VC & Associates Inc.
"Victory comes with challenge..."
PO Box 2656
Sanford NC 27330
Phone: 919-774-3125 Fax: 919-774-3155

Welcome to VC & Associates, Inc.

Thank you for choosing VC & Associates, Inc. We are committed to providing the highest quality of care.

We have given you a Registration Package so we can enroll you to receive services provided by our office. We ask that you complete all forms in your Registration Package. Please let our Patient Care Specialist(s) know if you have any questions or concerns about any of the forms. They will be more than glad to assist you.

Within your Registration Package you should find the following forms: New Individual Information form, MH/DD/SAS Individual Handbook, Notice of Privacy Practices, VC & Associates Inc., Policies and Procedures. You may also be asked to complete an Authorization to Disclose Health Information form (if you have received services prior to enrolling with our office).

Below is a brief summary of the purpose of each form we have asked you to complete.

- **New Individual Information Form:** To obtain demographic information, to enroll you to receive services from our office, and is a brief health screening and medical history form to establish an overview of your health status. It also gathers insurance coverage information so we will know how to process insurance claims for benefits.
- **MH/DD/SAS Individual Handbook:** This booklet is designed to provide you with valuable information about your care and services. The information in this booklet explains how to access services; discusses Person-Centered Planning process, Crisis Services, Your rights, Your responsibilities and other helpful resources.
- **VC & Associates, Inc. Policies and Procedures:** Explains your responsibilities pertaining to: appointments, financial responsibilities, your treatment plan, confidentiality, insurance authorizations and consent for treatment. It briefly explains your right to complain or file a grievance, compliment staff, or make suggestions, which will help us to serve you better.
- **Authorization to Disclose Health Information:** This form gives VC & Associates, Inc. authorization to obtain records from other offices that you have received care so we can better serve you.
- **Notice of Privacy Practices:** Describes how the medical information about you may be disclosed and how you can get access to this information.
- **Permission to Seek Emergency Medical Care:** This form gives VC & Associates, Inc. authorization to seek medical care for yourself or your child in the event of a medical emergency.

Again we are very pleased that you have chosen to receive services from our office. We look forward to providing you with excellent service and care.

Thank you,
Cynthia Reives, LPC
Clinical Director

Patient Name	Primary Insurance #	Record #	D.O.B

New Individual Information Form

Date completed: _____

Individual's Name: _____
(Print First) (Print Middle) (Print Last)

Nickname: _____ Maiden Name: _____

Home Address: _____
(Street) (P.O. Box)

_____
(City) (State) (Zip Code) (County of Residence)

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

Who should we contact in the event of an emergency? _____
Name Relationship Phone

Date of Birth: _____ SS#: _____ Gender: ☐Male ☐Female

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

Race: ☐White ☐African American/Black ☐American Indian, Native American ☐Alaskan Native ☐Asian ☐Pacific Islander ☐Multiracial ☐Other ☐Unknown

Ethnicity: ☐Hispanic, Mexican-American ☐Hispanic, Puerto Rican ☐Hispanic, Cuban ☐Other Hispanic ☐Not Hispanic ☐Unknown

Employment Status: ☐Unemployed ☐Employed Full Time ☐Employed Part Time ☐Student ☐Retired ☐Homemaker ☐Not Available for Work ☐Armed Forces ☐Seasonal/Migrant Worker ☐Unknown

Place of Employment: _____ Annual Income _____ Number in Household _____

Current or Highest Level of Education: _____ School Name: _____

Family Physician Name: _____ Phone #: _____ Date of last Exam: _____

Address: _____

Eye Doctor Name: _____ Phone #: _____ Date of last Exam: _____

Family Dentist Name: _____ Phone #: _____ Date of last Exam: _____

Are you currently taking any medications? ☐Yes ☐No If so, please list the names and dosages of each medication:
_____

Are you allergic to any medications? ☐Yes ☐No If so, please list the name and allergic reaction to each medication:
_____

What is the family's source of income? _____

___ SSDI (social security disability Insurance) ___ SSI (Supplemental security income) ___ General Assistance (public assistance)

___ TANF (temporary assistance for needy families) ___ Workers Compensation ___ Veterans Disability Benefits

Patient Name	Primary Insurance #	Record #	D.O.B

Primary Insurance Information

Insured's Name: _____
(Print First) (Print Middle) (Print Last)

Place of Employment: _____ Work Number: _____

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Date of Birth: _____ Social Security: _____

Relationship to the insured: ☐ Self ☐Spouse ☐Child ☐Other _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____
(Street) (City) (State) (Zip Code)

Policy#: _____ Group #: _____

Does this patient have coverage under another plan? Yes No If yes please fill out the information below.

Secondary Insurance Information

Insured's Name: _____
(Print First) (Print Middle) (Print Last)

Place of Employment: _____ Work Number: _____

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Date of Birth: _____ Social Security: _____

Relationship to the insured: ☐ Self ☐Spouse ☐Child ☐Other _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____
(Street) (City) (State) (Zip Code)

Policy#: _____ Group #: _____

I authorize payment of my insurance benefits to me made by my insurance company to VC & ASSOCIATES INC. I understand that these payments will be applied directly to my bill. I understand that I am responsible for the co-payment and any deductibles and that ultimately, I am responsible for payment of any fees.

I authorize the release of any and all information to my insurance company that is necessary to process and pay my claim for services. I understand that this information is confidential but may be required by my insurance company in order to process my claims. I may refuse release of this information if I do not wish for my insurance company to be billed for these services. I release VC & ASSICIATES INC from any responsibility in the insurance company management of this confidential information.

_____ _____
Individual/Individual's Legal Guardian Date