another medical office. (Health Information Release form can be found at www.eapsych.com under the Helpful Forms tab)

BILLING QUESTIONS

We contract with Transwarp Billing Service for our billing needs. If you have concerns or questions about your bill, you may contact Transwarp by phone: 919-870-0082 fax: 919-870-7802 or mail: PO Box 91322, Raleigh, NC 27675-1322

PORTAL

Our office offers a patient and provider-to-provider portal for secure, HIPAA compliant messaging. Please provide the front desk staff with your email and you will receive an email invitation to our portal. You will be asked to verify your date of birth and given a temporary password. Our portal can be used for requesting appointments, providing documentation, or general questions about your treatment. As email is not HIPAA compliant, we kindly request that patients utilize our portal for their treatment needs.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS

The responsibility of payment for services rendered to any minors whose parents are legally separated or divorced rests with the parent who brings the minor to the visit. Any court ordered responsibility judgments must be determined between the individuals involved without the inclusion of our office. E&A will not be involved with separation or divorce disputes.

I have reviewed the information above and understand the office etiquette policies for Ellison & Associates

_____ _____

Patient/Guardian Signature Date

ELLISON & ASSOCIATES OF RALEIGH, P.C.
REGISTRATION FORM
(Please Print)

Today's date: Code:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Relationship status Single / Partnered/ Married / Divorced / Separated / Widow

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )

Email Address: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

PHARMACY INFORMATION

Name: Phone no.: ( ) Fax no.: ( )

Address:

❑ Mail- Order

INSURANCE INFORMATION

(Please give your insurance card/driver's license to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Occupation: Employer

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ UBH ❑ State Health Plan ❑ CIGNA ❑ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone no.: ( ) Cell/Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that Ellison & Associates contracts with Transwarp Billing Service and I agree to cooperate in reasonable efforts to complete my claims. I also authorize Ellison & Associates or insurance company to release any information required to process my claims. I understand that I will be responsible for any NSF and NO CALL NO SHOW/LATE CANCELLATION fees and that should my account become delinquent and submitted to collections, that I will be responsible for all associated collection fees.

Patient/Guardian Signature *Date*

Ellison & Associates of Raleigh, P.C.
2301 Rexwoods Drive, Suite 102
Raleigh NC 27607

Consent to treatment

I, _____, (patient, parent, guardian) give my consent for Ellison & Associates of Raleigh, P.C., to provide assessment, treatment, and/or other services for the above-named patient. I reserve the right to withdraw at any time from this treatment. In addition, I reserve the right to refuse, at any time, any services offered. I understand that Ellison & Associates will assist me in obtaining crisis services, as appropriate, but that Ellison & Associates does not provide emergency treatment. I understand that Ellison & Associates provides outpatient treatment only.

FINANCIAL RESPONSIBILITY

I, _____, (patient, parent, guardian) agree that I am responsible for the full cost of services rendered by Ellison & Associates and that payment is expected at the time of service. **WE DO NOT ACCEPT CHECKS. I understand that cash, Visa, and MasterCard are accepted.** I understand that Ellison & Associates will provide me with a detailed billing statement that I may submit with any insurance claims and/or will provide reasonable assistance to help me file insurance claims. I understand that I will be responsible for any NSF and NO CALL NO SHOW fees associated with my account and that should my account become delinquent and be assigned to collections that I will be responsible for all associated fees.

Patient/Parent
Signature:_____

Provider
Signature:_____

Date:_____

Ellison & Associates of Raleigh, P.C.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PART 1 – YOUR RIGHTS

- You have a right to request limits on the way we use or disclose your health information. You must make the request in writing to our Privacy Officer. We will try to honor reasonable requests.
- You have the right to request how we provide confidential communications to you. For example, we may communicate medical information to you by mail or by telephone Or, you may ask us to send information to your work address instead of your home address; you may also request that we call you at work instead of at home. You must make this request in writing to our Privacy Officer. We are required to follow your request, if it is reasonable.
- In most cases, you have the right to look at or get copies of your records. You must make the request in writing to our Privacy Officer. We may charge you a reasonable fee based on copying and other costs. In certain situations, we may deny your request and will tell you why we are denying it. In some cases, you may have the right to ask for a review of our denial.
- You have a right to request a correction or an update of your records. You must make the request in writing to our Privacy Officer and provide a reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included in your PHI.
- You have a right to get a list of persons or agencies to which your records were sent after April 14, 2003. You must make this request in writing to our Privacy Officer.
- You have the right to withdraw your permission for us to release your information. If you sign an authorization to use or disclose information, you can revoke that authorization at any time. The revocation must be made in writing and given to our Privacy Officer.

