Capital Area Psychiatric Associates, P.L.L.C.
Child, Adolescent, and Adult Psychiatry

1135 Kildaire Farm Rd, Suite 200
Cary, NC 27511
Telephone: (919) 237-9081
Fax: (919) 890-0330

COMPREHENSIVE INTAKE FORM

I. FAMILY INFORMATION

Patient's Name ________________________________ Patient's DOB _______________ Race/Ethnicity____________

Social Security Number _________________ Home Phone ___________________ Cell Phone ___________________

Address (street, city, state, zip code) ____

Mother's Name ________________________________ DOB _______________ Race/Ethnicity____________

Address (street, city, state, zip code) ____

Home Phone _____________________________________ Cell Phone ____

Father's Name ________________________________ DOB _______________ Race/Ethnicity____________

Address (street, city, state, zip code) ____

Home Phone _____________________________________ Cell Phone ____

Guardian's Name ________________________________ DOB _______________ Race/Ethnicity____________

Address (street, city, state, zip code) ____

Home Phone _____________________________________ Cell Phone ____

Insurance Information

Primary Insurance______________________________ Primary Policy #_______________________________________

Secondary Insurance ____________________________ Secondary Policy # ___________________________________

Insurance Company's Phone/Fax # ____

In case of emergency, who should be contacted (name and phone) ___________________________________

____

Patient name: ____________________________________ MRN:___________ Medicaid ID: ________________

Payment Agreement / Assignment of Benefits

Agreement to Pay: Payment is due at the time service is provided. I agree to pay the established fee on each visit. I understand that I may be denied an appointment if I refuse to pay, when I have the ability to pay. It is my responsibility to inform Captial Area Psychiatric Associates PLLC of any changes that affect my ability to pay.

We may accept assignment of insurance benefits if we are contracted with your private insurance company. However, please understand:

1. We file insurance as a courtesy and it is your responsibility to verify insurance benefits. All charges are your responsibility, whether your insurance company pays or not (see Medicaid provisional below).
2. If the private insurance company does not pay your balance in 45 days, we ask that you contact the carrier.
3. If the private insurance company does not pay within 60 days, we ask that you pay the balance due (see Medicaid special provision below).

Assignment of Benefits: I authorize and direct all private and public insurers who have responsibility for payment of services to directly pay Capital Area Psychiatric Associates, PLLC. I authorize and direct any person or corporation having notice of this assignment to directly pay Capital Area Psychiatric Associates, PLLC all medical, liability or other insurance or third party benefits. I understand that I am financially responsible to Capital Area Psychiatric Associates, PLLC for charges applied to the insurance deductible and for all charges not paid by the insurance company (see Medicaid special provision below).

Release of Information for Payment: I authorize Capital Area Psychiatric Associates, PLLC to disclose any and all parts of my medical record and health information, which may include health information pertaining to psychiatric, drug and alcohol abuse conditions, AIDS, AIDS-related conditions, or HIV, for the purpose of review and payment as required by Medicaid, Medicare, and / or

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(Insurance Company / or Third Party Payer)

Medicaid Special Provision: With the exception of applicable co-pays, Medicaid recipients may not be held liable for any charges not paid by the Medicaid program. It is the responsibility of the recipient of services to present a Medicaid card each month and to inform Capital Area Psychiatric Associates, PLLC of any changes in Medicaid status, to include loss of benefits, to avoid financial liability.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any problems so that we can assist you in the management of your account.

_______________________________ _______________

Signature of Person Receiving Services Date

_______________________________ _______________

Signature of Legally Responsible Person Date

OFFICE POLICIES

We appreciate the opportunity to work with you and/or your family. The following information describes the procedural matters important to our patients. Please read this material. If you have any further questions, feel free to discuss them with me.

Confidentiality: All communication between the therapist and patient is held in the strictest confidence unless: 1) The patient authorizes the release of information with a signature; 2) The therapist is ordered by the court to release information; 3) Child or elder/abuse neglect is suspected; 4) We become concerned for the safety of the patient or others. In the latter two cases we are required by law to inform legal authorities and/or potential victims. Federal law also allows for the communication without written consent between two ongoing or past treatment providers in order to facilitate your further treatment. Specific signed releases are required for the content of psychotherapy notes in all cases except as required by law.

Insurance: Most health insurance plans provide for some outpatient mental health benefits. Please note that we are considered a “non-participating provider” with most insurance companies and will not be able to receive payment directly from those insurance companies that we do not participate with. In such cases we receive payment only from the patients themselves. If we are not a member of your insurance plan or network you may be reimbursed by your insurance company at a lower rate than for “in-network providers”.

