NEW DIRECTIONS TREAMENT CENTER

REGISTRATION FORM

(Please Print)

Today's Date:	Account Number	PCP:

PATIENT INFORMATION

Patient's last name First Middle Maiden Prefer to be called					Marital Status Sing Mar Div Sep Wid Partner
Email Address Appointment Reminder OK	Birth date:	Age	Sex M F		Social Security Number
Street address:					Home Phone Message OK ( )
P.O. box:	City:	State:	ZIP Code:		Cell Phone Message OK ( )
Occupation:	Employer:				Work Phone Message OK ( )
Referred By	Address				Phone
Medications:					
Other family members seen here					

EMERGENCY INFORMATION

Spouse/Partner	Home Phone ( )	Cell Phone ( )	Work Phone ( )
Nearest Relative Other Than Spouse	Address	Home Phone ( ) Cell Phone ( ) Work Phone ( )	
Person to Contact in Emergency	Home Phone ( )	Cell Phone ( )	Work Phone ( )

CONSENT FOR TREATMENT

The above information is true to the best of my knowledge.

I voluntarily consent to outpatient psychiatric care encompassing diagnostic and medical and psychological treatment by my physician, therapist, or their assistants or designees, as may be necessary in their judgment.

I am aware that the practice of medicine and therapy is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

_____ _____ _____ _____

Patient/Guardian signature Date Witness Date

Patient is unable to consent because of Minor Other_____ Date_____

PAYMENT IN FULL IS DUE AT TIME OF SERVICE

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE

CHARGES WILL BE MADE FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE

PERSON RESPONSIBLE FOR THE BILL

Person responsible for bill:	Birth date: Social Security #:	Address (if different):	Home phone no.: ( )
Employer:	Employer address:		Employer phone no.: ( )

I agree to be financially responsible for all fees incurred by _____ for New Directions Treatment Center services regardless of whether or not these services are covered by insurance. I understand that insurance is a contract between the patient or policy holder and the insurance company, and that failure of the insurance company to approve or cover the services does not relieve me of responsibility for the fees.

Signature _____ Date_____ Witness _____ Date _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Employer if Group Coverage	Policy Number	Group Number
Policyholder Name(If different from Patient	Policyholder Social Security Number	Policyholder Date of Birth	Relationship to Patient

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Employer if Group Coverage	Policy Number	Group Number
Policyholder Name(If Other Than Patient)	Policyholder Social Security Number	Policyholder Date of Birth	Relationship to Patient

PREAUTHORIZATION FOR VISITS

DOES YOUR INSURANCE REQUIRE AN AUTHORIZATION FOR MENTAL HEALTH SERVICES?	YES	NO
DO YOU HAVE THE AUTHORIZATION FOR TODAY'S VISIT WITH YOU?	YES	NO

AUTHORIZATION TO BILL INSURANCE COMPANIES

PLEASE READ AND SIGN

I AUTHORIZE NEW DIRECTIONS TREATMENT CENTER TO RELEASE INFORMATION AS MAY BE NEEDED TO INSURANCE COMPANIES AND CLAIMS PROCESSORS FOR PROCESSING INSURANCE CLAIMS. I UNDERSTAND THAT ALL FEES ARE DUE AND PAYABLE BY ME AND SHOULD THE INSURANCE COMPANY DENY PAYMENT, THEN THE RESPONSIBILITY LIES SOLELY WITH ME TO PAY IN FULL. SHOULD COLLECTION PROCEEDINGS BE REQUIRED, I GIVE MY PERMISSION FOR INFORMATION TO BE RELEASED TO CREDIT BUREAUS, COLLECTION AGENCIES AND ATTORNEYS FOR THE PURPOSE OF FACILITATING COLLECTION. I FURTHER AGREE TO PAY ADDITIONAL COSTS INVOLVED IN THE COLLECTION PROCESS.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO NEW DIRECTIONS TREATMENT CENTER.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES OF THIS FORM. I HAVE READ AND UNDERSTOOD THEM.

