



**COASTAL
BEHAVIORAL
SCIENCES**

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Robert M. Adams IV, MD
Psychiatrist

Kimberly S. Adams, PsyD, ABPP-CN
Neuropsychologist

Carol Lockman, FNP
Family Nurse Practitioner

Linda Burbank, LCSW
Psychotherapist

Morgan Lankford, MS, CRC, LPCA
Rehabilitation Counselor

Thank you for requesting an appointment at Coastal Behavioral Sciences, one of the area's leading providers of behavioral healthcare. Please take a few moments to read this letter introducing you to our office policies, procedures and approach to treatment. **Please keep this letter for your records.**

Please note that we cannot accommodate all requests for appointments. If our Providers believe that your requested needs may be better served by another mental health agency, we may refer you to that agency, as it is one of our goals to get you the most appropriate care possible for you and your family.

At Coastal Behavioral Sciences we emphasize a **team approach** to treatment that is tailored to meet the unique needs of each individual patient and family. We utilize the following providers:

Psychiatrist: Our board certified Child, Adolescent and Adult Psychiatrist assesses, diagnoses, and treats patients for behavioral health disorders. The primary mode of treatment is through prescribing psychiatric medications. Routine follow up appointments are 20 minutes long.

Psychologist: Our board certified Psychologist/Neuropsychologist evaluates and diagnoses patients using multiple behavioral health assessments. We offer cognitive, memory and neuropsychological testing, evaluations for ADHD and learning disorders, as well as brief cognitive behavioral therapy (CBT). Routine appointments range from 20 to 40 minutes, longer for testing.

Nurse Practitioner: Our board certified Family Nurse Practitioner works under the supervision of the collaborating physician to assess, diagnose and treat patients of all ages for behavioral health disorders. The primary mode of treatment is through prescribing psychiatric medications. Routine follow up appointments are 20 minutes long.

Psychotherapist: Our therapists clinically assess and treat children, adolescents and adults for a range of behavioral health issues including depression, anxiety, ADHD, family and marital issues, school problems, PTSD and stress management.

If you would like to request an appointment with one of our providers, **please read, fill out, and sign ALL of the information on the following forms. Incomplete forms may delay your getting an appointment.**

- **Patient Demographics Sheet (filled in completely)**
- **Patient Information Sheet (filled in completely)**
- **Signed and dated Office Policies Sheet (which includes our HIPAA privacy notice)**
- **A legible copy of your driver's license and health insurance card(s) (both sides if it is double-sided)**

Upon completion of the above, you may:

- a) mail the *completed forms* back to us using the address above;
- b) fax the *completed forms* to us at 910-254-4819; or
- c) bring the *completed forms* to our office in Howe Creek Landing at 710 Military Cutoff Road, Suite 120 in Wilmington.

We **strongly recommend** that you call your insurance carrier to verify your *mental health benefits, co-pays and deductibles*, as these are often different from other medical/specialist benefits.

Please visit **www.coastalbehavioralsciences.com** for more information on our providers and services.

Sincerely,

The Providers and Staff at Coastal Behavioral Sciences

Coastal Behavioral Sciences

Patient Demographics and Insurance Form

(Please fill out COMPLETELY and give to receptionist with copies of ALL your Insurance Cards)

- Today's Date: _____
- Patient's Last Name, First Name, MI: _____
- Date of Birth (MM/DD/YYYY): ____/____/____ Social Security #: ____-____-____
- Sex (circle one): Female / Male
- Student Status (circle *if applicable*): Full-time / Part-time
- Marital Status (circle one): Married / Single / Divorced / Separated / Widowed
- Street Address: _____
- City: _____ State: _____ Zip/Postal Code: _____
- Home Phone: (____) ____-____ Cell Phone: (____) ____-____
- Work Phone: (____) ____-____ ext: _____
- Employment Status: Full-time / Part-time / Self-Employed / Not Employed / Retired / Military / Disabled
- Employer: _____ Phone #: (____) ____-____ ext: _____
- Case Manager: Name: _____ Agency: _____
Phone: (____) ____-____ Fax: (____) ____-____
- Whom should we contact to schedule appointments? _____
- Referring Physician's Name, Address and Phone # (*Required, or write 'self-referral'*):

***If the patient is a minor (*less than 18 years old*), a parent or legal guardian MUST be present for ALL appointments where medication and treatment decisions will be made and to sign all accompanying consents for treatment (as required by NC Law), including the following:**

- Name of Minor's parent or legal guardian: _____
- Relationship to patient (circle one): Mother Father Guardian Other (explain) _____
- Address (*if different from patient*): Street: _____
City: _____ State: _____ Zip: _____
- Home #: (____) ____-____ Cell #: (____) ____-____

Insurance Information

(Insurance card MUST be presented at EVERY appointment or full fee may be required!)

- Do you have insurance you want us to file on your behalf (circle)? Yes No Self-Pay
- Name of your Insurance Company(s): _____
- Do you have **more than one** insurance carrier? Yes No (If 'Yes' list all above)
- Is the PATIENT the **PRIMARY** card holder? (*i.e. owns the policy & pays premiums*) Yes No
- If the patient is **NOT** the PRIMARY card holder, **ALL of the following is REQUIRED**:
 - Card Holder's Name: _____
 - Card Holder's Social Security Number: ____-____-____
 - Card Holder's DOB: ____/____/____
 - Card Holder's Address (if different): Street _____
City: _____ State: _____ Zip: _____
 - Home #: (____) ____-____ Cell #: (____) ____-____

Please submit a copy of the front and back of your Insurance Card(s) with this form!

