

## HOW TO COMPLETE THIS PACKET

Completing this packet will save time at your initial visit. If you have any questions regarding the completion of this form please call **919.800.2442**.

### **CLINIC FORMS:**

- These forms cover basic information/agreements that need to be completed before a patient can be seen in our office (ie: Billing agreement, Patient Rights and Responsibilities, etc.).
- Please read, sign, and date all forms. The forms will be reviewed and witnessed by a staff member when the patient arrives for their scheduled appointment.

### **HEALTH QUESTIONNAIRE:**

- This 4-page questionnaire briefly covers the patient's medical and family history. Please fill out the questionnaire as completely as possible before you arrive for your appointment.
- Additional records from other health care providers are always helpful; if you have them, please bring in any additional records that can be gathered (ie: psychological/psychiatric evaluations; imaging results (MRI/CT/EKG...); lab results; reports from other providers, etc.).

### **FAMILY HISTORY FORMS:**

- Please fill out this family history form completely. Include people's ages if known. (Note: Maternal means the mother's side, and paternal means the father's side.)

### **RATING SCALES/QUESTIONNAIRES:**

- These rating scales are age-appropriate and need to be completed before the patient arrives for his or her scheduled appointment.
- For children, parents should answer or help the child answer the questions, as is appropriate.

### **NP3:**

- This is an online questionnaire that is to be taken by the patient ***and*** companions before arrival. You will find a separate sheet of instructions in this packet which provides instructions for completing the NP3. Please follow the directions carefully.
- You will find that some of the questions on the NP3 are similar to some on the paper rating scales. While they are similar in some ways, they are separate and different; it is necessary that both the paper scales and the NP3 be completed.
- If you do not have access to the internet, you can complete the NP3 when you are in our office. You do not need access to a printer in order to complete the NP3.

**CHILD FACE SHEET**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security # \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

Child resides with: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

SS#: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

SS#: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Group Name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_

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

I understand that my health information may be used and disclosed by NC Neuropsychiatry to carry out treatment, to obtain payment, and to conduct healthcare operations. I understand that NC Neuropsychiatry has a Privacy Policy, which gives a more complete description of uses and disclosures of health information, and which is freely available for me to read. I hereby grant medical personnel of NC 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. Examples of my health information that may be released include clinical findings, diagnosis, assessment, laboratory results, progress notes, psychotherapy notes, treatment recommendations, names of health care personnel, dates of hospitalizations, charges, visits, and any other information that may be related to medical and psychiatric conditions, including drug and alcohol related problems and sexually transmitted diseases. I understand that medical personnel at NC 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 may fill out rating scales and take psychological tests, including computerized tests, as part of a routine or special evaluation. I have been informed that the data from these instruments may be used for the purpose of research; for example, to evaluate the reliability of a test, or to assess the cognitive effects of different medications. My identity, however, is detached from these data before they are ever used, and can never be discovered or revealed. 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 for the duration of my treatment at NC Neuropsychiatry or until rescinded in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office Use Only:**

**I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.**

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440

**RELEASE OF INFORMATION**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Information Released From:**

**Information Released To:**

\_\_\_\_\_  
Name (Health Care Provider)

\_\_\_\_\_  
Name (Hospital, Agency, MD)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

**Reciprocal Authorization for Release of Information** (Check if applicable)

\_\_\_\_ A reciprocal authorization allows NC Neuropsychiatry to have continuous dialogue between the medical personnel of NC Neuropsychiatry and the individual or group identified above.

**Description of Information to be Released:** This authorization is for full disclosure of the patient’s medical records including clinical findings, diagnosis, treatment, assessment, laboratory results, progress notes, psychotherapy notes, recommendations for further care, names of health care personnel, dates of hospitalizations, charges, visits, and any other information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases. All records are kept confidential and shared only with pertinent personnel involved.