_____ _____

Signed (Patient, or parent if under 18 years of age) Date

NEW DIRECTIONS

The Treatment Center For Anxiety and Depression

2990 Bethesda Place, Suite 602 A, Winston-Salem, NC 27103
(336) 768-8281 • FAX (336) 768-5685

NAME _____ DATE ____/____/_____ HEIGHT_____ WEIGHT_____

DATE OF BIRTH____/___/____ JOB _____ HOW LONG?_____YRS

PREVIOUS PSYCHIATRIC TREATMENT

DATE	CLINICIAN	REASON	LENGTH OF TREATMENT	HOSPITALIZED?

CURRENT SYMPTOMS

APPETITE

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ WEIGHT GAIN _____ LBS
- ☐ WEIGHT LOSS_____LBS
- ☐ BINGING
- ☐ VOMITING
- ☐ LAXATIVE ABUSE
- ☐ PREOCCUPAIED WITH WEIGHT OR BODY APPEARANCE

MOOD

- ☐ ELEVATED
- ☐ SAD OR DEPRESSED
- ☐ CHANGEABLE
- HOW OFTEN?_____
- ☐ BETTER IN AM
- ☐ BETTER IN PM
- ☐ BETTER IN SUMMER
- ☐ BETTER IN WINTER
- ☐ ANGRY/IRRITABLE/ EXPLOSIVE
- ☐ SUICIDAL PLANS
- ☐ WISHES FOR DEATH
- ☐ SUICIDAL THOUGHTS
- ☐ PAST SELF INJURY/ATTEMPT
- ☐ THOUGHTS OF DEATH

ACTIVITY

- ☐ EXCESSIVE
- ☐ CAUSES ME PROBLEMS
- ☐ EXCESSIVE MONEY SPENT
- ☐ EASILY DISTRACTED
- ☐ COMES AND GOES
- ☐ POOR CONCENTRATION
- ☐ SOMETIMES OUT OF CONTROL
- ☐ CAN NOT COMPLETE TASKS

SLEEP

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ I FEEL LITTLE NEED FOR SLEEP
- ☐ NEED MORE SLEEP
- ☐ DIFFICULTY FALLING ASLEEP
- ☐ LOUD SNORING
- ☐ DIFFICULTY STAYING ASLEEP
- ☐ DAYTIME SLEEPINESS
- ☐ LEG MOVEMENTS OR FEELINGS INTERFERE WITH SLEEP
- ☐ SLEEPINESS INTERFERES WITH DRIVING

ENERGY

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ VERY CHANGEABLE

ANXIETY

- ☐ ATTACKS OF PANIC OR FEAR
- ☐ SHORTNESS OF BREATH
- ☐ DIFFICULTY SWALLOWING
- ☐ NUMBNESS OR TINGLING
- ☐ RAPID HEART RATE
- ☐ DIZZINESS/BALANCE LOSS
- ☐ WORRY THAT A DISASTER WILL HAPPEN TO ME OR FAMILY
- ☐ TROUBLING OR UNWANTED THOUGHTS /URGES /ACTIONS
- ☐ REPETITIVE BEHAVIOR
- ☐ FEELING UNREAL
- ☐ WORRY OVER HEALTH
- ☐ FEAR OF LOSING CONTROL
- ☐ FEAR OF HEIGHT
- ☐ FEAR OF BEING CLOSED IN
- ☐ OTHER FEARS _____

IS THERE ANY VIOLENCE IN YOUR HOME? ☐ NO ☐ YES _____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS, ALCOHOL ABUSE, DRUG ABUSE, OR LEGAL PROBLEMS

