Connecticut Institute of Behavioral Health Inc.
495 Gold Star Hwy Ste 220 Groton, CT 06340
(P) 860-326-5405 (F) 860-326-5571

NEW PATIENT PAPERWORK

Client Name: ____

Date of Birth: _______________________ Age: ________ Social Security #: _______ - ____ - _______

Male: _____ Female: _____ Other: ____________________________

Address: _______________________________City: ___________State: _____ Zip Code: ________

Home Phone: ____________________________ Cell Phone: _______________________________

Work Phone: _______________________Email: ____

Are you currently employed? Yes_____ No____ Employer:__________________________________

How would you prefer the office to contact you?

Email ____ Cell phone _____ Home phone _____ Can we leave a message? Yes_____ No_____

Emergency Contact Name: ____

Relationship to client: ________________________________ Phone: ________________________

Race:

American-Indian _____Asian _____Black _____White _____Hispanic/Latino _____Other____________

Dependence & Illicit Substance Abuse History:

Do you smoke? Yes / No If yes, how many packs a day? ________ How many years? ________

If you are a former smoker? Yes / No What year did you quit? _______________

Do you drink Alcohol? Yes / No Type: Beer Wine Liquor How many: ______________

Frequency: Socially Minimally Infrequently Frequently

Drug Use: Yes / No If yes, what type: _______________ Other Habits: ______________________

Connecticut Institute of Behavioral Health Inc.

Pharmacy:

Pharmacy Name: ______________________________________ Phone: _______________________

Address: ____________________________City: ____________ State: _____ Zip Code: ____________

Your most recent:

Height: __________________ Weight: ________________ Blood Pressure: _______________

Current Medications & Doses:

Please list all prescriptions and over the counter medications that the client is currently taking.

Medication	Dose	Directions	Prescriber

Allergies:

Please list all medication allergies and the reactions of the client

Allergy / Medication	Reaction	Allergy / Medication	Reaction

Informed Consent for Medication and / or Psychotherapy:

I, give my consent to be treated with medication. I will discuss the possible risks and side effects and will have access to the prescribing physician/nurse if I have any questions or problems with my medication. It is my responsibility to notify you of problems with the medication and follow up with my medication appointments.

I, give consent for treatment using the following modalities: individual psychotherapy, family therapy and/or group therapy per my individualized Treatment Plan discussed with my therapist.

____ ________________

Signature of Client or Authorized Legal Representative Date

Connecticut Institute of Behavioral Health Inc.

CLIENT INSURANCE INFORMATION:

Bills should be sent to (***if other than patient***):

Name: ____ DOB: _________________

Relationship to patient: _________________ Address: ________________________________

City: ____________________________ State: _________ Zip Code: ____________________

PRIMARY INSURANCE:

Subscriber's Name: ____

Date of Birth: ___________________ Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___

Patient's relationship to insured (circle one): Self Spouse Child Other

Insured's Employer: __________________________________ Effective Date: _____________

Insurance Company: _______________________ Insurance Company Phone: ____________

Insurance ID #: ____________________________ Group #: ___________________________

SECONDARY INSURANCE:

Subscriber's Name: ____

Date of Birth: _____________________ Social Security#: ___ ___ ___ - ___ ___ - ___ ___ ___

Patient's relationship to insured (circle one): Self Spouse Child Other

Insured's Employer: ____________________________________ Effective Date: ___________

Insurance Company: _____________________ Insurance Company Phone: ______________

Insurance ID #: ___________________________ Group #: ____________________________

I authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Connecticut Institute of Behavioral Health Inc for services rendered to me or my dependent by Connecticut Institute of Behavioral Health Inc. Should my insurance carrier deny Connecticut Institute of Behavioral Health, Inc payment, I understand that I am financially responsible for the charges.

I authorize Connecticut Institute of Behavioral Health Inc. to release any and all of my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information when any changes occur.

____ _______________

Signature of Client or Authorized Representative Date

FINANCIAL POLICY:

We, the staff at Connecticut Institute of Behavioral Health Inc. thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact the office manager. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff. We make payment as convenient as possible by accepting cash, money order, MasterCard, Visa, Discover and checks. A $20.00 service fee will be charged for all returned checks.

Insurance:

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. **When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.** Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out of network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments:

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee will apply. These fees are $50.00. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

____ _______________

Signature of Client or Authorized Representative Date

Connecticut Institute of Behavioral Health Inc.