**Purpose of Release of Records:** (check one)

- Continuing Treatment       Personal       Legal Involvement
- Disability Determination       Moving       Other
- Worker’s Compensation       Insurance

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any medical personnel of NC Neuropsychiatry, or any other individual listed above to disclose my protected health information as described on this form to the recipients listed. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. This authorization shall be valid for the duration of the patient’s treatment at NC Neuropsychiatry or until rescinded in writing. I hereby release NC Neuropsychiatry from all legal responsibility or liability that may arise from this authorization.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440

**INSURANCE, BILLING AND COLLECTION POLICIES:**

**All copayments, coinsurance and deductibles and any outstanding balances are due at the time of service.** As a courtesy to our patients, and as time allows, we will verify benefits. In order to do so, we request a copy of your insurance card before your visit. The information we receive is not a guarantee of payment, benefit or claim. We recommend that you reference your benefit booklet or consult with your insurance company.

Participating Insurances:

- BCBS-Most PPO’s
- Out-of–State policy holders; **charges base on Medical Necessity. Any non-covered charges are the patients’ responsibility.**
- State of NC Teachers and employees
- NC Health Choice
- Medcost/Medcost Primenet
- Multi Plan –previous called UP& UP
- TriCare **Standard Only**
- Workers Compensation
- Cigna Medicare **Only**
- Medicaid
- Cigna
- Cigna Behavioral Health
- CBHA

**All of our doctors are on different insurance plans. Please verify individual doctor participation status for insurance coverage.**

Patients with any other insurance must self-file. Patients that self-file must complete a self-pay waiver, and pay in full at the time services are rendered. Some services may not be covered by your insurance policy. It is your responsibility to check your benefits ahead of time and to be prepared to make any out-of-pocket payments at the time of the visit.

**Please be aware that your MENTAL HEALTH COVERAGE AND BENEFITS** may differ from your medical. You are advised to verify your coverage.

The procedure code(s) that usually apply when checking MENTAL HEALTH INSURANCE BENEFITS for these evaluations are listed below. Some may need **PRE-AUTHORIZATION. Please check with your insurance company regarding pre-authorization.**

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440

**INSURANCE, BILLING AND COLLECTION POLICIES continued:**

**PROCEDURE CODES MOST COMMONLY USED:**

- 99205 (initial office visit medical)
- 90801 (initial office visit psych)
- 99215 (follow up visit medical)
- 90807 (follow up visit psych)
- 96101 (psychological testing per time unit)
- 96118 (neuropsychological testing per time unit)
- 96119 (neuropsychological testing per time unit)
- 96120 (neuropsychological testing per time unit)

**MISSED APPOINTMENT POLICY:** A minimum of \$40 or a fee up to the amount of the scheduled visit will be charged for appointments missed. All therapy visits that are a no show or same day cancelation will be charged a fee of \$75.

We require **24 HOUR IN ADVANCE CANCELLATION NOTICE**. Insurance companies do not reimburse for missed appointments fees. You will have to pay this out-of-pocket.

**INSURANCE CHANGES:** It is the patient’s responsibility to inform our billing department of any insurance changes before the next scheduled appointment that is affected by this change.

**ELECTROCARDIOGRAM (EKG):** The patient will be responsible for the cost of the EKG in the event it is not a covered benefit by the patient’s insurance. The self-pay rate for the EKG is \$40. You will be responsible for any balance not covered by your insurance plan.

**We are not responsible for any lab work (blood, urine) charges incurred. You may be billed separately by LabCorp/Carilion. It is your responsibility to provide insurance information to LabCorp/ Carilion.**

**COLLECTION POLICY:** In the event that the patient does not pay in full at the time of service or neglects to pay co-payments, the patient is required to pay all past balances at the next scheduled appointment. Any Balances that age past 90 days will automatically transfer to a collection agency. We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, and/or terminate you as a patient of this practice.

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440

**INSURANCE, BILLING AND COLLECTION POLICIES continued:**

**FORMS:** There will be a fee of \$20 to complete any forms. These forms include, but are not limited to: Disability Forms, Medical Records, forms your provider is required to take time to fill out. Payment must be made in advance.

**SERVICES RENDERED TO MINOR PATIENTS:** The individual who initiates services for a minor is responsible for assuring payment is made at the time of service and for notifying the party responsible for medical bills of the upcoming charges.

**PHONE CONSULTATIONS:** Phone consultations will be billed as deemed necessary by the provider. The first ten minutes will be billed at the rate of \$30. Each ten minutes thereafter will be subject to additional charges. These charges are not covered by insurance and will be billed directly to the patient. A fee of \$25 will be assessed for non-emergency calls made to the on call provider during after hours, weekends and holidays.

