WILMINGTON
MENTAL HEALTH

Main Office Address
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Wilmington, NC 28411

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info@wmhwc.com

Outpatient Care and Procedures: Psychotherapy, Psychiatry, Substance Use Disorders, Laboratory Tests, and Primary Care

WELCOME TO WMH

To our valued Patients,

Thank you for allowing us the privilege of participating in your care. WMH practices behavioral medicine to prevent, diagnose, and treat psychosomatic disorders, as well as common psychiatric and medical conditions.

Please take a moment to familiarize yourself with our policies and procedures. Our goal is to simplify our processes and to help you develop a positive relationship with your provider. Before you start, we ask that you complete all forms in this packet and read the instructions given below:

- Carefully read the next page, *Consent and Service Agreement.* When you are ready, *please initial, sign, and* confirm that you fully understand and accept the terms and conditions of your treatment.
- The HIPAA Privacy Rule requires that we distribute a *notice* that provides a clear explanation of your rights with respect to your personal health information and the privacy practices of health plans and health care providers. Please sign *page 3* to acknowledge receipt of the notice.
- Fill out the *Patient Registration* form to the best of your abilities. If you are the parent/legal guardian or authorized representative of the person seeking treatment, you must provide information as it pertains to your child.
- We will ask you to provide identification documents (i.e., Driver License or Passport) for accuracy and to ensure that we are providing information to the correct person. A copy of the document will be stored in your records.
- Print your name and initials, and sign and date each document.

Treatment often follows this order: *Exploration → Process → Maintenance and → Termination*. Following registration, you may be asked to complete a thorough assessment with your therapist, psychiatrist or primary care provider. This intake assessment is used to analyze and interprete your presenting problem, identify a diagnosis, formulate a case and offer treatment recommendations. During your second or third appointment, your provider may help you identify goals and develop a treatment plan that best suits you. The plan may be used to guide your treatment and evaluate your progress.

If you are seeking mental health assistance today, we would like to share with you that many people come to us experiencing anxiety and hesitation about treatment. In fact, being here today may be a big step for you and your anxiety may be an indicator of your fear and hesitation. Our mission is to offer you privacy, safety, and support. Our providers are trained to facilitate conversations while making you feel comfortable and calm. We will be happy to answer any questions or discuss any concerns you might have regarding your treatment at any point.

We agree to offer recommendations when appropriate and coordinate with other professionals who may be able to offer additional services. We also agree to check our voicemail regularly and return your calls or messages as soon as possible. Should you experience a mental health, psychiatry, or medical crisis, we ask that you please contact 9-1-1 or go to your local hospital emergency room.

Treatment is a goal-directed and systematic process that progresses as you and your provider build a therapeutic alliance. In our continuous effort to offer person-centered treatment, we look forward to your thoughts, questions, and feedback on how we can better tailor your treatment and address your needs.

"Perseverence is a quality and virtue we all possess but struggle to make it relevant when fighting our fears and demons"
Joseph Rengifo

CONSENT AND SERVICE AGREEMENT

It is important to understand the services you will receive and the terms and conditions of these services. Please review this form carefully and feel free to ask any question or share any concerns you might have.

You have the right:

- To become educated about the nature of any symptom, condition, illness, or disorder affecting you.
- To be treated with dignity, respect, and human care without mental, emotional, sexual, or physical abuse, neglect.
- To be free from discrimination based on race, religion, gender, or any other unlawful category before, or during treatment.
- To be free from exploitation for the benefit or advantage of your mental health, psychiatry, or medical provider.
- To have any therapy procedure or method explained to you before it is used.
- To be informed of the cost of your treatment before receiving services.
- To receive culturally sensitive treatment.
- To refuse any test, evaluation, or therapy of any kind, although if ordered by court, you may face legal consequences.
- To refuse to be photographed, audio-taped or video-taped, unless you give consent to these requests.
- To privacy and confidentiality as defined by state and federal law.
  - All information you disclose during the session is strictly confidential and private and will not be revealed to anyone outside without your (or an authorized representative's) written permission or consent.
  - Exceptions to this rule include disclosures required or permitted by law, typically involving substantial risk of physical harm to oneself or to others, suspicion of child abuse or neglect, or when a subpoena by a government agency is issued to compel testimony or produce evidence.
- To expect treatment from a provider who has met the minimal qualifications of training and experience required and to examine public records about his or her credentials.
- To receive information on potential risks and possible benefits of mental health, substance user disorder, psychiatry or primary care treatment.
  - Your counselor cannot promise specific results from your therapy treatment, but commitment to your treatment and compliance with treatment recommendation can increase the chance of experiencing positive results during therapy.
  - Benefits of Therapy: Significant reduction of adverse or negative symptoms, improved interpersonal satisfaction, greater personal awareness, and insight, as well as enhanced coping and resolution skills, among others.
  - Risks of Therapy: During therapy, you may also be asked difficult questions and recall unpleasant memories, which can bring discomfort to you. Some individuals have even reported feeling worse after receiving therapy. It is important that you talk to your counselor if you experience any symptoms or adverse reaction during your treatment.
- To timely obtain and be able to have access to information pertaining to you, including your clinical records.
- To refuse follow up calls after your treatment ends or your involvement with our facility is discontinued.
  - Wilmington Mental Health may conduct follow-up calls three to six months after your discharge to discuss whether the gains made during your treatment have been maintained. Staff might also call you for feedback regarding your experience. If you prefer not to be contacted, simply tell your provider and your decision will be respected.
- To obtain a copy of the Ethical Code of the Mental Health, Psychiatry or Medical Profession from
  - The Board of Licensed Professional Counselors: PO Box 77819, Greensboro, NC 27417, or
  - The North Carolina Social Work Certification and Licensure Board: P.O. Box 1043 Asheboro, NC 27204.
  - The North Carolina Medical Board: P.O. Box 20007, Raleigh, NC 27619.
- The right to an investigation of a complaint.
- To report complaints, call the North Carolina Board of Licensed Professional Counselors at 844-622-3572 or 336-217-6007, the North Carolina Social Work Certification and Licensure Board at 336-625-1679, or the North Carolina Medical Board at 919-326-1109 or 800-253-9653 ext. 501.

Safety Agreement: I agree to keep myself safe if I experience suicidal feelings and impulses. This is a promise I make to both myself and my provider that I will discuss any suicidal feelings during treatment so that we can work together to maintain physical and emotional safety. I have been advised that with patterns of self-harm, my care may be better provided by a facility that specializes in conditions of self-harm. Ways to stay safe until suicidal feelings go away include calling the Suicide Hotline at 9-8-8 or 9-1-1; taking your medication as prescribed; going to your local ER or Mental Health Hospital; and calling the Mobil Crisis Line at 844-709-4097.

My initials below certify that I have read, understand, and accept this Consent and Service Agreement. I agree to abide by the rules and regulations of treatment included in this Consent and Service Agreement. This form must be signed by you, the patient, rather than another person unless you lack physical or mental capacity to make decisions or sign.

Initials	X Name of Patient or Representative	X Signature of Patient or Representative	Date

NOTICE OF PRIVACY PRACTICE OF WILMINGTON MENTAL HEALTH

The notice you received describes your rights regarding the protection of your health information and how you may exercise those rights. The notice also gives you the names of contacts should you have questions or comments about the policies and procedures Wilmington Mental Health uses to protect the privacy of your health information. Please review the document carefully and ask for clarification if you do not understand any portion of it.

Wilmington Mental Health must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of Wilmington Mental Health to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

Acknowledgment

- I have received a copy of Wilmington Mental Health's *Notice of Privacy Practices*.
- I understand that my health information will be used to conduct, plan, and direct my treatment; follow-up with other healthcare providers directly involved in my treatment; obtain payment from third-party payers; and/or conduct healthcare operations such as quality assessments and authorizations.
- I understand that the *Notice* is subject to change and that the most recent version can be found at www.wilmingtonmentalhealth.com or in the office waiting room.
- I understand that I can obtain a copy of the new Notice by contacting 910-777-5575 or by writing a letter to the Privacy Officer at:

  Wilmington Mental Health, PLLC
  Attn: Joseph Rengifo
  3825 Market Street, Ste 4
  Wilmington, NC 28403

E-mail and Texting

We do not recommend sharing confidential health information about you or any of your family members via email or text. If you initiate electronic communication with your therapist, you are consenting to receive a response in a similar manner. If you wish to communicate with us electronically, please consider the following:

- Emails are not a substitute for personal treatment or other mental health care.
- Emails and text messages are not part of your clinical records unless relevant treatment information is shared.
- Emails and text messages can be both accessed and intercepted by others, putting your privacy at risk.
- Confidentiality cannot be guaranteed as protected health information shared electronically can be stored and exposed.
- WMH staff will attempt to reply to all messages in a timely manner but cannot guarantee an immediate response.
- It is your responsibility to follow-up with the message recipient and confirm your appointment, if applicable.
- A written consent is needed for all email communications with third parties.
- You can request to stop communicating electronically with your provider at any time.

Social Media

To protect the development of a patient-provider relationship built in the confinement of our clinic, "dual relationships" with your provider will be avoided. Your provider will not be able to "friend" you via social media (e.g., Facebook, Twitter, Instagram, etc.) to prevent compromising your privacy and blurring the boundaries of the patient-clinician relationship.

Telehealth – Distance health-related services are offered using a HIPAA compliant, two-way, real-time interactive audio and video software when face-to-face interaction is not possible. It is important to know that:

- Online treatment provides convenient access to care, continuity of care, and reduction of travel cost.
- Your provider may have trouble conducting clinical observations of relevant issues during online interactions.
- Complex issues related to equipment malfunction may be difficult to resolve during the session time.
- You always retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any benefits to which you would otherwise be entitled.
- All existing confidentiality protections are equally applicable during a telehealth session.
- Your access to information transmitted during distance treatment is guaranteed.
- Dissemination to researchers or other entities of any identifiable images or information you share online shall not occur.

X _____ ***X*** _____ ____/____/_____

Name of Patient or Representative | Signature of Patient or Representative | Date

Note: *Patient* received a copy of the Notice of Privacy Practices. *Wilmington Mental Health retains this signed page.*

FOR OFFICE USE ONLY

☐ Individual refused to sign; ☐ Communications barriers prohibited obtaining acknowledgement; ☐ Other (specify) _____

PATIENT INFORMATION

Today's Date: _____/_____/_____. Please take a moment to fill in the following information. Leave blank any question you would rather not answer. If anything changes during your treatment, please let us know.

Type of Service: ☐Screening ☐Individual ☐Couple/Family ☐Group ☐Evaluation ☐Substance Abuse ☐EAP

PERSONAL INFORMATION:

DOB: _____/_____/_____ ▪ SSN: _____ - _____ - _____ ▪ Gender: ☐F ☐M ☐Unknown ▪ Pronouns: _____

Patient Name (First, Middle, Last): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ - _____ - _____ ▪ Email: _____

RESPONSIBLE PARTY INFORMATION:

Relationship to patient: ☐Parents ☐Guardians ☐Foster Parent ☐Other (specify): _____

Patient Name (First, Middle, Last): _____

Contact Number: _____ - _____ - _____ ▪ Email: _____

EMERGENCY CONTACT: Person in a position to help you prevent harm to yourself or another person

Patient Name (First, Middle, Last): _____

Contact Number: _____ - _____ - _____ ▪ Relationship: _____

MARITAL STATUS:

☐Single ☐Engaged
☐Cohabiting ☐Civil Union
☐Married ☐Separated
☐Divorced ☐Widowed

RACE/ETHNICITY:

☐American Indian ☐Asian
☐Black ☐Pacific Islander
☐White ☐Hispanic or Latino
☐Mixed ☐Other

EDUCATION:

Highest grade completed:
☐< High School ☐High School/GED ☐Diploma
☐Some college ☐College

EMPLOYMENT:

☐Unemployed ☐Per Diem or Seasonal ☐Full-Time ☐Part-Time ☐Part-Time Student
☐Full-Time Student

INSURANCE INFORMATION:

Primary Insurance ❑ No Insurance/Self-Pay ❑ Insurance Card Available For Copy

Insurance Company: _____ Policy Number: _____

Name of Policyholder: _____ DOB: _____/_____/_____ ▪ Relationship: _____

Secondary Insurance ❑ N/A ❑ Insurance Card Available For Copy

Insurance Company: _____ Policy Number: _____

Name of Policyholder: _____ DOB: _____/_____/_____ ▪ Relationship: _____

MENTAL HEALTH - PRESENTING PROBLEM OR HISTORY: Reason(s) you are seeking treatment today.