Consent to Use and Disclose Your Health Information:

This form is an agreement between you and Connecticut Institute of Behavioral Health Inc. When we use the term "you" or "your", we are describing the patient and / or the authorizes representative that has been designated.
When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

***If you do not sign this form agreeing to our privacy practices, we cannot treat you*.** In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

GENERAL OFFICE POLICY:

Confirmation calls:

- ✓ Confirmation calls are a courtesy. It is the clients' responsibility to keep their appointments or cancel them, no less than 24 hours before the appointment. Connecticut Institute of Behavioral Health Inc., charges for all missed or late cancelled appointments.
- ✓ It is our policy to discharge clients who miss or late- cancel three appointments in a six-month period, even if these incidents are not consecutive.

Medication Refills:

- ✓ We require 24-72-hour notice to your medications running out.
- ✓ Controlled substances will only be written out or called into a pharmacy for a quantity that will be enough medication until the next scheduled appointment.
- ✓ No medication will be called in a patient that has not been seen in the office for over a 3-month period and does not have a scheduled follow-up appointment.
- ✓ Lost or mis-utilized medications will not be replaced until client is seen by the prescriber and a valid / verifiable reason is given.

Paperwork/Forms:

- ✓ If you request a letter, form or document to be completed, we have 10 business days to complete your requests.
- ✓

Medical Records request:

- ✓ If you request records of any kind, we have 30 days to completer your request**.**

____ ________________
Printed name of Client DOB

____ ________________
Signature of Client or Authorized Legal representative Date

Connecticut Institute of Behavioral Health Inc.

CONTROLLED MEDICATIONS ADHERENCE POLICY

We, at CIBH, realize that controlled medications (stimulants, anxiolytics, etc.,) can be an essential part of the medication regimen our clients need in order to maximize their symptom control and their level functioning.

Unfortunately, these medications have in the past been over used (taken in higher than prescribed), misused (taken by other route than they were intended for) or diverted (given to people other than the patient intentionally or unintentionally).

While we believe that the vast majority of our client do use their medications in an appropriate and responsible fashion, we also believe that addiction is a very powerful disease that can make people behave in ways that defy logic and moral values.

In order to maintain the integrity of our programs and assure the proper utilization of all controlled medications, the following rules will apply:

- All clients on controlled medications will agree to fill all of their prescriptions at one pharmacy. They will notify CIBH if they need to change their pharmacy for any reason.
- All medications must be used as prescribed and without any adjustments or modifications unless discussed and authorized by the prescriber.
- It is the responsibility of each client to protect and guard their medications. Stolen, lost or damaged medications will be replaced one time only. Second such incidents will result in discontinuation of the controlled medication in the way the provider sees clinically fit.
- The amount of controlled medications prescribed will be carefully calculated by prescribers to assure that the supply will last only until the next scheduled visit. Prescriber can give less amount as he assesses the need to control the amount dispensed.
- All clients receiving controlled medications will inform their other physician(s) about being on those medications. Having controlled medications prescribed by more than one prescriber, without the proper notification, can be reason for discharge. We can easily find this out by checking the Connecticut Registry for Controlled Prescriptions.
- All clients on controlled medications will agree to submit a urine sample on a regular or random basis, as requested.
- All clients on controlled medications will agree to, and comply with, any random medication count the provider may deem necessary.

It is our goal and intention to provide all of our clients with the most clinically sound and safe environment to address their needs successfully.

____ ____________________

Printed name of Client DOB

____ ____________________

Signature of Client or Authorized Legal representative Date

Connecticut Institute of Behavioral Health Inc.

TELEPSYCHIATRY INFORMED CONSENT

Patient Name:____ Date Of Birth:_______________

Telepsychiatry is a form of telemedicine that allows clients to access psychiatric care using electronic communications to enable health care providers at different locations to share individual client medical information for the purpose of improving client care. The information may be used to diagnosis & treat, psychotherapy, follow- up and / or client education.

Purpose

The purpose of this form is to obtain your consent to participate in our telepsychiatry services.

Benefits of Telepsychiatry

- Improved access to psychiatric care by enabling a client to remain at his / her own home or office.
- More efficient psychiatric evaluation and management

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the mental health professions.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

Medical Information & Records

All existing laws regarding your access to medical information and copies of your medical records apply to telepsychiatry services. Please note that telecommunications are not recorded or stored.

Confidentially

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data to ensure its integrity against or unintentional corruption.

By signing below, you are acknowledging that you agree to participate in telepsychiatry services.

Signature of Client or Authorized Legal Representative: ____________________________ Date: ______________

Printed name of Client or Authorized Legal Representative: ____