CAROLINA NEUROSERVICES
THE HEAD INJURY CENTER
SINCE 1991

PATIENT INFORMATION

Date: _____ ☐NEW PATIENT ☐UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

Patient Date of Birth: _____ Age: ____ SSN# _____

Address: _____
ADDRESS LINE 1

_____
CITY, STATE, ZIP

HOME: _____

Referral? ☐Yes ☐ No

CELL: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
ADDRESS LINE 1

WORK: _____ X

_____ DIRECT: _____

E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____ TEL: _____

_____ TOLL-FREE: _____

_____ FAX: _____
CITY ST ZIP CODE

I certify the above information is correct to the best of my knowledge. I hereby guarantee payment in full of any amounts due for services rendered and authorize the assignment of benefits and/or release of information to my insurance companies or representatives.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize CAROLINA NEUROSERVICES-THE HEAD INJURY CENTER OF CHARLOTTE to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Other persons allowed to receive my healthcare information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of psychotherapy notes, which is protected under North Carolina law not to be released unless otherwise authorized by the patient

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

CONSENT FOR TREATMENT

I hereby consent to the rendering of medical care, which may include individual psychotherapy, neuropsychological testing and such treatment as my physician considers necessary. I understand that it is the policy of Carolina Neuroservices that no procedures are performed upon me unless I have the opportunity to discuss the procedure with my physician.
I have the right to consent or refuse any proposed treatment.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for Carolina Neuroservices detailing how my protected health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Signature: _____ Date: _____

CAROLINA NEUROSERVICES
THE HEAD INJURY CENTER

P. Jeffrey Ewert, Ph. D, A.B.P.P.
Diplomate in Clinical Neuropsychology
American Board of Professional Psychology

CANCELLATION POLICY

If you need to cancel an appointment, you must call our office at least 24 hours prior to the appointment. Cancelling your appointment with a reasonable notice allows us to offer this time to someone else who may need to be seen right away. Offenders of this policy are subject to a fee or dismissal from the practice. The no-show or non timely cancellation fee is $90.00. This fee is non negotiable. We appreciate your help and consideration.

X_____ Date: _____
(Signature of patient or responsible party)

ASSIGNMENT OF BENEFITS

I hereby assign to Carolina Neuroservices-The Head Injury Center, any insurance or other third party available for health care services provided to me. I understand Carolina Neuroservices has the right to refuse or accept assignment of such benefits. If the benefits that are assigned are NOT paid directly to Carolina Neuroservices, I agree to forward all heath insurance and other third party payment that I receive for services rendered to me immediately upon to receipt to Carolina Neuroservices. I agree that any services not covered by my insurance company is my financial responsibility.

X_____ Date: _____
(Signature of patient or responsible party)

CAROLINA NEUROSERVICES
THE HEAD INJURY CENTER

R. Jeffrey Ewert, Ph.D., A.B.P.P.
Diplomate in Clinical Neuropsychology
American Board of Professional Psychology

NOTICE OF PRIVACY PRACTICES

(Please detach and keep this form for your own records.)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other healthcare professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment, or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided and the condition being treated.

Health Care Operation: Your health information may be used as necessary to support the day-to-day activities and management of Carolina Neuroservices – The Head Injury Center. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may interest you.

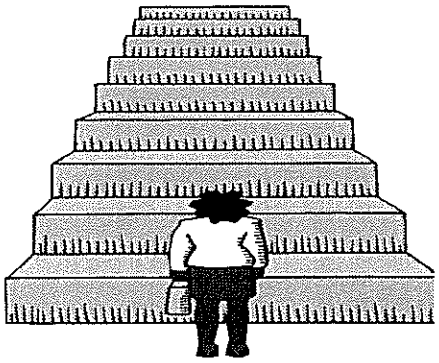
CAROLINA NEUROSERVICES
THE HEAD INJURY CENTER
6853 FAIRVIEW RD. STE B, CHARLOTTE, NC, 28210 (704)366-9930 (F) 704-366-9931

P. Jeffrey Ewert, Ph. D, A.B.P.P.
Diplomate in Clinical Neuropsychology
American Board of Professional Psychology

APPT DATE: _____ TIME: _____

There are 2 sides to your insurance. Medical and Mental/Behavioral Health. Please contact the mental health side of your insurance prior to your first visit with Dr. Ewert. Simply ask if there is an authorization needed for a consultation/office visit. Any other services that may be offered will be the responsibility of our facility to obtain those benefits and/or authorizations. If an authorization is required, your insurance company will give you an authorization number. Please bring this number with you to your appointment. This number will be needed to file this visit properly.

MEDICARE WILL PAY FOR THIS VISIT. YOU WILL NOT NEED TO CALL MEDICARE FOR AUTHORIZATION, HOWEVER, SOME SECONDARY POLICIES MAY REQUIRE AUTHORIZATION.



PLEASE LET US KNOW IF YOU WILL NEED ASSISTANCE WITH THE STAIRS TO OUR SECOND FLOOR OFFICE. ELEVATORS NOT AVAILABLE.

ONE HOUR HAS BEEN SET ASIDE FOR YOUR APPOINTMENT. WE ASK THAT YOU CONTACT US WITHIN 24 HOURS NOTICE IN THE EVENT YOU NEED TO CANCEL. PLEASE NOTE, IF YOU HAVE REPEATED CANCELLATIONS OR NO SHOW APPOINTMENTS, FUTURE APPOINTMENTS WILL NOT BE RESCHEDULED.