_____

COPING STRATEGIES: What have you tried to make things better so far?

_____

SELF-CARE ACTIVITIES THAT YOU PRACTICE: ☐Physical ☐Emotional ☐Spiritual ☐Mental ☐Practical ☐Social ☐Safety

WHAT IS MOST IMPORTANT TO YOU? ☐Family ☐Friends ☐Health ☐Work ☐Education ☐Community ☐Fun ☐Religion

REFERRAL SOURCE:

☐Internet ☐Patient ☐Family ☐Friend ☐Physician ☐Attorney ☐Insurance ☐EAP ☐Social Media ☐TV/Radio

TREATMENT HISTORY

1. When? _____ ☐Outpatient ☐Inpatient ▪ Reason:_____
2. When? _____ ☐Outpatient ☐Inpatient ▪ Reason:_____
3. When? _____ ☐Outpatient ☐Inpatient ▪ Reason:_____

Are you, or another family member, currently seeing another therapist/counselor/psychologist? ☐No ☐Yes

PREFERENCES: ☐AM appointment ☐PM appointment ☐Night appointment ☐Female therapist ☐Biofeedback ☐Group therapy ☐Faith-based therapy ☐Trauma therapy ☐Other (specify): _____

FINANCIAL POLICY

This Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Please complete this form in its entirety. All patients 18-year-old and older are required to provide a picture ID (school ID, military ID, etc.) for verification and to prevent insurance fraud. Please keep us informed of any changes related to your credit card, insurance, or worker's compensation information to prevent being in default under this agreement.

Payment

- Payment is expected at the time of service.
- Patients are responsible for the payment of all services rendered by Wilmington Mental Health providers and affiliates.
- Any deductible, co-insurance and co-pay balances are the patient's financial responsibility.
- We may charge an extra $5 for copayments not paid at the time of service.
- We reserve the right to reschedule, cancel, and/or terminate services due to payment noncompliance.
- Any "promise to pay" not satisfied by third-party vendor is ultimately the patient responsibility. Patients are responsible for collecting any reimbursement directly from the vendor.
- We ask patients not to discuss account balance or financial information with their provider or medical staff.

Standard Self-Pay Fees	Rate		Rate
Initial Intake Assessment	$250	Follow-up treatment - Psychiatric	$125
Initial Psychiatric Evaluation	$300	Follow-up Treatment – Medical	$100
Initial Medical Evaluation	$150	Lost Prescription / Prescription Refill	$25
Psychotherapy Session 50-53 min (approx..)	$150	Medical Record Requests (per page)	$75¢
Family/Couples Therapy	$150	No-Show/Late Cancellation	$100
Group Therapy	$50	Drug Screens (instant drug test)	$15
Crisis Intervention (In Person/Virtual)	$200	Telephone consultations over 15 min	$100

Rates and fees will be discussed before treatment starts. Rates may differ depending on the therapy format.

Network Participation

- Patients are responsible for understanding their insurance plan and benefits.
- If we participate with an insurance plan, we will verify the network benefits and submit claims after each service is rendered; the insurance carrier will pay us accordingly. The amount the insurance will allow and pay for is determined by the insurance company and the policy the patient has chosen. Payment, however, is the patient's responsibility regardless of insurance coverage.
- Patients are expected to pay any balances on their account if a claim is returned as not paid.
- Prior authorizations must be obtained by the patient directly from the insurance company prior to starting treatment.
- Patients who do not carry insurance or provide updated insurance information will be treated as self-pay patients.

Telehealth Services

- Telehealth billing information is collected in the same manner as regular office visits, and visit fees are the same for face-to-face visits and telehealth visits at Wilmington Mental Health.
- If technology fails for a videoconferencing session, the visit will be moved to a phone appointment, and the patient will still be responsible for the full visit fee.

Non-covered Services

- Almost all health plans will cover ordered lab services.
- Patients are financially responsible for any clinical laboratory testing services not covered by their healthcare benefits.