MOTHER_____ FATHER_____

BROTHERS_____ SISTERS_____

GRANDPARENTS_____

AUNTS AND UNCLES_____

FIRST COUSINS_____

CHILDREN_____

GENERAL HEALTH

LAST PHYSICAL EXAM DATE_____ RESULTS_____

CURRENT MEDICAL PROBLEMS	DOCTOR	ANY MEDICINES PRESCRIBED

PREVIOUS MEDICAL HOSPITALIZATIONS

_____

DATE

ALLERGIES TO MEDICINES OR FOOD

☐ NONE _____

☐ ALLERGIC TO: _____

_____

ALCOHOL USED NUMBER OF DRINKS PER WEEK _____ USAGE OR PROBLEMS IN THE PAST?_____

ANY NON-PRESCRIPTION DRUG USE?_____ USAGE OR PROBLEMS IN THE PAST?_____

LEGAL PROBLEMS ☐ NO ☐ YES_____

HEART AND LUNGS

☐ CHEST PAIN
☐ IRREGULAR RHYTHM
☐ HEART ATTACKS
☐ TROUBLE BREATHING
☐ HARD TO LIE FLAT
☐ BLOOD CLOTS

BOWELS

☐ REGULAR ☐ IRREGULAR
☐ BLOOD IN STOOL
☐ CONSTIPATION ☐ DIARRHEA
MOVEMENTS EVERY _____ DAYS
☐ OTHER _____

HEARING AND VISION

☐ HEARING PROBLEMS OR CHANGES?
☐ CHANGES IN VISION?
☐ GLAUCOMA
☐ PAIN IN EYES OR EARS
☐ OTHER_____

GLANDULAR TROUBLE

☐ THYROID ☐ PARATHYROID
☐ PITUITARY ☐ ADRENAL
☐ THYMUS ☐ LYMPH
☐ OVARIES ☐ TESTES
☐ CHANGE IN SKIN OR HAIR TEXTURE
INTOLERANCE TO: ☐ HEAT ☐ COLD

SKIN

☐ ANY CHANGES?_____
☐ SWELLING IN HANDS, FEET, OR LEGS
☐ SKIN DISEASES OR PROBLEMS?_____
_____

NERVOUS SYSTEM

☐ SEVERE HEADACHES
HOW LONG?_____ HOW OFTEN?_____
☐ SEIZURES OR FITS ☐ FAINTING SPELLS
☐ NUMBNESS ☐ WEAKNESS
☐ UNCONSCIOUS AFTER HEAD INJURY
☐ OTHER_____

BONES AND JOINTS

☐ ARTHRITIS ☐ GOUT
☐ OSTEOPOROSIS
☐ OTHER _____

KIDNEYS AND BLADDER

☐ INFECTIONS ☐ STONES
☐ TROUBLE STARTING STREAM
☐ TROUBLE STOPPING STREAM
☐ WETTING AT NIGHT OR DURING DAY
☐ SEXUALLY TRANSMITTED DISEASE
☐ PROSTATE PROBLEM

WOMEN'S HEALTH

☐ POST PARTUM DEPRESSION
☐ IRREGULAR PERIODS
☐ MENSTRUAL PROBLEM:_____
☐ BREAST PROBLEMS_____
☐ BIRTH CONTROL PILLS
☐ LAST MENSTRUAL PERIOD _____
☐ TERMINATED PREGNANCY

FAMILY MEDICAL HISTORY

MOTHER'S AGE _____ HEALTH _____ _____ FATHER'S AGE _____ HEALTH_____

OTHER _____

PATIENT
SIGNATURE_____DATE____/____/_____

REVIEWED_____DATE____/____/____
REVIEWED_____ DATE____/____/____

New Directions Treatment Center 602-A Bethesda Court Winston-Salem, NC 27104 Phone 336-768-8281 Fax 336 768-5685

Name: _____
Date: _____

Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems? (Please circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in someway	0	1	2	3

(For office coding: _____ + _____ + _____ + _____)
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, care of things at home, or get along with other people?