Generally, you should be able to collect directly from your own insurer if you follow these steps: We will give you a written statement at each visit to show what service you received that day and what you paid. This statement can be submitted to the insurance companies for reimbursement directly to you. You simply need to fill out your own insurance form, attach the statement, and send these to your insurance company, asking them to pay you rather than our practice. If there is no place to specify paying you rather than the doctor on the form then write the following in red somewhere on your insurance form: “PAY SUBSCRIBER, NOT PROVIDER.”

Please determine what your insurance plan requires of us in order to process a claim. We will make every effort to meet the insurance plan’s requirements. We will fill out the insurance treatment plans for patients who attend treatment more often than every 3 months. This will allow patients to obtain “medical authorization” for insurance to reimburse them at out of network rates. If the patient comes less frequently than 3 months we will also fill out treatment plans but at the cost of $45 per treatment plan. Be aware that these insurance companies often ask for fairly confidential information to “justify” treatment. It is your responsibility to learn what coverage is provided by your insurance plan and to submit insurance claims.

Payment: All payments and copays are due in full at the end of each session. Accounts more than 30 days in arrears may be assessed a monthly finance charge of 2%. Checks returned for insufficient funds will incur an additional fee of $30 as well as the original charge.

Professional Fees:

The following is a brief listing of professional fees and is not comprehensive -

Initial Evaluation/Single Consultation Evaluation, New Patient: $280

Individual Session (45 minutes): $180

Family Session (45 minutes): $180

Medication Management (15 minutes): $80

Routine Follow-up with counseling (25 minutes): $130

Court Appearance: $600, plus billing at an hourly rate of $200 for preparation, transit time, pre-trial meetings, and total time required during actual court appearance.

Cancellation Policy: When you agree to a scheduled time, that time frame will not be offered to another individual. Often this means that patients need to be turned away because an adequate alternative time could not be found. Cancelled and missed session cannot always be filled. For these reasons you are asked to assume responsibility for your scheduled time. Therefore, you will be expected to pay for your appointment even if you do not come; unless you cancel prior to 24 hours before the scheduled time. However, there will not be a charge for a genuine emergency, or if your time can be filled by another patient at the last minute. Any initial appointment no-shows will result in no further appointments for the next 6 months. Frequent no-shows may result in termination of our clinical relationship and referral elsewhere.

Messages/Emergencies: You can leave messages by calling (919) 237-9081 throughout the week and weekend. We will make every effort to return calls promptly. Occasionally, however, there may be a delay. If it is an emergency, please follow the instructions on the voice mail to reach us directly. If for some reason you are not able to immediately contact us, in the case of an emergency, you should either call 911 or contact the emergency room of your local hospital.

Coverage: When your provider is away or unavailable, coverage will be arranged with another psychiatrist. If it necessary to visit that other psychiatrist while your provider is away his or her professional fees and policies apply to that visit. Our voice mail will state which doctor is covering.

As the patient or legal guardian of the patient please sign the line below indicating that you have read, understand, and agree to these policies/procedures:

Signature: ____ Date: ____________________

Consent for Child & Adolescent Outpatient Treatment

I, the undersigned, am the legal guardian of ____,

date of birth ________________________, a minor child. I agree to his/her outpatient psychiatric

treatment and/or assessment with Capital Area Psychiatric Associates. I have been informed the risks and benefits of psychiatric treatment. I understand that I have the right to refuse treatment or withdraw consent for treatment at any time and this refusal shall not be used as the sole grounds for termination or threat of termination of services unless the intervention refused is the only viable treatment option available at this clinic as outlined in North Carolina Administrative Code and General Statues - 10A NCAC 27D .0201, G.S. 122C, 10A NCAC 27D .0303 (c), G S § 122C-57, General Statutes 122C-51,NCAC 27G .0205. I grant permission to Capital Area Psychiatric Associates to seek emergency medical care from a hospital or physician for my child listed above if it should prove necessary during the course of treatment.

____ ____

Signature of Parent/Guardian/Authorized Representatives Print Name

__________________________ __________________ ____

Relationship Date Witness Signature

Privacy Practice Notification

The signature below is to acknowledge that I was provided a copy of notice of privacy practices for Capital Area Psychiatric Associates, PLLC.

Signature: ____ Date: __________________

Patient name: ______________________________________ MRN:____________ Medicaid ID: _________________

Client’s Rights Notification

The signature below is to acknowledge that I was educated about and provided a copy in writing of client’s rights by Capital Area Psychiatric Associates, PLLC which included information about my right to contact Disability Rights North Carolina.