Out of Network Reimbursement Policy

- WMH providers are out-of-network with some medical insurance companies.
- Patients are responsible for submitting their own claims to the insurance company. Reimbursement is not guaranteed.
- Insurance companies do not always reimburse for virtual appointments (even if a patient has out-of-network benefits).
- Any request to provide an itemized receipt can take us up to a week to complete.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Any existing balance will be collected immediately after termination.
- WMH will charge the credit/debit card on file for services not paid by the insurance company within 90 days from the day the service was rendered, including copays, deductibles and/or coinsurance.
- Payment arrangement may be offered if the patient is able to demonstrate financial hardship.
- Any current/future appointments may be cancelled until full payment is received.

Cancellation And Missed Appointments
• We may send an automated appointment reminders via text 24-hours before any scheduled appointment
• Patients are responsible for tracking their appointment and keeping their scheduled appointment.
• Appointments may be scheduled, rescheduled, or cancelled by phone, email, or text.
• Except for emergency situations, patients are required to give 24-hour notice to cancel or reschedule an appointment.
• WMH does not close due to weather unless it is a State of Emergency. Dire emergencies (i.e., hospitalization, accident, death in the family) are addressed on an individual basis.
• Arrival to an appointment either in person or virtual should be made in a timely manner. Your appointment may need to be rescheduled if you arrive more than 15 minutes late to an intake appointment or follow up appointment.
• Insurance companies do not reimburse for missed appointments; patients are responsible for the full cancellation fee.
• Up to 2 missed appointments will be charged at $100.00 each ($50 for group therapy). After 3 missed appointments, we will bill the full amount for the service. Providers reserve the right to terminate treatment after three consecutive absences.
• We may ask for a credit card to hold the appointment, otherwise services may be withheld, denied, or limited, depending on our discretion and the patient's immediate needs.
• We may ask for a $100 deposit up front when a credit card is not available. The amount will be refunded after termination, provided it has not been used to cover any late cancellation or no show.
• A discharge letter will be sent in the mail after three consecutive cancellations or no show over what is recommended.
• Any conflict of interest may result in the patient being automatically discharged from our clinic.

Workers Compensation Policy
• We bill the employer or the workers' compensation carrier for services rendered in worker's compensation cases.
• We will accept payments by the workers' compensation carrier as per contracted rates in worker's compensation cases.
• If payment is denied from the workers' compensation carrier, we may attempt to submit the claim to a private insurance company, provided that we have this information on file.

Laboratory & Genetic Tests
• If laboratory tests are prescribed for you, you are entitled to copies of the results.
• Blood work or urine tests will be sent out to our partner medical laboratory for processing.
• Patients are responsible for the cost of lab work if the insurance company does not cover it.
• We offer genetic tests that analyze genetic variations in your DNA to inform your prescriber how you may respond to certain medications. The self-pay rate when insurance companies deny coverage should be no more than $330.

Divorce or Custody Case Policy
• The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in a divorce decree or who has custody or insurance.
• We ask that current and updated information is provided on the child or person who will be receiving services.
• We ask that any changes made to the insurance plan is communicated to us in advance.

Credit Card Authorization
Name on Card: _____

Address: _____

Credit Card #: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CCV (3–4-digit code): _____ Billing Zip Code: _____

We accept: 

• I consent to electronic signature with credit card swiped.
• There is a fee of $35.00 for returned checks.
• Refunds cannot be processed once service has been provided.

Medical Record Requests
• Requests for documentation are granted on a case-by-case basis at the sole discretion of the provider.
• Our providers generally do not release patient evaluations, progress notes or therapy notes. A summary of care will be provided to patients and/or third parties when medical records are requested.
• Typically, several sessions and consistent engagement in treatment is required for a provider to feel comfortable providing documentation of any kind.
• Professional fees for the review and preparation of a narrative summary of the patient's medical record for each medical request shall be charged at a rate of seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page from pages 26 through 100, and twenty-five cents (25¢)for each page in excess of 100 pages, provided that we may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs.
• Documentation requests may include, but are not limited to clinical summaries of diagnostic impressions or treatment plans, comprehensive clinical evaluations or intake assessments, pre-bariatric surgery psychological evaluations, alcohol or drug mental health assessments, emotional assistance animal letters, letters to verify work absences, documentation to

show attendance of mental health/psychiatric/medical appointments, disability paperwork, and summaries of clinical recommendations or impressions requested by outside medical professionals.
• For FMLA, short term disability, emotional support animals, court documents etc., it is the patient's responsibility to discuss the issue in advance with the provider. Certain requirements may need to be met before the provider is able to fill out the forms.