PART 2 – ELLISON & ASSOCIATES RESPONSIBILITIES

We are required by law to provide you with our Notice of Privacy Practices. Under Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must protect the privacy of your "protected health information" or PHI. PHI is information that we have created or received regarding your health or payment for your health care. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

We are required to:

- Keep your protected health information private except as indicated below
- Follow the terms of the Notice currently in effect
- Give you this Notice

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update our Notice and make it available to you.

PART 3 – HOW ELLISON & ASSOCIATES MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU

Here are some examples of how we may use or disclose your personal health information without your authorization.

To provide treatment; for example:

- We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care.
- We may disclose information to other professionals providing your health care. For example, we may need to tell another mental health professional about your medical conditions if we refer you to another practitioner.

To receive payment for services we provide or to obtain insurance authorization for services we recommend; for example:

- If you have health insurance, we may request payment from your health insurance plan for the services we provide.
- We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan.

To carry out healthcare operations; for example:

- We may use or disclose your health information in order to manage our business activities.
- We may use or disclose health information to notify, or assist others in notifying a family member, your personal representative or other person responsible for your care, of your location or your general condition. If you are present, we will provide you with an opportunity to object to such disclosures prior to use or disclosure of the information. In the event you become incapacitated or have a medical emergency, we will disclose your health information based on our professional judgment that the disclosure is directly relevant to that person's involvement in your healthcare.
- We may use and disclose medical information to contact you by telephone or by mail as a reminder that you have an appointment for treatment or to inform you of test results.

***--For Abuse Reports and Investigations*: We** may use and disclose information regarding suspected cases of abuse, neglect, or domestic violence, when the law so requires.

--To *Avoid Serious Threat to Health or Safety*: We may use and disclose protected health information when we believe it necessary to avoid a serious threat to the health or safety of a person or the general public.

--As *Required by Law:* We may use and disclose protected health information when required by federal or state law.

OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

Uses and disclosures not described in this Notice will be made only as allowed by law or with your written authorization. You may revoke your authorization to use or disclose protected health information at any time; the revocation must be in writing. The revocation will not affect uses or disclosures that have already been made.

PART 4 – HOW YOU MAY ASK FOR HELP OR COMPLAIN

You may request a copy of this Notice at any time. For More Information, please contact:

Privacy Officer, Ellison & Associates of Raleigh, P.C., 2301 Rexwoods Drive, Suite 102, Raleigh, NC 27607 (Ph) 919-787-1932 (Fax) 919-787-1938

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the address above. You may also complain to the Secretary of the U.S. Department of Health and Human Services, at the address below. You will not be retaliated against for filing a complaint.

Form 2A-2005

ELLISON & ASSOCIATES OF RALEIGH, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ HEREBY

ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE

ELLISON AND ASSOCIATES PRIVACY NOTICE.

SIGNATURE_____

DATE_____

Ellison & Associates of Raleigh, P.C.

Child/Adolescent/Young Adult (up to age 21) Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of the medical record

Name *(Last, First, Middle Initial):*	Gender: ☐ M ☐ F	Date of birth:

Presenting Problems

Please check if child/adolescent has/has had displays the following behaviors/symptoms:

☐ Yes ☐ No	Low mood for more than two weeks
☐ Yes ☐ No	Increased sleep
☐ Yes ☐ No	Lack of interest in previously enjoyed activities
☐ Yes ☐ No	Feelings of guilt/worthlessness
☐ Yes ☐ No	Low energy
☐ Yes ☐ No	Difficulty with concentration
☐ Yes ☐ No	Change in appetite/weight
☐ Yes ☐ No	Slower movement
☐ Yes ☐ No	Suicidal ideation
☐ Yes ☐ No	Grandiosity (feelings of superiority or excessive self-esteem)
☐ Yes ☐ No	Increased activity that's high risk
☐ Yes ☐ No	Decreased judgment
☐ Yes ☐ No	Distractibility
☐ Yes ☐ No	Irritability
☐ Yes ☐ No	Decreased sleep
☐ Yes ☐ No	Elevated mood
☐ Yes ☐ No	Speech speed increased
☐ Yes ☐ No	Thought speed increased/ racing thoughts
☐ Yes ☐ No	Auditory hallucinations
☐ Yes ☐ No	Visual hallucinations
☐ Yes ☐ No	Delusions
☐ Yes ☐ No	Feeling of people watching/talking about you
☐ Yes ☐ No	Feeling that the media is directing messages to you
☐ Yes ☐ No	Disorganized speech or behavior
☐ Yes ☐ No	Panic attacks (trembling, tremors, muscle tension, chest pain, difficulty breathing, fear of dying, etc.)
☐ Yes ☐ No	Excessive worry
☐ Yes ☐ No	Restlessness or feeling "edgy"
☐ Yes ☐ No	Easily fatigued
☐ Yes ☐ No	Obsessive thoughts
☐ Yes ☐ No	Repetitive/ritualistic behaviors
☐ Yes ☐ No	Re-experiencing traumatic event
☐ Yes ☐ No	Dreams/flashbacks of traumatic event
☐ Yes ☐ No	Avoidance behavior regarding traumatic event
☐ Yes ☐ No	Easily startled/hyper-vigilant
☐ Yes ☐ No	Fear of performance situations, social environments, or other fear
☐ Yes ☐ No	Avoidance of social environments
☐ Yes ☐ No	Excessive concern for body image or appearance
☐ Yes ☐ No	Binge-eating and/or purging behavior
☐ Yes ☐ No	Restriction of food with negative body image

Yes No	Fear of abandonment/rejection
Yes No	Unstable relationships
Yes No	Low self-esteem
Yes No	Intense anger/outbursts
Yes No	Self-damaging behavior
Yes No	Impulsivity
Yes No	Inappropriate mood for situation
Yes No	Forensic history including arrests and/or imprisonment
Yes No	Aggressive/violent behavior
Yes No	Lack of empathy or remorse
Yes No	Lack of concern for safety of self or others
Yes No	Failure to give close attention to details
Yes No	Makes several careless mistakes
Yes No	Difficulty with listening
Yes No	Inability to finish tasks
Yes No	Difficulty with organization
Yes No	Hyperactivity/restlessness
Yes No	Lack of patience
Yes No	Interrupts
Yes No	Short attention span
Yes No	Difficulty understanding social cues
Yes No	Lack of eye contact
Yes No	Learning difficulties
Yes No	Obsessions with objects, TV shows, etc.
Yes No	Stimulating behaviors such as preference for tight clothing, certain fabrics, self-touch, etc.

Mental Health History:

Past psychiatric treatment or therapy/counseling? Yes No

If yes, please provide the following information:

Name of Provider	Year & Month Began	Year & Month Ended

Past psychiatric hospitalizations? Yes No

If yes, please provide the following information:

Year	Reason	Hospital	Duration of Stay

Please list any psychotropic (used for mental health purposes) medications that child/adolescent PREVIOUSLY USED:

Name of Medication	Strength/Dosage	Frequency Taken	Side Effects/Reactions

Family Health History

Does this child/adolescent have any blood-related relatives been diagnosed with the following? :

Diagnosis	***Yes/No***	***Relation***
Bi-Polar Disorder	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes ☐ No	
Substance Abuse	☐ Yes ☐ No	
Developmental Disability/ Autism Spectrum Disorder	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Please describe child/adolescent's family:

Relation		***Age***	***Significant Health Problems:***
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling	☐ M ☐ F		
Sibling	☐ M ☐ F		
Sibling	☐ M ☐ F		
Sibling	☐ M ☐ F		
Sibling	☐ M ☐ F		

Medical History

*Practice name of primary care provider):*_____	*Last visit:* _____

Please list any chronic medical concerns:

_____

_____

_____

Please list any prescribed medications, over-the-counter medications, vitamins, and inhalers that child/adolescent CURRENTLY uses:

Name of Medication	Strength/Dosage	Frequency Taken

Please list any surgeries or medical hospitalizations:

Year	Reason	Hospital

Sex (for adolescents age 13+)

Is this adolescent sexually active?	☐ Yes ☐ No
If yes, please list contraceptive or barrier method used: _____	or ☐ None

For females only (if applicable, if not, please check N/A): ☐ N/A

Age of onset of menstruation: ____	Date of last menstruation: _____	Period every ____ days

Please list any allergies:

Name of allergen	Reaction

Exercise:

☐ Sedentary (no exercise)	☐ Mild exercise (i.e. climb stairs, walk three blocks, golf)
☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min)	☐ Regular vigorous exercise (i.e. work or recreation 4+x/week for 30+ minutes)

Diet:

Dieting? ☐ Yes ☐ No	If so, is it a physical prescribed diet? ☐ Yes ☐ No	Number of meals on an average day:____
Rank salt intake:	☐ Low ☐ Medium ☐ High	
Rank fat intake:	☐ Low ☐ Medium ☐ High	
Any concerns regarding appetite/eating habits?	☐ Yes ☐ No	

Sleep:

Does this child/adolescent have any problems falling asleep?	☐ Yes ☐ No
Does this child/adolescent sleep excessively?	☐ Yes ☐ No
Does this child/adolescent have any problems staying asleep?	☐ Yes ☐ No

Substance Use:

Does this child/adolescent have a history of using tobacco/alcohol/drugs?	☐ Yes ☐ No
If yes, what type of substance(s) has s/he use(d)? ☐ Alcohol ☐ Tobacco ☐ Benzodiazepines ☐ Marijuana ☐ Amphetamines ☐ Pain medication ☐ Cocaine/crack ☐ Sedatives ☐ Barbiturates ☐ Opiates ☐ Hallucinogens ☐ Methadone ☐ Inhalants ☐ Other: _____	
If yes, has there ever been any legal involvement regarding their substance use?	☐ Yes ☐ No
If yes, has this child/adolescent ever had substance abuse treatment?	☐ Yes ☐ No
If yes, what type of substance(s) does this child/adolescent use? _____	
If yes, what is the frequency of use? _____	

Developmental History

Pre-natal care?	☐ Yes ☐ No
Length of pregnancy:	_____ Months
Birth weight:	___ lbs. ___ oz.
Place (city) of delivery:	_____
Age of mother at delivery ____ Age of father at delivery ____	
Marital status of biological parents: ☐ Never married ☐ Married ☐ Separated ☐ Divorced	
Did mother use alcohol, cigarettes or drugs during pregnancy?	☐ Yes ☐ No
Did mother suffer from any accident, illness, or stresses during pregnancy?	☐ Yes ☐ No
Delivery:	☐ Vaginal ☐ C-Section
Duration of labor:	_____ hours
Post-partum complications:	☐ Yes ☐ No
Did child meet all developmental milestones?	☐ Yes ☐ No

Education

Name of School: _____	Grade: _____
Type of school: ☐ Public ☐ Private ☐ Charter ☐ Magnet ☐ Other: _____	
Does child/adolescent have behavioral problems at school?	☐ Yes ☐ No
If so, please describe? _____	
Does this child/adolescent have excessive absences from school?	☐ Yes ☐ No
If so, please explain? _____	
What grades does this child/adolescent average? ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's For numerical grading: ☐ 1's ☐ 2's ☐ 3's ☐ 4's	
Has this child/adolescent ever received any special education services (IEP, 504 plan, etc.)?	☐ Yes ☐ No
If yes, what are the accommodations? _____	
Does this child/adolescent take honors/AP/gifted courses?	☐ Yes ☐ No

Personal Safety

Is there any history of abuse/trauma? (physical, sexual, emotional, neglect, etc.)	☐ Yes ☐ No
Has there been any Child Protective Services (CPS) or Department of Social Services (DSS) involvement in this child/adolescent's family?	☐ Yes ☐ No
Has there been any interactions with the juvenile justice system?	☐ Yes ☐ No
Has the child/adolescent been destructive to property?	☐ Yes ☐ No
Does this child/adolescent have a history of starting fires?	☐ Yes ☐ No
Has this child/adolescent ever been placed out of the home?	☐ Yes ☐ No

What brings this child/adolescent in today:

_____

_____

_____

_____

_____

_____