MindPath Care Centers

PATIENT INFORMATION

(Please Print Using Black or Blue Ink)

PATIENT			
Last Name:	**First Name:**		**MI:**
Address:	**City:**	**State:**	**Zip:**
Phone (Required):	**Preferred Phone (Select One): C ☐ W ☐ O ☐**		
Home/Cell:	**Work:**	**Other:**	
Email:			
SS#:	**DOB:**		
Sex:	**Gender Identity:**	**Marital Status: Single ☐ / Married ☐ / Other ☐**	

SELF-IDENTIFICATION (OPTIONAL)		
Race:		
☐ American or Alaskan Indian	☐ Asian	☐ African American or Black
☐ Hawaiian or Pacific Islander	☐ White	☐ Other
Ethnicity:		
☐ Hispanic or Latino	☐ Not Hispanic or Latino	
How did you find out about MindPath Care Centers at Carolina Partners in Mental Healthcare, PLLC:		

PATIENT EMPLOYER INFORMATION:	☐ **Employed**	☐ **Student**	☐ **Other**
Company:	Employer Phone#:		
Address:	City:	State:	Zip:

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF NOT PATIENT)			
Last Name:	**First Name:**	**MI:**	
Address:	**City:**	**State:**	**Zip:**
Phone (Required):	**Type (Select One): C ☐ W ☐ O ☐**		
Email:			
SS#:	**DOB:**	**Relationship to Patient:**	
Sex:	**Gender Identity:**	**Marital Status: Single ☐ / Married ☐ / Other ☐**	
Company:	Employer Phone#:		
Address:	City:	State:	Zip:

PATIENT'S PRIMARY CARE DOCTOR		
Doctor:	Practice Name:	
Address:		Phone:

EMERGENCY CONTACT	
Name:	**Phone:**

I hereby authorize payment directly to the physician of the surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

PATIENT OR RESPONSIBLE PARTY SIGNATURE	
SIGN:	**DATE:**

MindPath Care Centers

PATIENT INFORMATION

(Please Print Using Black or Blue Ink)

PLEASE READ CAREFULLY AND COMPLETE			
I have read the Policy and Procedures and understand and accept the policies described above. I agree to pay my insurance co-payment or deductible / co-insurance, and balance due prior to each session.			
PRIMARY INSURANCE INFORMATION			
Insurance Company:			
Ins ID No. of Patient:	**Suffix #:**	**Group Name or No.:**	
Address:	City:	State:	Zip:
Ins Phone:	Ins Fax:		
Policy Dates: From:	To:	Employer Plan: ☐ **Y** ☐ **N**	
Policy Holder (Subscriber) Name:			
Relationship To Patient:			
Address:	**City:**	**State:**	**Zip:**
Policy Holder Phone:	**Date of Birth:**	**SS#:**	
SECONDARY INSURANCE INFORMATION			
Insurance Company:			
Ins ID No. of Patient:	**Suffix #:**	**Group Name or No.:**	
Address:	City:	State:	Zip:
Ins Phone:	Ins Fax:		
Policy Dates From:	To:	Employer Plan: ☐ **Y** ☐ **N**	
Policy Holder (Subscriber) Name:			
Relationship To Patient:			
Address:	**City:**	**State:**	**Zip:**
Policy Holder Phone:	**Date of Birth:**	**SS#:**	

INSURANCE AUTHORIZATION FORM

PLEASE READ CAREFULLY AND COMPLETE

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM.

INSURANCE AUTHORIZATION

☐	I authorize use of this form on all my insurance submissions.
☐	I authorize release of information to all my insurance carriers.
☐	I understand that I am responsible for any co-pay, coinsurance, unmet deductible amounts and/or any fees not covered by insurance at the time of my scheduled appointment.
☐	I authorize MindPath Care Centers to act as my agent in helping me obtain payment for my insurance carriers.
☐	I authorize payment directly to my provider, and herby assign my right to reimbursement for services rendered to MindPath Care Centers.
☐	I permit a copy of this authorization to be used in place of the original.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

PATIENT OR RESPONSIBLE PARTY PRINTED NAME:

SIGNATURE:	**DATE:**

AUTHORIZATION TO RELEASE INFORMATION:

Valid for 1 year

I,_____, hereby authorize MindPath Care Centers to release the following information:

☐ **BILLING**

☐ **SCHEDULE APPOINTMENTS**

☐ **PERSONAL HEALTH INFORMATION AS WRITTEN IN MY MEDICAL RECORDS**

To the following person(s):

Name:	**Relationship to Patient:**
Name:	**Relationship to Patient:**
Name:	**Relationship to Patient:**
Name:	**Relationship to Patient:**

PATIENT OR RESPONSIBLE PARTY SIGNATURE

PATIENT OR RESPONSIBLE PARTY PRINTED NAME:

SIGNATURE:	**DATE:**

FINANCIAL ACCEPTANCE FORM

PLEASE READ CAREFULLY AND COMPLETE

We make payment as easy and convenient as possible. You may pay by cash, check, credit or debit card. For outstanding balances, you may pay on our website: www.mindpathcare.com.

