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 $25 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 cell phone (919/636-0297) and if I don't answer, leave a message. 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**: Please use email only for non-urgent communications. My outgoing emails are encrypted. My email address is cyanuck@yanuckcenter.com.

**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 12/31/23)*

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

**The Yanuck Center**
*For Life and Health*
www.YanuckCenter.com
329 Providence Road
Chapel Hill, NC 27514

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

**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: _____

*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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