3713-B University Drive
University Commons
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Triangle NeuroPsychiatry PLLC

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# Adult Face Sheet

## PATIENT INFORMATION:

Name: _____ DOB: ____/____/_____ Gender: _____

Address: _____ Town/ City: _____

State: _____ Zip Code: _____ Social Security #: _____/_____/_____

Home Phone #: _____ Cell/ Work Phone #: _____

Email Address:_____ May we communicate with you via email? Yes No

Employer Name: _____Occupation: _____

Who referred you to our clinic: _____ Primary Care Physician: _____

## EMERGENCY CONTACT INFORMATION:

Name: _____ Home Phone: _____ Relationship: _____

Cell/ Work Phone: _____ Address: _____

Email Address:_____

## INSURANCE INFORMATION:

Insurance Company: _____ Address: _____

Group Name: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ____/____/_____

Policy Holder's Social Security #: _____/_____/_____ Policy Holder's Relationship:_____

### CONSENT TO THE USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS:

I understand that my health information may be used and disclosed by Triangle Neuropsychiatry to carry out treatment, to obtain payment and to conduct healthcare operations. I have read and understand the Notice of Privacy Policy, provided by Triangle Neuropsychiatry, which gives a more complete description of uses and disclosures of health information. I hereby grant the medical personnel of Triangle Neuropsychiatry permission to release health information acquired in the course of my examination and treatment to the appropriate parties, with all due discretion, when necessary for treatment, payment, healthcare operations and emergency purposes. I understand that the medical personnel at Triangle Neuropsychiatry will communicate, on a regular basis, with other treating health care providers. All records are kept confidential and shared only with pertinent personnel involved.

I understand that I have the right to request restrictions on how health information may be used or disclosed, but that the provider designated is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on the consent. I agree that this consent shall be valid until rescinded in writing or replaced in writing by one at a later date.

**The individual is informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MD/IDD/SA disability.**

Remarks, Stipulations: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____