Signature: ____ Date: ____________________

Patient name: ____________________________________ MRN:___________ Medicaid ID: ________________

Capital Area Psychiatric Associates, PLLC

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our office and ask to speak to the Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object
We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:
Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a

member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.
Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (919)237-9081 **or info@capitalpsychiatry.com** for further information about the complaint process.

This notice was published and becomes effective on **06/22/2012.**

Patient name: ____________________________________ MRN:___________ Medicaid ID: ________________

CLIENT RIGHTS

Capital Area Psychiatric Associates, PLLC, abides by policies of the state and federal government in assuring basic human rights to all clients served. Below is a summary of rights that you, as our client, will be guaranteed.

1. You have a right to receive treatment which includes access to medical care and habilitation (being supplied with the means to develop maximum independence)free of discrimination that may be based on race, color, creed, national origin, sex, age, disability, degree of mental illness, substance abuse, sexual orientation, or gender expression.

2. You have the right to refuse treatment as described in NC General Statutes General Statutes 122C-51 NCAC 27G .0205 without the threat of termination of services except as outlined in the statute.

3. You have the right to contact Disability Rights North Carolina (formerly the Governor's Advocacy Council for Persons with Disabilities).

4. You have a right to dignity, privacy, humane care, and freedom from physical punishment, abuse, neglect, coercion, and exploitation.

5. You have the right to live as normally as possible while receiving care and treatment, with all the civil rights of any other citizen of North Carolina, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil action, and marry and divorce.

6. You have the right to receive care, services and treatment based on a Person-Centered Plan (PCP) written especially for you, which must be available for your approval within 30 days of your admission to Capital Area Psychiatric Associates, PLLC.

7. Before you agree to your PCP, you will be informed of the benefits or risks involved in the services you receive.

8. While you are receiving services, you have a right to be free from unnecessary or excessive medication of any kind. You have a right not to have medication used as a punishment, for discipline or for the convenience of staff.

9. You have the right to receive services voluntarily and will be free from any involvement in research projects without your expressed consent.

10. You cannot be treated with electroshock therapy, experimental drugs or procedures, or be given surgery unless it is emergency surgery without your written permission.

11. If you have asked to receive services, you always have a right to agree to or refuse any specific treatment. The ONLY time you can be treated without your consent is

In an emergency;

If your treatment has been ordered by the court, when more than one professional agrees that you need that specific treatment in order to improve or to prevent harm;

or

If you are less than 18 years old, and your parents have given permission over your objections.

12. Physical restraints or seclusion may not be used. It is the policy of Capital Area Psychiatric Associates, PLLC, to utilize non-violent crisis intervention. If there is immediate danger of abuse or injury to yourself or other persons, or substantial property damage is occurring, Agency staff will call 9-1-1 for assistance and staff will not themselves intervene. Capital Area Psychiatric Associates, PLLC, does not inflict corporal punishment on any client.

13. You have the right to make a complaint if you feel your rights are violated, without fear or retaliation or barriers to services. You have the right to have your complaint considered in a fair, timely, and impartial manner.

14. You have a right to keep private your records as a client with Capital Area Psychiatric Associates, PLLC. Any information about your care, including the fact that you are receiving services, is confidential. Capital Area Psychiatric Associates, PLLC, will not disclose your health information without your authorization unless required or allowed by State and Federal laws, rules, or regulations. A full description of your privacy rights and Capital Area Psychiatric Associates, PLLC, obligations to maintain your privacy are found in the accompanying Notice of Privacy Practices.

15. When you become 18, upon your request, you may have any court records related to your being here destroyed.

16. Client rights may not be restricted except under very strict rules. Restrictions will be made only by a Qualified Professional.

For any further clarification of your rights, contact Capital Area Psychiatric Associates, PLLC, Hasan A. Baloch, M.D. at (919) 237-9081 or hasanbaloch@capitalpsychiatry.com.

You can also gain further information regarding your rights from the following agencies::
The NC Mental Health Consumer's Organization, Inc.: 1-800-326-3842
The NC Careline: 1-800-662-7030,
Disability Rights North Carolina
Toll-free: 1-877-235-4210; Phone: 1-919-856-2195; Fax: 1-919-856-2244
Website: http:www.disabilityrightsnc.org
Email: info@disabilityrightsnc.org
Postal: 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608, Department of Health Service Regulation: 1-800-624-3004