Medication Refills
• We do not provide any automatic refills.
• All prescriptions are given at the time of service and are written for enough medications until the next appointment.
• Patients are responsible for scheduling follow up appointments in a timely manner such as they do not run out of medications.
• Patients who run out of medication after cancelling an appointment or who lose their prescription must pay a fee to get a new prescription sent to the pharmacy.
• For all refill requests outside of appointments, patients are required to have an upcoming appointment scheduled.
• Prescription refills are called Monday through Friday, during regular business hours.
• Covering providers do not refill controlled substances.
• A partial refill until the upcoming appointment may be considered at the discretion of the provider, subject to a $25 charge.

Good Faith Estimate
• You have the right to receive a good faith estimate explaining how much your health care will cost.
• Under the law, we must give patients who do not have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.
• As an out-of-network provider with some insurance companies, we may be permitted to bill for the difference between what the insurance plan agrees to pay, and the full amount charged for a service.

Refunds
• Any refund or credit issued to a credit card could take between 3-5 days to be credited back on the account.
• In some cases, we may send a check by mail when processing account credits or refunds that fall outside of the timeframe allowed by our credit card processor to complete these transactions.

Discharge/Termination
• Prescriptions, scheduling, or assistance during crisis cannot be performed during termination.
• At a minimum, on-going patients are seen every three months. Patients who have not been seen for 6 months or more will be considered inactive.
• Termination may occur for the following reasons: (1) Voluntary transition to another provider; (2) violation of our terms and policies; (3) treatment recommendations from the provider; (4) a higher level of care not offered by us is required; (5) the provider lacks the skills necessary to adequately treat the patient or their condition; (6) the patient is not following up at intervals specified by the provider; (7) the patient has not been seen for 3+ months.
• We are not responsible for letters not reaching their intended destination if the patient has moved and does not notify us.
• We cannot guarantee the availability of a schedule, treatment approach, or specific provider after the patient has become inactive or terminated.
• Patients resuming treatment after becoming inactive may be required to have a new intake assessment completed.

Attestation
• You signature below indicates that you understand your responsibility regarding payment for all services associated with your treatment, including copayments, coinsurance, and annual deductibles.
• Your signature confirms that all information provided on this form is accurate and gives Wilmington Mental Health permission to charge your credit card, bill your insurance company, and request payment for your treatment from third-party companies other than your insurance provider.
• Wilmington Mental Health and/or any of its associates will charge your credit card for any covered service, no-show/late cancellation fees, and any balance that is 30 days overdue.
• If you decide to revoke this privilege and your account is paid up in full, you may withdraw this authorization at any time and communicate this request by contacting Wilmington Mental Health at 910-777-5575 or by email at info@wmhwc.com.

X _____ _____

Signature of Patient or Authorized Representative | Date

FOR OFFICE USE ONLY

Revocation note: Date: Staff Initials:

OFFICE POLICIES

All initial appointments begin with a brief screening, comprehensive clinical assessment, psychiatric evaluation, or medical evaluation, depending on your specific presentation. The intake paperwork must be completed and returned to front office staff before treatment starts or the appointment may be cancelled.

Patient Responsibilities

- We do not allow and are not responsible for unattended children in the waiting area.
- Patients are responsible for knowing what medications they are currently taking when scheduling an appointment.
- Individual practitioners also may have different limitations and restrictions as to what they are able to prescribe with regards to controlled substances.

Phone Consultation

- Direct phone calls to our providers should be for emergency purposes only. All other matters are best discussed in session.
- With your permission, our clinicians may communicate with other providers or collect collateral information.

Email Requests

- We have established an email address at info@wmhwc.com for routine matters that do not require immediate response.
- Email communications will only be used with established patients and have a 24-hour turnaround.
- When sending email, please include your name and telephone number in the body of the message.
- Unprofessional remarks or comments in email communications are prohibited.

Telehealth Services

- Telehealth services can only be provided to patients who are physically located in the state of North Carolina, at the time of their visits.
- Recording any telepsychiatry sessions without prior written consent from your provider is a violation.