THANK YOU!

Patient Information Sheet for Coastal Behavioral Sciences

****Please fill in ALL information as completely as possible so we can best assess your needs****

Patient's Name: _____ Today's Date: ____/____/____
Patient's Date of Birth: ____/____/____ Age: _____
Pharmacy Name: _____ Pharmacy Phone #: _____

1. Please describe **IN DETAIL** the reason(s) you are seeking psychiatric/psychological assessment or treatment:

2. Please list ALL MEDICATIONS you are CURRENTLY taking, including dose, times, how long taken:

3. Please list ALL major medical problems/surgeries you have had (i.e. diabetes, heart disease, seizures, etc):

4. Developmentally, did you suffer any traumas during or after your birth? Have you ever been the victim of abuse, whether emotional, physical or sexual? (if 'YES' to either, explain, or write 'None'):

5. Please list **ALL** previous treatment for the above condition(s), including medications/doses tried, how long taken, side effects, why/when stopped, previous therapists, psychiatric hospitalizations, etc:

6. Please list ALL medications you are allergic to: NONE or _____.

7. Please list marital status, employment status, military status, educational level, children, disabilities, and/or other social information you feel may be important, including legal charges/probation, past and present:

8. Please list ANY & ALL alcohol, substance or tobacco use/abuse habits you have or may have had, including any previous treatment for alcohol/substance abuse:

9. Please list ANY family history of psychiatric/psychological illness or substance abuse:

Coastal Behavioral Sciences (CBS) Office Policies

(Please carefully read the policies below and sign 'Acceptance' of policies. Required for treatment.)

- ✓ **Co-pay and Deductibles**: With few exceptions, patients usually have a co-pay associated with their insurance. Co-pays, co-insurance & deductibles are due and expected at the time of service before being seen. Deductibles and co-insurance are the responsibility of the patient and are normally in addition to their co-pay. Balances remaining after 60 days from date of service must be paid by the patient until account issues are resolved. Balances remaining after 90 days will be turned over to our collections department unless other payment arrangements have been made.
- ✓ **Missed Appointment Charge**: A \$25.00 fee will be billed *to the patient* for failure to show for a scheduled appointment, except for unavoidable delays or emergencies. As a courtesy, we will attempt to place a reminder call to you for your scheduled appointment. However, it is your responsibility to keep track of your appointments. Failure to receive a reminder call does not excuse a missed appointment, and the fee will still apply.
- ✓ **Termination**: Treatment may be terminated after two 'No-Shows' for scheduled appointments or for failure to follow-up regularly for ongoing treatment as determined by your Provider. Termination will be immediate for any inappropriate or illegal behavior toward staff or Providers on the part of the patient or his/her family or acquaintances.
- ✓ **Late Cancellations**: A \$25.00 fee will be charged for appointments cancelled without 24 hours advance notice.
- ✓ **Medication Refills**: It is our standard practice to give patients enough medication refills to last until their next scheduled appointment. Therefore most medication refill requests cannot be granted without an appointment to discuss the benefit and possible side-effects of medications prescribed. Rare exceptions may be made, at the discretion of the Provider, to prevent withdrawal or adverse events, until a patient can be seen in the office.
- ✓ **Returned Checks**: A \$25.00 processing fee will be charged for all returned checks. After one returned check, the patient or guardian will be required thereafter to pay only by cash or credit/debit card.
- ✓ **Late Charges**: A 1.5% monthly fee will be applied to accounts greater than 60 days overdue.
- ✓ **Document Preparation Fee**: Within reason we will make every effort to fill out school or work notes, write letters of support, or prepare other reports requested patients, at the discretion of the Provider, though prepayment of a \$50 per 15 minute document preparation fee may be required
- ✓ **HIPAA Privacy Notice**: I, the patient or guardian, understand that the 'HIPAA Privacy Notice' is clearly posted in the waiting room at CBS, and that I may view and request a copy of it at any time. The HIPAA Privacy Notice regards the privacy and protection of my treatment information at CBS. I understand that my treatment records are the sole property of CBS.
- ✓ **Disability/FMLA Paperwork Policy**: I understand that the Providers at CBS do NOT complete ANY disability forms including, but not limited to, short-term or permanent disability, FMLA, or other related forms. I understand that I may request for my medical records to be mailed or faxed to another provider or agency, provided CBS has a properly signed and authorized Release of Information form. I also understand that there may be a \$25 administrative fee associated with processing/mailing my records, should I request them to be forwarded.
- ✓ **Insurance Information**: It is the responsibility of the patient/guardian to understand his/her insurance benefits. Once the patient has paid his/her required co-pay and the insurance company has paid their portion of the charge, it is the patient's/guardian's responsibility to pay the remaining balance of any allowable charges, if any, depending on your insurance company's policies, deductibles and Provider-Carrier contracts. It is your responsibility to inform us of ANY change in your insurance coverage or personal demographic information, as this information is required when filing your insurance claims. The Billing Department at CBS is available during business hours to discuss any insurance/questions you may have. Accounts with unpaid balances remaining after 60 days must be paid by the patient/guardian. Further, you hereby agree to assign benefits from your insurance company to CBS for all services rendered.

ACCEPTANCE OF ALL ABOVE POLICIES:

I have read, understand, and accept in full, all of the above statements, terms and conditions for treatment and payment for services rendered by the Providers and staff at Coastal Behavioral Sciences.

Patient/Guardian Signature

Printed Name of Signature

Date Signed and Accepted