SEVENHILL ASSOCIATES, P.A.

2019

5318 NC Hwy 55, Suite 206
Durham, NC 27713
Phone: 919-544-4300
Fax: 919-544-7676

1365 Westgate Center Drive, Suite L-1
Winston-Salem, NC 27103
Phone: 336-659-7878

PATIENT DEMOGRAPHIC FORM

(Form updated yearly or with any information changes)

Patient Name: _____ Social Security Number: _____-____-_____

Date of Birth: ___/___/_____ Gender_____ Marital Status: □Single □Married □Divorced □Widow(er)

Address: _____
(Street) (City) (State) (Zip Code)

Home phone: _____ Cell phone: _____ Appointment reminder preference: □Call **or** □Text

Email Address: _____ Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: _____ Cell Phone: _____

Referred By: _____ Primary Care Physician: _____

Previous Psychiatric Treatment: _____

Medications: _____

Allergies: _____ Pharmacy In Use: _____ Phone: _____

Insurance: _____ID: _____Group: _____

Claim PO Box: _____Copay: $_____

(Please read and sign)

You will be charged $50.00 for a cancellation with LESS THAN 24 HOURS notice. You will be charged $75.00 for a "NO SHOW". Co-payments MUST be made at time of appointment.

Assignment of INSURANCE TO PHYSICIANS: I authorize direct payment of medical benefits to the provider. The benefits referred to herein would be payable to me if I did not make assignment and include Major Medical Insurance. I understand that I am personally responsible to the physician for charges not covered or paid by this assignment and for informing SEVENHILL ASSOCIATES, P.A. immediately of changes in my insurance coverage, address, or other pertinent information. SEVENHILL ASSOCIATES, P.A. is authorized to release any medical information required in the administering of applications for financial coverage for services rendered. Treatment is authorized as prescribed by SEVENHILL ASSOCIATES, P.A.

I have carefully completed this form and to the best of my knowledge, it does not contain any false, incomplete, or misleading information.

Signature:_____ **Date:**_____

SEVENHILL ASSOCIATES, P.A 2019

Consent to Treat and Acknowledgement of Receipt of Privacy Notice

I, _____, give consent to receive treatment from the providers at Sevenhill Associates, P.A. I understand that the healthcare provider and staff may share my medical information for treatment, billing, and healthcare business purposes. I acknowledge that I have been offered information that describes how my medical information is used and shared. I understand the organization has the right to change the Privacy Notice at any time. I may obtain a current copy of the Notice by contacting the office at Sevenhill Associates, P.A.

My signature below constitutes acknowledgement that I have given consent to treatment and been offered/received, if desired, a copy of the Privacy Practice:

_____ ____/____/____
Signature of Patient or Legal Representative Today's Date

_____ ____/____/____
Print Full Name Date of Birth

If signed by a legal representative, relationship to the patient:_____

Please complete the following if unable to secure a written acknowledgement of receipt of notice

I was unable to secure a written acknowledgement of Receipt of Privacy Notice because:

( ) Patient has a guardian and no legal representative available to sign
( ) Patient is physically unable to sign acknowledgement because:

_____

( ) Other reason: _____

_____ _____/_____/_____
Signature of Provider/Employee **Date**

Sevenhill Associates, P.A. **2019**

PATIENT INFORMATION RELEASE FORM

PATIENT:_____ **DATE OF BIRTH:** ____/_____/_____

I hereby authorize the release of information in my medical records **TO**:

SEVENHILL ASSOCIATES, P.A.

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FROM (name of provider's office): _____

ADDRESS & PHONE NUMBER (if known):_____

Specific request include (check all that apply):

( ) results of ALL laboratory tests- thyroid profile, CBS, serum chemistries

( ) results of EKG'S, MRIs

( ) admission history & physical and/or discharge summary

( ) all other tests and/or office notes pertaining to both medical and psychiatric care

The doctrine of informed consent, contents to be released, and the need for the information have been explained to me. I hereby acknowledge that this consent is truly voluntary and that there are regulations protecting the confidentiality of the authorized information. I further understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. I also authorize the above mentioned persons to discuss my treatment as needed.

_____
(Signature of patient or legally appointed representative)

_____
(WITNESS)

_____/_____/_____((DATE)

Sevenhill Associates, P.A.

2019

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to assist in the maintenance of my mental health treatment.

I, _____ consent to **Sevenhill Associates, P.A.** sharing information related to my mental health with the following person(s):

Name	**Relationship to patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ I do **not** consent to have my information shared with any parties at this time.

I understand that I may request to make changes to the above list as I wish.

_____ _____

Signature *Date*