Professional Collaboration

- We will be happy to collaborate with any existing provider when a written consent has been completed.
- We will collaborate to develop a treatment plan that fits the patient's individual needs.

Interactions Outside of Therapy

Your provider may run into you outside of the practice and not acknowledge your current or former relationships with him/her unless you acknowledge him/her first. Likewise, she/he may behave as though he/she does not know you if there is another person with you. This is done to protect your privacy and confidentiality. Any interaction in public is expected to be brief and exclude others in your company.

Inclement Weather

- In some cases of inclement weather (i.e., hurricane, snowstorm), appointments may need to be canceled or rescheduled.
- We follow the New Hanover County schedule for delays and closures. However, there may be some instances when we are open or operating on a normal schedule despite closings or delays in the community.
- In some cases, we may call you to request that you come in earlier or later than your scheduled time due to the weather.
- If your appointment is cancelled, every effort will be made to reschedule your appointment.

Crisis Management

- WMH does not provide crisis management or emergency psychiatry services.
- Physicians at WMH do not have admitting privileges. If there is a crisis regarding your safety, you will be directed to the closest hospital emergency room for evaluation and possible admission.

Urinalysis and Laboratory Work

- Urine specimen collections and blood work may be collected during your treatment and sent to the lab for testing.
- How often samples are collected can vary from patient to patient.

Patient Portal

- Through the patient portal we may send you questionnaires or other information prior to your appointment. Please complete any forms/questionnaires at least 24 hours prior to being seen for a follow-up appointment.

Patient Etiquette

- Disrespectful/ abusive behavior or harassment towards office staff or providers will not be tolerated and patients will be immediately terminated from the practice should this occur.
- Patients who have a strong pre-existing relationship (friend, family, etc.) with an assigned provider are encouraged to consider seeking care from another provider.

Forensic Affairs

- Our fees related to court cases (preparing for depositions, travel time, court time, etc.) are billed at a higher hourly rate than basic services.

Termination of Treatment

We reserve the right to terminate treatment with a patient due to threatening or abusive behavior towards office staff, sexual advances, repeated no-shows, treatment non-compliance that jeopardizes patient's safety, successful completion of the treatment program, refusal to follow the treatment plan or violating the terms of the treatment contract such as failure to pay bills and/or being in collection.

X _____ ***X*** _____ ____/____/_____

Name of Patient or Representative | Signature of Patient or Representative | Date

SYMPTOM CHECKLIST

Circle ⊙ the answer that best applies to you and do not skip any items.

Please indicate how much you have been bothered or distressed by the following problems during the past week.	Not at all	Mildly	Moderately	Severely
Grief/loss (personal or material)	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Depression (sadness, weeping, feelings of guilt)	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Mood swings	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Changes in sleep pattern: sleeplessness or hypersomnia?	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Decreased/increased self-esteem:	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Periods of high energy/activity with less need for sleep	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Suicidal attempts - when?	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Suicide thoughts - when?	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Suicide plan (specify):	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Change in weight or eating habits	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Overeating	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Restrictive eating, dieting, or purging	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Feelings of insecurity or inferiority	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Stress	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
School-related issues	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Change in work habits	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Work/career changes	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Nausea or upset stomach	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Anxiety, nervousness, or panicky feelings	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Avoiding places or situations	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Difficulty making decisions	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Brain fog, fuzzy thinking, or dissociation	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Trouble remembering things	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Confusion or disorganized thoughts	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Marriage-related conflict	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Anger or temper problems	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Disability	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Codependency	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Communication issues	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Decreased or loss of interest in enjoyable activities	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Flashbacks or intrusive memories	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Physical problems, pain, or illness	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Loss of sexual interest or pleasure	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Sexual worries or problems	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Inability to stop watching pornography	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
The idea that something is wrong with your mind	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Repetitive thoughts or behaviors	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Procrastination (tasks, time management, etc.)	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Trauma (victim of a crime, abuse, natural disaster)	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Cultural (race) or gender (LGQBT) issues	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Spirituality: God, faith, church/ministry related issues	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Substance abuse or relapse	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10
Other (specify):	⊙0	⊙1 ⊙2 ⊙3	⊙4 ⊙5 ⊙6 ⊙7	⊙8 ⊙9 ⊙10

▼ ▼

How serious are these matters to you currently?

