Senior Health and Education Partners, PLLC
5306 NC Highway 55, Ste 105 Durham, NC 27713
Phone: 919-457-1517 Fax: 919-363-7697

Scan this QR code to submit this form online.

PATIENT DEMOGRAPHICS: ☐ **Please Attach photocopy of patient's identification card (if available)**

First Name: ________________Middle______________ Last _______________ Preferred Name:__________________

DOB____/_____/_______ Social Security # _________________________ Gender: ☐ Male ☐ Female

Phone number (please mark preferred): ☐ HOME (________) ___________ ☐ Cell Phone:(______)___________________

Patient Email Address: ____

FACILTY PARTNER NAME (NOTE: if at **SKILLED NURSING FACILITY**, you **MUST** include **referral/order)**

Facility Partner Name:____ ☐ **SNF Referral/Order Included**

Facility Address (including room number): ____

INSURANCE INFORMATION: ☐ **Please attach photocopy of insurance card(s)**

Medicare #:_____________________________________ Medicaid #: ____________________________________

Other/Supplemental: ____

FORM OF PAYMENT: Card will be kept on file but not be charged until time of service for co-pays (if required) and after insurance has been billed for any deductibles required for collection by patient's insurance.

Name on Card:__________________________________ Card Number: ________________________________

Expiration (Month/Year):___________________________ CVV:____

RESPONSIBLE PARTY: Is patient capable of making own healthcare decision: ☐ Yes ☐ No

Check One: ☐ Healthcare POA ☐ Legal Guardian ☐ No current POA or Legal Guardian

Emergency Contact/Healthcare POA/Legal Guardian: ☐ **legal documents attached**

Healthcare POA/Legal Guardian Name:__________________________________ Phone (______)__________________

Address:____

City:___________________________________ State:_______________ Zip Code: ______________________________

Relationship to Patient:_____________________ Email Address:_______________________________________

☐ Please check here if you consent to receive email updates regarding patient

Name and contact information of any other individuals allowed to obtain details in patient care information

Name:____ Phone (______) ___________________________________

Address:____

City:___________________________________ State:_______________ Zip Code: ______________________________

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PATIENT FULL NAME: _________________________________PATIENT DATE OF BIRTH: _____/______/_________

Consent for Service & Medications, Authorization of Payment, and Record Release

1. I request for services provided by Carol Gibbs, MD and/or clinicians supervised by Carol Gibbs, MD and employed by Senior Health and Education (SHAE) Partners, PLLC
2. I request that payment authorized insurance (including Medicare) benefits be made on my behalf to SHAE Partners, PLLC for services including but not limited to:
    a. Behavioral Health Services
    b. Integration of behavioral health integration care management services
    c. Tele-health visits and all communication-based technology services—additional details at shaepartners.com/telepsychiatry
3. Medication Consent: I and/or my legal guardian consent to the following regarding medication(s) and/or therapies to be prescribed for their intended treatment process. Some of the major side-effects can be reviewed at shaepartners.com/medication
    a. I understand that there are risks, side effects, benefits, and possible drug-drug interactions of possible prescribed medication(s), as well as those of all medications currently prescribed by this office for this patient.
    b. I understand, where applicable, there are increased risks in pregnancy, in the elderly, and other pertinent risk factors, such as FDA black box warnings.
    c. Alternatives to medications, such as therapy and non-medication strategies, are understood to be prescribed for their intended use as part of the treatment process.
4. I authorize the release of my medical records to SHAE Partners, PLLC upon its request for dates of treatment going back 2 years from the date below, including all discharge summaries, progress notes, consult notes, laboratory testing, and imaging studies.
5. I authorize SHAE Partners, PLLC to release to my insurance company and/or to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to/for related services, including but not exclusive of a clinical diagnosis, treatment plans and summaries and/or copies of the entire record.
6. I acknowledge that I am financially responsible for all charges for services provided to me, including but not limited to any portions of my medical care that my insurance company assigns to me for in-person and non-face-to-face services provided. My responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise. Once insurance is filed, I authorize the use of my credit or debit card for payment of these balances owed. I understand that my credit card will be securely saved on file for future transactions on my account until expiration of provided card.
7. I understand my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record.
8. I authorize SHAE Partners, PLLC to seek emergency medical care on my behalf if deemed necessary.
9. I have received SHAE Partners, PLLC Notice of Privacy Practices and Client Rights and Grievance Policies. A copy is available on our website at shaepartners.com/npp
10. I acknowledge that I have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in G.S. 122-C-57(d); 10A NCAC 27D. 0303 (c). This consent for treatment may be withdrawn at any time.
11. I have received and read the complete HIPPA Form on the SHAE Partners, PLLC website at shaepartners.com/hippa