**RETURNED CHECKS:** A fee of \$40.00 will be added to your balance for returned checks.

**Signature:** I understand that I am legally responsible for my entire bill. NC Neuropsychiatry will file claims with participating insurance companies.

Patient or Parent/Guardian Signature: \_\_\_\_\_

Print: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office Use Only:**

**I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.**

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT’S RIGHTS AND RESPONSIBILITIES**

**PATIENT’S RIGHTS:**

- Individuals have the right to be treated with dignity and respect.
- Individuals have the right to fair treatment. This is regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Individuals have the right to a confidential relationship with their provider and to have their treatment and other personal information kept private, except when laws or ethics dictate otherwise such as if the patient is in danger of harming him/herself or others, or if the patient is suspected of being abused. Any disclosure to another party will be made with the informed consent of the individual. Only by law, may records be released without the patient’s permission.
- Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.
- Individuals have the right to easily access care in a timely fashion.
- Individuals have the right to receive full information from the potential treating professional about that professional’s knowledge, skills, preparation, experience, and credentials.
- Individuals have the right to have a clear explanation of their condition.
- Individuals have the right to be informed about the options available for treatment interventions (including risks and benefits) and the effectiveness of the recommended treatment. This is regardless of cost or coverage by the patient’s benefit plan.
- Individuals have the right to share in developing their treatment plan.
- Individuals have the right to information about their treatment in a language they can understand.
- Individuals have the right to know about advocacy and community groups and prevention services.
- Individuals have the right to information about their insurance/third party payer, its’ practitioners, services and role in the treatment process.
- Individuals have the right to provide input on their insurance/third party payer policies and services.
- Individuals have the right to freely file a complaint, grievance, or appeal and to learn how to do so.
- Individuals have the right to know about the laws that relate to their rights and responsibilities.
- Individuals have the right to know of their rights and responsibilities in the treatment process.

**PATIENT’S RESPONSIBILITIES continued:**

- Individuals have the responsibility to treat those giving them care with dignity and respect.
- Individuals have the responsibility to give providers accurate information they need. This is so providers can deliver the best possible care.
- Individuals have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in their care.
- Individuals have the responsibility to follow treatment plans for their care. The treatment plan is to be agreed upon by the patient and provider.
- Individuals have the responsibility to follow their agreed upon medication plan.
- Individuals have the responsibility to tell their provider about medication changes, including medication given to them by others.
- Individuals have the responsibility to keep their appointments. Individuals should call their providers as soon as possible if they need to cancel visits.
- Individuals have the responsibility to let their providers know when their treatment plan and/or medication regimen no longer works for them.
- Individuals have the responsibility to let their providers know about problems with paying fees.
- Individuals have the responsibility to not take actions that could harm themselves or others.
- Individuals have the responsibility to report abuse.
- Individuals have the responsibility to report fraud.
- Individuals have the responsibility to openly report concerns about the quality of their care.

**I have read and understand my patient rights and responsibilities as explained above.**

Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Patient or Patient’s Parent/Guardian Signature Date

**For Office Use Only:**  
**I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.**

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY POLICY**

*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.* The providers, medical staff and employees of NC Neuropsychiatry are committed to respecting and preserving the privacy and confidentiality of patient information. This Privacy Policy describes the personal information we collect, and how and when we use or disclose that information.

**Understanding Your Medical Record**

Each time you visit NC Neuropsychiatry, a record of your visit is made. Typically, this medical record contains your health and medication history, symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The information contained in your medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A source of information for public health officials charged with improving the health of the nation, and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Although your health record is the physical property of NC Neuropsychiatry, the information belongs to you. You have the right to:

- Obtain a paper copy of this privacy policy upon request,
- Inspect and obtain a copy of your medical record,
- Request an amendment of your medical record,
- Obtain an accounting of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**

Providers, medical staff and employees of NC Neuropsychiatry are responsible for:

- Maintaining the privacy and confidentiality of your health information,
- Providing you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abiding by the terms of this privacy policy,
- Notifying you if we are unable to agree to a requested restriction, and
- Accommodating reasonable requests you may have to communicate health information by alternative means or at alternative locations.