You may pay past due balances by setting up an End of the Month Pay Plan that would be processed on the 30th day of each month. Please keep in mind, if the 30th day falls on a weekend or holiday, the monthly payment will be processed on the next following business day. If you would like to continue with an End of the Month Pay Plan, please provide us with a credit or debit card.

☐ Credit / ☐ Debit:	Card No.:	Exp Date:
Name (As Printed on Card):		
☐ Credit / ☐ Debit:	Card No.:	Exp Date:
Name (As Printed on Card):		

I authorize MindPath Care Centers to charge any past due balances on my account to the above credit or debit card number on a monthly basis.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

PATIENT OR RESPONSIBLE PARTY PRINTED NAME:

SIGNATURE:	**DATE:**

MINDPATH CARE CENTRERS AT CAROLINA PARTNERS IN MENTAL HEALTHCARE, PLLC CLINICAL RESEARCH INSTITUTE

You may be contacted by MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC a MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC clinician, or an agent of the practice with information about clinical trials that might be of benefit to you or someone for whom you are authorized to make medical decisions. Whether or not you choose to participate in a particular study as a study subject will be voluntary and subject to the circumstances of each trial.

Would you occasionally like to be notified to undergo the screening process for the opportunity to participate in a clinical trial?	☐ Yes	☐ No
May we Email you about – and during – a research study?	☐ Yes	☐ No
May we Text you about – and during – a research study?	☐ Yes	☐ No

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRICACY PRACTICES"

PLEASE READ CAREFULLY AND COMPLETE

THIS **ACKNOWLEDGMENT** THAT WE HAVE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR "NOTICE OF PRIVACY PRACTICES" IS REQUIRED BY FEDERAL LAW. THANK YOU FOR YOUR COOPERATION.

I,	_____, acknowledge that I have received from MindPath Care Center that "Notice of Privacy Practices" and have had adequate opportunity to read and review the document. **(Patient or Responsible Party Name Printed)**

MEDICAL RECORDS CONSENT	
I,	_____, understand that if I am referred to another provider outside of MindPath Care Centers, notes about substance abuse may be shared with the provider to whom I am referred. **(Patient or Responsible Party Name Printed)**

CONSENT TO TREATMENT	
I,	_____, agree to receive treatment from MindPath Care Center. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal. **(Patient or Responsible Party Name Printed)**

PATIENT OR RESPONSIBLE PARTY SIGNATURE	
PATIENT OR RESPONSIBLE PARTY PRINTED NAME:	
SIGNATURE:	**DATE:**

PATIENT FEES

Please Be Aware that when you make an appointment that time is especially made for you. We really look forward to seeing you at your scheduled appointment. However, our goal is that all patients are seen in a timely manner; therefore, the following will be followed:

PRIMARY INSURANCE INFORMATION	
Cancellation (**with** – 24 Hour Notice)	No Charge
Cancellation (**without** – 24 Hour Notice)	$60.00
No Call / No Show	$60.00

***** PATTERNS OF CANCELLATIONS WILL BE DISCUSSED WITH YOUR PROVIDER*****

PLEASE NOTE: FEES ARE SUBJECT TO CHANGE FOR SPECIALITY SERVICES

NOTICE

You will not be rescheduled for another appointment beyond these parameters without permission from your provider.

Insurance does not pay for Cancelled or No-Show appointments. The above fees will be an Out of Pocket expense for you as an induvial.

If you have any questions or concerns about this, please discuss them with your provider.

ACKNOWLEDGEMENT
PATIENT OR RESPONSIBLE PARTY SIGNATURE

I HAVE READ AND UNDERSTAND THIS POLICY. I AGREE TO PAY ACCORDING TO THE ABOVE GUIDELINES.

PATIENT OR RESPONSIBLE PARTY PRINTED NAME:

SIGNATURE:	**DATE:**