PORT HEALTH

PATIENT REGISTRATION

Date: _____ Reason for your visit? _____

Name: _____ _____ _____ _____
(Last) (First) (Middle) (Maiden)

Alias (Name you would like to be called): _____ Social Security #: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female County of Legal Residence: _____

Address: _____ _____ _____ _____
(Mailing Address) (City) (State) (Zip)

_____ _____ _____ _____
(Physical Address, if different) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Allergies: _____ Reactions: _____

Sexual Orientation:	Marital Status:	Race:	Ethnic Origin:
☐ Bisexual ☐ Heterosexual ☐ Gay ☐ Declined	☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partners ☐ Single (Never Married) ☐ Annulled	☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian ☐ American Indian ☐ Asian (non-Pacific Islander) ☐ Pacific Islander ☐ Other ☐ Declined	☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Not Hispanic Origin ☐ Other Hispanic
Military Status:	**Housing:**	**Living Arrangement:**	**Employment Status:**
☐ Active ☐ Veteran ☐ No	☐ Assisted Living ☐ Supervised Living ☐ With Family ☐ Independent/Own Dwelling ☐ Other	☐ Private Residence ☐ Nursing Home ☐ Group Home ☐ Adult Care Home ☐ Institution ☐ Correctional Facility ☐ Homeless ☐ Other	☐ Unemployed ☐ Employed F/T ☐ Employed P/T ☐ Student ☐ Military ☐ Disabled ☐ Retired ☐ Homemaker ☐ Seasonal/Migrant

Highest level of education completed: _____ Primary Language: _____

Referral Source:

☐ Adult Court/Corrections	☐ MCO	☐ Psych Service-hospital
☐ Community Agency	☐ Mobile Crisis	☐ Schools
☐ DSS	☐ Other Healthcare	☐ Self/No referral
☐ Family/Friends	☐ PORT program	☐ State Facility
☐ Juvenile Court	☐ Primary Care Physician	☐ TASC

Emergency Contact: _____ _____
(Name) (Address)

_____ _____
(Relationship) (Telephone #)

Number Living in Household (including self): _____ Annual Income: $_____

Number of Arrest(s) in the last 30 days: _____

Frequency of Attendance of Self Help Programs (examples NA, AA, Etc) in the last 30 days?

☐ No Attendance
☐ 1-3 times in the past month
☐ 4-7 times in the past month
☐ 8-15 times in the past month
☐ 16-30 times in the past month
☐ Some attendance
☐ Unknown

For patients under 18 years old ONLY

Mother's name: _____ Father's Name: _____

School: _____ Legal Guardian Telephone #: _____

Custody: ☐ Mother ☐ Father ☐ Both Parents

☐ Other: _____ (Name) _____ (Relationship)

If the minor is under a legal custody or guardianship court order, please present the appropriate legal documentation

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PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your health provider. We are committed to providing you with quality and affordable health care. We ask all patients to review this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2. Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. Registration: All patients must complete our patient registration form, which will be entered into our electronic health record to maintain accurate information for proper billing. We must obtain a copy of your valid photo ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
4. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.
5. Uninsured patients: We offer a reduced fee to our patients who do not have insurance. This fee is assessed using your monthly income and number of persons within your home. Please be advised that this fee is due at each visit.
6. Credit and collection: If your account is more than 90 days past due, you will receive a letter stating that you have 30 days to make a payment on your account. Payment arrangements can be made by calling (252) 830-7551. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency.

Thank you for adhering to the financial agreement. Please let us know if you have any questions or concerns.

☐ **I have read and understand the financial policy and agree to abide by its guidelines.**

PORT HEALTH

CONSENT FOR TREATMENT

PORT Health Services provides services to patients who have mental health and substance use issues/problems. The staff are trained to provide appropriate services in partnership with patients, as needed, to meet each individual's expressed problems and desired outcomes. I agree to treatment and services as offered by PORT Health for:

☐ Myself ☐ My Child ☐ The person for whom I am legal guardian/custodian

Unless I have been court ordered to attend this service, I understand that my participation is voluntary and I may withdraw from services at any time. If I do not withdraw this consent, it shall be valid for one year.

I have elected PORT Health Services as my Provider for services that may include, but are not limited to: mental health and/or substance use outpatient therapy, medication management, medication assisted therapy, group therapy, facility-based crisis, opioid treatment, residential treatment, day treatment, drug treatment court, school based therapy, and work first.

PORT Health Services staff have provided me with relevant, objective information about other providers that offer the above selected service(s). I understand that I may elect to change providers or professionals involved in my treatment at any time.

Patient Rights and Responsibilities: I have been encouraged to read the Patient Rights Handbook (handbook) and Notice of Privacy Practices (NOPP) and I understand that it is my right and responsibility to ask questions if I need clarification or have concerns. I have the right to make a complaint or grievance as outlined in the handbook. I understand that a copy of the handbook and/or NOPP will be available to me upon request and relative information is prominently displayed in the clinic's waiting area.

Emergency Care: I authorize PORT Health to seek emergency medical or dental care in the event that I (the patient) become ill or have an accident while participating in treatment/services. This shall include emergency first aid rendered by PORT personnel. In the event that emergency care beyond first aid is required, PORT will call 911 for evaluation and transportation to the nearest hospital, and will notify my emergency contact person listed below to meet me in the hospital. PORT may further authorize emergency medical treatment if my emergency contact person cannot be reached. I will hold harmless PORT Health and it personnel against any liability caused by the use of this emergency procedure. I agree to this emergency care process. I will assume full responsibility of all incurred emergency treatment expense.