**NOTICE OF PRIVACY POLICY continued:**

We reserve the right to change our privacy policy. Should our privacy policy change, we will mail a revised notice to the address you've supplied us and post the revised privacy policy in our offices. We will not use or disclose your health information without your authorization, except as described below. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization.

**Examples of Uses and Disclosures of Private Health Information**

We will use and/or disclose your health information:

- For purposes of treatment, payment, and quality improvement health operations.
- To your primary care physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.
- To a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- As required by law, such as disclosures about victims of abuse, neglect, or domestic violence; disclosures for judicial proceedings; and disclosures for law enforcement purposes.
- For purposes of evaluating and standardizing test instruments that may result in publication.
- To researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. Patients involved in research at our practice would first read and sign an informed consent document.
- To our business associate, such as a medical laboratory, so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- To notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- To provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- To the FDA and/or a Pharmaceutical Company, your health information relative to an experienced side effect to a prescribed medication that was previously unreported to enable product recalls or changes in reported side effects.
- To the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440

**NOTICE OF PRIVACY POLICY continued:**

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the practice’s Privacy Officer, Jeni Groves at 919-785-5055 ext. 1008.

If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer or with the Office for Civil Rights. **Office for Civil Rights** U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201

Patient Name: \_\_\_\_\_

I have carefully reviewed and understand the Notice of Privacy Policy provided to me by North Carolina Neuropsychiatry. If requested, I may receive a copy of the Notice of Privacy Policy. The Notice of Privacy Policy describes how my medical information may be used and disclosed and how I can get access to this information. At any time I may request further explanation regarding the use and disclosure of my protected health information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

**For Office Use Only:**

**I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.**

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**INFORMED CONSENT FOR TREATMENT**

I agree and consent to participate in psychiatric services offered by a provider at North Carolina Neuropsychiatry, PA. I understand that I am consenting and agreeing to services provided within the scope of my provider’s license, certification, and training or the scope of a provider’s license, certification, and training who is directly supervised within the practice. I understand that I may see another provider within the practice if my provider is unavailable.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment or I am legally authorized to initiate and consent to treatment on behalf of this individual. I will provide a copy of my custody and/or guardianship papers as requested.

Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date

**For Office Use Only:**

**I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.**

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

MEDICATION CONSENT

My provider has educated me regarding the medication that has been prescribed to \_\_\_\_\_ me, \_\_\_\_\_ my child, or \_\_\_\_\_ a person for whom I am the legal guardian and I consent to the administration of this medication. I have been informed of the purpose for which this medication is prescribed as well as the most common side effects of this medication. I am also responsible for checking with my pharmacist about additional drug interactions and side effects regarding this medication.

I have been educated about the importance of reporting all side effects that I experience, including, but not limited to, which side effects to report immediately to a health care provider.

I agree to tell my provider about other medications I may be taking, including prescribed and over-the-counter medications; what food and drug allergies I have; and what medical conditions I have.

If I should become or am pregnant, or breast feeding, I will discuss this with the provider before taking any medication. If I become pregnant after starting the medication, I will notify the provider immediately.

Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

## NP3

**Step 1:** Please log into our website at [www.ncneuropsych.com](http://www.ncneuropsych.com) to complete our NP3.

*This is a secure database and the information you give is completely protected.*

This assessment will take approximately 20 minutes to complete.

**Step 2:** Once you've gone to our home page, along the top of the screen will be several icons, please click:



**Step 3:** On the new page, along the top of the screen, please click on the button marked:



**Step 4:** A window will pop up, inside this window it will ask for:

**Patient's First Name**  
**Patient's Last Name**  
**Patient's Date of Birth**

**Step 5:** Next window will ask:

<b>Respondent</b>	<b>Select the respondent's relation to the patient</b>
<b>Battery</b>	<b>Select "children"</b>
<b>Time Frame</b>	<b>Select "over the past couple of weeks"</b>

If other family members or teachers would also take this assessment of the patient, please follow the above steps.

Once you have completed the assessment, your results will be sent to our office. If you have any questions or concerns, please feel free to call us at any of our offices indicated below.

If you do not have access to the internet, you can complete the NP3 when you are in our office. You do not need access to a printer in order to complete the NP3.

Thank you and we look forward to seeing you.

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440