Printed Name of Patient/HCPOA: ____________________________ Signature of Patient/ HCPOA ____________________________

Specify relationship to patient __________________________ Date ___________________

VERBAL CONSENT: Please specify why written consent of patient cannot be obtained (i.e. blind, etc.):______________________

****WITNESS REQUIREMENT: MUST HAVE DOCUMENTATION OF 2 WITNESSES for VERBAL CONSENT****

Verbal Consent obtained by____________________________ Date:______________ Time:______ Phone Number:__________

Printed Name of 1st Witness:___________________________ Printed Name of 2nd Witness:________________________________

1st Witness Signature _________________________________ 2nd Witness Signature______________________________________

PATIENT FULL NAME: ______________________

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Patient History Questionnaire

Caregiver/Family Member Concerns Regarding Symptoms, Issues, Questions:

____

____

PLEASE LIST PAST PSYCHIATRIC DIAGNOSES and YEAR of DIAGNOSIS (if known):

____

____

MEDICATION LIST : ☐**please attach copy of full medication list and/or MAR (medication administration record)**

Psychiatric Medication Trials & Dosage	Response/Reaction	Why Stopped	Date started/stopped if known

PREVIOUS OUTPATIENT PSYCHIATRIST: ____

INPATIENT PSYCHIATRIC HISTORY:

____

____

ALLERGIES: ____

PREFERRED HOSPITAL: ____

PREFERRED PHARMACY: Name:__________________________________ Phone:_____________________________

PRIMARY CARE PROVIDER: ____

SURGICAL HISTORY: ____

FAMILY HISTORY: MOTHER: ☐ Living ☐ Deceased, age: ________Psychiatric/Medical History:______________________

FATHER: ☐ Living ☐ Deceased, if so, age: _______ Psychiatric/Medical History:_________________________________

BROTHER(S) OR SISTERS: ☐ Living #_____ ☐ Deceased, if so, age: _______Psych/Medical History:____________________

CHILDREN: ☐Living #_______ ☐Deceased, if so, age: ________ Psych/Medical History:____________________________

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____

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_______/_______/______________

Patient History Questionnaire (Continued)

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Level of Education ☐ Grade: _________ ☐ High School/ GED ☐ College ☐ Post-Graduate Degree: ________________

Occupation: ____________________________

Place of Birth: _____________________________________

Tobacco Use ☐ Current, #/day _______# Years used:___________ ☐ Former Smoker, Quit Date _____________ ☐ Never

Alcohol Use ☐ Personal History of Alcoholism ☐ Current: Drinks/day____________ ☐ Never

Drug Use: ☐ Personal History of Drug/Illict Substance Abuse, Type:___________Quit Date:________________________

☐ Current user, Substance of use: ______________, amount/frequncy used:_________ ☐ Denies illicit drug use/misuse

HISTORY OF MEMORY ISSUES/DEMENTIA:

Does patient have memory issues or diagnosis of dementia? ☐ Yes ☐ No When did issues start? ______________________

Please describe **LEVEL OF FUNCTIONING** of patient **PRIOR TO** memory issues (i.e. ability to work, social engagement, manage household, finances, organization skills, prepare and manage food, etc)

____

____

Please describe **PERSONALITY** of patient **PRIOR TO** memory changes:

____

____

Please describe **BEHAVIORAL** concerns or habits **PRIOR TO** memory changes: (i.e. social abilities, relationships, aggressive/passive actions)

____

____