Positive Perceptions, PLLC
10400 Mallard Creek Rd Suite 210
Charlotte, NC 28262

704-999-7946 Phone
980-237-7592 Fax
www.positiveperceptionspllc.com

Patient: _____ Age: _____ Sex: M F

Address: _____

_____ e-mail _____

Phone: (_____)_____ Cell: (_____) _____Date of Birth: ____/_____/_____

SS#: _____-____-_____ Emergency Contact & #: _____

Responsible Person: (Note: If this information is same as patient, write "same as above")
Name: _____ Relationship: _____

Address: _____

_____

Phone: (_____)_____

Insurance Information:
Insurance Company: _____ Phone: _____

Patient's ID # _____ Group #: _____

Subscriber's Name & Address: _____

_____

Subscriber's SS#: _____ Subscriber's DOB: _____

Subscriber's Employer's Name: _____

Subscriber's Relationship to Patient: _____

Secondary Insurance? _____

Consent for Treatment:
I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my provider and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

_____ _____
Patient/Legal Representative Signature Date

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Office Policies

Confidentiality

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, neither your name, nor any identifying information about you is revealed.

Phone & Urgent Contact

If you need to contact us by phone, do not hesitate to call the office number. If we are not available, you can leave a message on our voicemail and we will usually return the call that day. In the event of an emergency, please dial 911. You will be charged for phone calls if we have a conversation of an information-exchanging or problem-solving nature that lasts more than 5 minutes. If you cannot reach me in an emergency, you can find help at the following suicide prevention/crisis numbers: (800) 824-6423

Cancellation of Appointment

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a "No Show" or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges.

By initialing here, you acknowledge that you have received a copy of the "Notice of Privacy Practices" and the "Patients' Rights and Responsibilities." _____

_____ _____
Patient/Legal Representative Signature Date

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Fee Agreement

Fees & Insurance: Fees are approximately $130 for follow-up medication evaluation & individual therapy and are subject to change without notice. Sessions are 20-50 minutes in length. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, longer sessions, etc. will be billed at the same rate. Returned checks are subject to a $35 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed.

Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverag. You are responsible for any applicable deductibles and copays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that **you are responsible for full payment if the insurance company denies the claim.**

If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

Cancellation policy: The scheduling of an appointment involves the reservation of time specifically for you. Our office makes every attempt to notify you of your scheduled appointment prior to leaving our office, and/or within 48 hours via phone, email and text. Please be aware that insurance companies will not cover cancellation charges. Patients are required to provide a credit card number which will be charged the full session fee in the event of a "no show" or failure to give a full 24-hour notice of cancellation.

In the event of a "No Show" or failure to give a full 24-hour notice of a cancellation, you will be charged the full session fee for all late cancellations and missed appointments. If you are a Medicaid participant, on the first "No Show" or failure to give a full 24-hour notice, you will not be charged a fee, however you will be discharged from the practice.

Credit Card Authorization:

I, _____, am authorizing Positive Perceptions, PLLC to charge the full session fee to the credit card indicated below in the event that I (or the patient, if services are being paid for by parent or other adult) fail to give 24 hours notice of cancellation of a scheduled appointment. I further authorize Positive Perceptions PLLC to charge my credit card for any unpaid balances for services rendered that remain on the account.

Card Type (circle one): Visa Mastercard

Card Number: _____ _____ _____ _____ Exp. Date _____

CVV code (3-digit code on back of card) _____

Name as printed on card _____ Billing zip code _____

Authorized cardholder signature _____ Date _____

I have read the above fee agreement and discharge notification document carefully, and I understand it and agree to all of its terms and conditions.

_____ _____

Patient or Guardian Signature Date

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Symptom Inventory & Treatment History

Patient Name _____

Person completing form (if different from patient) _____

Patient's Occupation _____ Education Level _____

Ethnicity _____ Religion _____ Practicing? Yes No

Reason for visit: _____

_____

Please rate the severity of the following symptoms over the last month according to the following rating scale:

0-No difficulty
1-Mild
2-Moderate
3-Severe

_____ Decreased appetite
_____ Increased appetite/eating more
_____ Bingeing and/or purging
_____ Weight change? +/- _____ lbs.
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up
Avg. # hours sleep _____
_____ Decreased sexual desire
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Crying
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Decreased attention span
_____ Inattentive/Distractible
_____ Memory problems: Long-term; short-term
_____ Self-injurious behavior
_____ Thoughts of suicide
_____ Thoughts of harming others
_____ Impulsivity
_____ Hyperactivity
_____ Nightmares
_____ Hypervigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heart beat
_____ Trouble breathing
_____ Sweating
_____ Phobia
_____ Police/Probation involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent behavior towards others
_____ Destruction of property
_____ Harming animals
_____ Fire setting
_____ Opposition
_____ Anger outbursts
_____ Irritability
_____ Flashbacks of traumatic event
_____ Worry/Fear
_____ Anxiety/Nervousness

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Patient's Name _____

How many alcoholic beverages do you consume per week? _____

List street drugs used in last 10 years (type/frequency/amount): _____
_____

List any legal concerns (i.e. pending custody case, charges for larceny): _____
_____

Family history of mental health or substance abuse problems? _____
_____
_____

Previous psychological or psychiatric treatment? (List dates & provider names): _____
_____

_____

Any psychiatric hospitalizations? _____
_____

Medical history: _____
_____

_____

Current medications & dosages: _____
_____

Name of prescribing physician: _____

Current stressors: _____

_____

Goals for treatment: _____

_____

_____

Any other information you would like your provider to know? _____

_____