Not at all difficult _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? (Please circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score: T_____ = _____ + _____ + _____)

New Directions Treatment Center
2990 Bethesda Place, Suite 602B; Winston Salem, NC 27103

Phone: 336-768-8281 Fax: 336-768-5685

Office Visits:

- **Scheduling** – Appointments may be scheduled by contacting the office at 336-768-8281. At this time, we are not able to make reminder calls prior to appointments.
- **Missed or late canceled appointments** – Appointments cancelled without 24-hours notice are subject to $50/$75 fee. If this becomes chronic, it may increase to the rate of the scheduled visit. This fee is ***NOT*** covered by insurance and will need to be paid prior to your next appointment. Messages may be left on the general message line to cancel, when necessary, after hours.
- **Copay or Full Payment is due at time of service.** Cash, Check, Debit and Credit Cards (Visa, MasterCard and Discover) are accepted.

Prescription Refills:

- When prescribed medication, an initial prescription and refills will be provided to last until the suggested follow-up visit. It is the patient's responsibility to schedule a follow-up appointment before the prescription runs out to ensure a continuous supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To give good clinical care, patients must be seen on a regular basis.
- It may take up to 24-48 business hours to review your medical history and decide if the requested refill is appropriate.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescriptions will not be provided on weekends. **Under no circumstances will benzodiazepines (e.g. Xanax, Klonopin, Valium, Ativan, etc.) be written after hours or on weekends.**
- Prescription refills resulting from missed or canceled appointments will be subject to a $15.00 charge.

Controlled Substances:

- Prescriptions for stimulants (e.g. Adderall, Concerta and Vyvanse) are required by DEA guidelines to be re-written every three months and can ***NOT*** be replaced if lost.
- As always, Class II drugs (which include stimulants) cannot be called in to a pharmacy under any circumstances and will be e-prescribed (sent via computer) during scheduled appointments ***ONLY***.
- We use the NC Controlled Substance Reporting System to check patient history of controlled substance use.
- Due to the fact that stimulants must be e-prescribed (sent via computer), this will only be done during appointment. Any changes such as pharmacy changes for vacations and/or other requests will warrant a fee of $10.00 (if not due to medication shortages).

Prior Authorizations:

- Because of the increase in prior authorization requests, we have implemented a $15.00 charge to complete the paperwork. In some instances, the paperwork and/or phone calls to the insurance companies can take up to one hour to complete.

Services Subject to Charge:

- Telephone consultation, request for records, and prescription refills not provided during an appointment.
- Completion of form letters and/or reports if not done during an appointment.

Emergency/After Office Hours:

- Should you experience a life-threatening medical emergency, please call 911 or go to the nearest hospital emergency department.
- An on-call physician is available after office hours for emergencies ***ONLY***.
- Routine prescriptions will be ***NOT*** authorized by the on-call physician.

I have read and understand the information listed above and have been offered a copy.

_____ _____

Signature Date

New Directions Treatment Center's Policies and Practices to Protect to the Privacy of Patient Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information (PHI), for treatment, payment, and health care operations* purpose with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health records that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  -Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another mental health provider.
  -Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke any authorization of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If you give use information which leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
- **Adult and Domestic Abuse**: if information you give us gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- **Health Oversight**: Any state licensing board (e.g., North Carolina Medical Board) has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without

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NEW DIRECTIONS

Treatment Center for Anxiety and Depression
2990 Bethesda Place, Suite 602-B Winston Salem, NC 27103
(336)768-8281 Fax (336)768-5685

JAMES D. MATTOX, MD
Diplomate American Board of Psychiatry and Neurology

CHRISTINE CHILDS, MD
Board Eligible Psychiatrist

CRISTIE W. FAIRCLOTH, PA-C, RDN, LDN
Physician Assistant
Registered Dietitian/Licensed Nutritionist

A. RICHARD COOK, PhD
Licensed Psychologist

TEVEN HARMON-TOWNSEND, LCSW
Licensed Clinical Social Worker

MARY LADD HEBERT, LCSW
Licensed Clinical Social Worker

NANCY LONG, LCSW
Licensed Clinical Social Worker

DIXIE SANSPREE, LCSW
Licensed Clinical Social Worker

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received the Notice of Privacy Practices statement of **New Directions – Treatment Center for Anxiety and Depression.**

Signature: _____

Date: _____

Hard copy available upon request.