



THE YANUCK CENTER

for Life and Health

APPOINTMENTS

Appointments can be made in advance by phone. For clients in ongoing therapy, every effort will be made to establish a regular appointment time as soon as possible. Extra or emergency sessions can be arranged if necessary. ***If an appointment must be canceled, please try to give at least a full week's notice; however, no charge will be made if notice is given at least 24 hours in advance.*** With less notice, you are responsible for the **full** amount - insurance does not cover this.

FEES AND BILLING

Feel free to ask me about my fees and any insurance questions. There is no charge for brief phone calls. Calls longer than five minutes and time spent preparing reports or letters will be billed at the rate of \$20 for every five minutes. Overdue balances will accrue 8% interest per year, prorated monthly. Full payment is due at the end of each session. Every month, you will receive a statement with all the information routinely needed for insurance claims. I encourage you to be well informed about your insurance policy. I accept payment in the form of checks or cash, **not credit cards**. A \$20 processing fee will be charged for returned checks.

EMERGENCIES

In case of emergency, please call my office (919/493-0406) and leave a message, then call my cell phone, 919/636-0297, and leave a message as directed. I will answer my cell phone as soon as practically possible, but not during sessions. I may not hear my phone in the middle of the night, or possibly at other times. If you cannot reach me during a true crisis, call UNC Medical Center (919/966-4131) and ask for the psychiatrist on call, or go to the nearest emergency room. Always leave me a message about any emergency situation.

Texting: Although I use Signal, a HIPAA compliant texting app, texting MAY not be confidential. If you choose to text me, you understand that you risk a breach of confidentiality. Please limit texts to last minute appointment changes if you are unable to reach me in other ways.

Email: The Yanuck Center office manager can forward emails to me when she is in the office. This is not the preferred means of communication, as it can be significantly delayed. Please try reaching me via my office phone or fax if possible instead of emailing.

CONFIDENTIALITY

The confidentiality of our work together is respected. No one else has access to my messages. Information about your treatment will only be released under one of the following circumstances:

1. You have given me explicit permission to talk to or send information to other health care professionals, insurance companies, family members, etc.
2. I am legally required to report suspected child or elder abuse.
3. I am legally required to protect you and others from harm. If I believe a person is a danger to himself/herself or someone else, I will do what I can to prevent harm.

If you have questions about any of these policies, let me know. Please save this sheet for future reference. (revised 12/31/18)

Cheryl H. Yanuck, MD, PC
Tel: 919/493-0406
Fax: 919/401-9900

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www.YanuckCenter.com
329 Providence Road
Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN,
FIAMA
Tel: 919/401-9500
Fax: 919/401-9900

MEDICAL HISTORY

PATIENT'S NAME: _____

Date form completed: _____

Age: _____ Gender and pronouns: _____

Marital status: _____

Religion: _____

Height: _____

Weight: _____

For what condition or difficulty are you seeking treatment at this time?

Do you currently take any medications? If so, please list names, dosages, and frequency:

Please list any known allergies: _____

Do you have any medical problems currently? _____ If so, please describe:

Please list any past surgeries and past major illnesses:

Do you use (or have you used) any of the following? If so, please indicate quantity and frequency:

tobacco: _____

caffeine: _____

alcohol: _____

stimulants (cocaine, amphetamine, etc.), sedatives (Valium, barbiturates, etc.), narcotics (codeine, Darvocet, heroin, etc.), or other mood altering substances:

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Are you experiencing any of the following symptoms? If yes, please describe:

- Fatigue
- Change in sleep patterns (describe:)
- Change in appetite
- Change in weight
- Change in sex drive
- Lack of interest in usually pleasurable activities
- Crying spells
- Sadness
- Feeling empty
- Feeling unreal
- Feeling helpless, hopeless, or worthless (please circle)
- Feeling extremely guilty
- Trouble concentrating
- Trouble with your memory
- Racing thoughts
- Excessive energy
- Irritability
- Euphoric or elevated mood
- Speaking rapidly
- Thoughts you can't get rid of
- Actions or rituals you feel compelled to repeat
- Thoughts of death
- Thoughts of hurting yourself
- Thoughts of hurting others
- Hearing, seeing, or smelling things that others don't hear, see, or smell
- Feeling like you have special powers
- Having ideas others don't believe
- Heart palpitations
- Dizziness
- Nervousness
- Shortness of breath
- Tingling in fingers, toes, or face
- Pain (describe):
- Chest pains
- Excessive sweating
- Change in temperature tolerance
- Skin or hair changes
- Change in digestive function
- Change in bladder function
- Change in sexual function
- Change in sense of smell, taste, touch, hearing, or vision
- Change in muscular strength or coordination
- Unusual bruising or bleeding
- Fever and/or infections
- Other symptoms:

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NEW PATIENT INFORMATION FORM

Patient's name: _____
Address: _____

Telephone number: (H) _____ (W) _____
Cellular phone: _____ which number(s) is/are best to call? _____
Social Security number: _____ Date of birth: _____
Email address: _____

May I leave messages at your home number? _____ work number? _____
In messages, should I identify myself as (circle one): Dr. Yanuck/Cheryl Yanuck/Cheryl

Insurance company: _____
Name of insured: _____ Relationship to patient: _____
Insured's date of birth _____ Employer _____
Insurance policy number: _____ Group number: _____
Does your insurance require pre-authorization of outpatient psychiatric services? _____
Telephone number for pre-authorization: _____
Number of sessions/year covered by insurance: _____ Copay amount: _____

Person to notify in case of emergency: _____
Telephone number: _____ Relationship to patient: _____
Address: _____

"I certify that I have received and read Dr. Yanuck's Policy Sheet."
(please sign if applicable) _____ (date)

"I authorize Dr. Cheryl Yanuck to release necessary information to my insurance company, managed care company, or their agent if they request it."
(please sign if applicable) _____ (date)

(Only for certain managed care contracts) "I authorize my insurance company to pay Dr. Yanuck directly for services rendered. I realize I am responsible for copayments, deductibles, and non-covered services."
(please sign if applicable) _____ (date)

(updated 5.17)

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