Emergency Medical Information:

Patient's Doctor: _____ Phone #: _____

Care Provider (if applicable): _____ Phone #: _____

Medications: _____

_____

Confidentiality and Disclosure of Information: In accordance with state and federal laws, information maintained about you at this agency will be protected from unauthorized disclosure. No information will be sent to your employer, family members, friends, or anyone else, unless it is discussed with you ahead of time and your permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you, such as: 1. In the interest of public safety (life threatening situation); 2. In response to a court order and 3. Where state laws require that information be disclosed to the appropriate authorities (e.g., suspected abuse or neglect of children or disabled adults, communicable disease, etc.). I understand that PORT Health Services is an agency provided of the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Their policies require that I receive appropriate treatment and continuity of care. In order to provide quality care, information may be shared between treating agencies and Substance Abuse Services. The DMH/DD/SAS require

reporting of non-identifying client information. This information is stored in computerized record systems for statistical, program planning, research evaluation and funding purposes. Patient records relating to substance abuse are protected by more stringent federal confidentiality rules. Rules regarding disclosure of substance abuse information must be strictly followed. Consent forms must specify in writing what substance abuse information is being released. A general authorization for release of medical or other information is NOT sufficient for this purpose.

Photography: I consent to be photographed for identification purposes as part of my treatment and to protect my identity and prevent fraud. My image will become part of my medical record and be stored in PORT's secure electronic health record system and will not be published.

Participation in Off-Site Activities, including Transportation: During the course of treatment, patients may participate in outings. During these times, I agree to release PORT Health from all liability and responsibility for myself/my children/my ward. This consent also includes consent to allow PORT Health to transport me/my child/my ward to these off-site activities. This consent is valid until the patient's separation from the program or until it is revoked in writing by the patient/parent/guardian.

Urine Drug Screens: During the course of my treatment, I agree to regular and random supervised urine drug screens by licensed/certified medical personnel provided by a contracted provider or a PORT Health Services staff member.

Telepsychiatry/Telemedicine: I agree to telepsychiatry/telemedicine treatment and understand the following:

1. I am aware of all parties that will be present at each end. This includes knowledge of their names, credentials, and the location of the medical practitioner.
2. I have been informed about how the technologies/equipment works.
3. I have been informed that I have the right to exclude anyone from either site with the exception of emergencies.
4. I have been informed of the role of the psychiatrist/Licensed Practitioner and staff who are going to be responsible for ongoing care.
5. I have been informed that I have the right to have appropriately trained staff immediately available to attend emergencies or other needs.
6. Contingency plan for transmission failure have been explained to me.
7. I have been informed that I have the right to refuse these services and I am aware of the alternatives and potential risks.

Orientation Checklist: As a patient at PORT, I will be oriented to the services provided by the agency. The following list includes information that is important for participation in treatment:

- Explanation of your rights and responsibilities as a patient (See Patient Rights Handbook) and the grievance and appeal procedure (See Agency Grievance and Appeal Policy)
- Information on how you can provide input about the quality of care you receive, the achievements you make while in treatment and your level of satisfaction with the care you receive (For example: yellow satisfaction survey).
- Code of Ethics and Confidentiality
- If applicable, requirements for follow-up for court mandated treatment
- Explanation of the services and activities, expectations and hours of operation specific to the program in which you are receiving services
- Explanation of financial obligations, fees and financial arrangements
- Tour of the facility including emergency exits, first aid kits and fire extinguishers, designated smoking areas and smoking policy
- Use of emergency interventions
- Explanation regarding prohibited items including weapons, drugs and paraphernalia
- Explanation about treatment including the purpose and process of assessment, transition/discharge/aftercare services, therapeutic interventions, court appearances which impact treatment, development of your individual plan, access the after-hours crisis services, and the person responsible for coordinating your care

- Program Rules: (if applicable, see group specific documentation)
- Group Rules: (if applicable, see group specific documentation)
- Potential for loss of rights and privileges and ways to regain rights and privileges
- Education regarding advance directives, if applicable.

Advance Directives: Information on Advance Directives has been made available to me and has been explained to me in a way that I can understand. I understand that it is my right and responsibility to ask questions if I need clarification or have concerns.

Communications Consent: PORT uses an automated appointment reminder system to contact patients prior to their scheduled appointment. The automated message will state the name of our organization (PORT Health Services), the patient name, and the date and time of the appointment. I consent to receive reminder calls and texts from PORT Health for upcoming appointments at any of the phone numbers indicated above.

☐ **I consent to the above services, treatment, and conditions. If I do not consent to one of the above mentioned statements, I will cross out the corresponding section. I acknowledge that I may ask for a copy of this consent form.**

COORDINATION OF CARE

In order for PORT Health Services to serve you with the highest quality of care, we would like to share information to and from other medical providers. With my attached consent, I give permission for my health information to be released to:

☐ Primary Care Physician/Practice: _____

☐ Other health care providers: _____

☐ I do not have a Primary Care Physician and was provided with a list of local primary care providers.

☐ I do not want my health information to be released. *An inability for medical providers to freely share information may result in limitations of treatment options for PORT patients.

_____ _____
Patient's Signature Date

_____ _____
Legally Responsible Person's Signature (If required) Date

_____ _____
Signature of Witness Date