1 = Very serious | 2 = Serious | 3 = Not too serious | 4 = Not at all serious

How long have you had these problems?

0 to 3 months | 3 to 12 months | 1 to 5 years | More than 5 years

Adapted from Derogatis, Lipman, & Covi 1973's SCL-90: An outpatient psychiatric rating scale

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

(Circle ⊙ the answer that best applies to you)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	◯ 0	◯ 1	◯ 2	◯ 3
2. Feeling down, depressed, or hopeless	◯ 0	◯ 1	◯ 2	◯ 3
3. Trouble falling or staying asleep, or sleeping too much	◯ 0	◯ 1	◯ 2	◯ 3
4. Feeling tired or having little energy	◯ 0	◯ 1	◯ 2	◯ 3
5. Poor appetite or overeating	◯ 0	◯ 1	◯ 2	◯ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	◯ 0	◯ 1	◯ 2	◯ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯ 0	◯ 1	◯ 2	◯ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	◯ 0	◯ 1	◯ 2	◯ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	◯ 0	◯ 1	◯ 2	◯ 3
	Add columns		**+**	**+**
	Total:	0		

► If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

GENERALIZED ANXIETY DISORDER (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	◯ 0	◯ 1	◯ 2	◯ 3
2. Not being able to stop or control worrying	◯ 0	◯ 1	◯ 2	◯ 3
3. Worrying too much about different things	◯ 0	◯ 1	◯ 2	◯ 3
4. Trouble relaxing	◯ 0	◯ 1	◯ 2	◯ 3
5. Being so restless that it is hard to sit still	◯ 0	◯ 1	◯ 2	◯ 3
6. Becoming easily annoyed or irritable	◯ 0	◯ 1	◯ 2	◯ 3
7. Feeling afraid as if something awful might happen	◯ 0	◯ 1	◯ 2	◯ 3
Add the score for each column:		**+**	**+**	**+**
Total Score (add your column scores) =	0			

► If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PTSD CHECKLIST FOR DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	IN THE PAST MONTH, HOW MUCH WERE YOU BOTHERED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
CLUSTER B	1. Repeated, disturbing, and unwanted memories of the stressful experience?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	2. Repeated, disturbing dreams of the stressful experience?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	4. Feeling very upset when something reminded you of the stressful experience?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
CLUSTER C B	6. Avoiding memories, thoughts, or feelings related to the stressful experience?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
CLUSTER D	8. Trouble remembering important parts of the stressful experience?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	10. Blaming yourself or someone else for the stressful experience or what happened after it?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	12. Loss of interest in activities that you used to enjoy?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	13. Feeling distant or cut off from other people?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
CLUSTER E	15. Irritable behavior, angry outbursts, or acting aggressively?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	16. Taking too many risks or doing things that could cause you harm?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	17. Being "superalert" or watchful or on guard?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	18. Feeling jumpy or easily startled?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	19. Having difficulty concentrating?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
	20. Trouble falling or staying asleep?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

PCL-5 (11 April 2019) • National Center for PTSD

SUBSTANCE USE HISTORY

Patient Name: _____ Today's Date: _____

Frequency Codes: *0 = None/Sporadic, 1 = 1-2x per week, 2 = 3-6x per week, 3 = 1-3x in past month, 4 = daily* · **Route Codes:** *1 = Oral, 2 = Inhalation, 3 = Nasal, 4 = Injection, 5 = Topical*

Substance	Age at first use	Frequency					Amount	Route					Date of last use	Max. Freq.				
		0	1	2	3	4		1	2	3	4	5		0	1	2	3	4
Caffeine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Tobacco		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Alcohol		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Cannabis/Hashish		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Methamphetamine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Cocaine/crack		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Phencyclidine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
LSD/MDMD		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Inhalants		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Benzodiazepines		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Prescribed Medicine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

History of overdose, seizure, blackout, or hospitalization due to drug use? If yes, please explain: ☐ Yes ☐ No

Your Drug of Choice:

► Please provide details about your drug use, progression, sobriety, and history of relapses in this section:

CAGE-AID QUESTIONNAIRE

When thinking about drug use, including illegal drug use and non-prescribed drugs…	Yes	No
Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