Connecticut Behavioral Health Associates, P. C.

NEW PATIENT PAPERWORK

For Office Use Only: Accepted:______ Entered:_______ **ID Present**: Yes/ No **Insurance Card Present:** Yes/ No

Client Name: ____ DOB: _______________ Age: _______

Address: ______________________________________ City/State/Zip: _______________________

Social Security #: _______ - _____ - _______ ☐ Male ☐ Female ☐ Other: ____________________

Home Phone: _______________________________ Cell Phone: _______________________________

Work Phone: _______________________________ Email: ___________________________________

Are you currently employed? ☐YES ☐NO Occupation: _______________________________

Race: ☐ American-Indian ☐ Asian ☐ Black ☐ White ☐ Latino/Hispanic ☐ Other

Emergency Contact Name: ______________________________ Relationship: __________________

Contact Phone: ______________________________ if okay to release information, consent must be signed.

Form Completed By: ☐Self ☐Parent ☐Spouse ☐Legal Representative ☐ Other

If you are the Authorized Legal Representative (ALR), what type of legal documents are you presenting w/today?

☐ Conservatorship ☐ POA ☐DCF ☐Assigned by Court ☐ Other: ______________________

GENERAL OFFICE POLICY

Please read and review page 8 of the new patient paperwork entitled "General Office Policies". Please sign to confirm that the client or authorized legal representative is aware of and in agreement with CBHA's company policies. Please retain page 8 for your records.

Signature of Client or ALR: ____ Date: ____________________

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Client Name: ____ DOB: ___________________

Pharmacy Name: _______________________________________ Phone: ________________________

Address: ___________________________________ City/State/Zip: ___________________________

Your most recent: Height: _________ Weight: _________ Blood Pressure: ______________

CURRENT MEDICATIONS & DOSES

Please list all Prescription and Over the Counter medications that the client is currently taking

Medication	Dose	#times per day	Prescriber	Medication	Dose	#times per day	Prescriber

ALLERGIES:

Please list all medication allergies and the reactions of the client

Allergy/Medication	Reaction	Allergy/Medication	Reaction

DEPENDENCE & ILLICIT SUBSTANCE ABUSE HISTORY:

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day & for how long? ______________

If you are a former smoker, how long has it been since you quit? ___________________________

Do you drink Alcohol? ☐Yes ☐No **Type:** ☐Beer ☐Liquor ☐Wine

How many: ___________ **Frequency:** ☐Socially ☐Minimally ☐Infrequently ☐Frequently

Drug Use: ☐ Yes ☐ No If yes, what type: ______________________________

Other Habits: ☐ Yes ☐ No If yes, please specify: ______________________________

Client Name: ____ DOB: ____________________

INFORMED CONSENT TO TREAT FOR MEDCATION 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 ALR: ____ Date: ____________________

TELEPSYCHIATRY INFORMED CONSENT

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 professionals
- 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.

Confidentiality

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 intentional or unintentional corruption.

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

Signature of Client or ALR: ____ Date: ____________________

Client Name: ____ DOB: __________________

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you and Connecticut Behavioral Health Associates, P.C. When we use the term "you" or "your", we are describing the patient and/or the authorized 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 we do change it, you can get a copy from any of our office locations, or by calling us at (860) 437-6914.
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.

Signature of Client or ALR: ______________________________________ Date: ____________________

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CLIENT INSURANCE INFORMATION

Client Name: ____ DOB: ___________________

PRIMARY INSURANCE INFORMATION

Subscriber's Name: ____

Subscriber's Date of Birth: ___________________ Subscriber's Social Security #: ___________________

Client's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Employer: _________________________________ Effective Date: _____________________

Insurance Company: _____________________________ Insurance Company Phone: _________________

Insurance ID#: ____________________________________ Group #: ____________________________

SECONDARY INSURANCE INFORMATION

Subscriber's Name: ____

Subscriber's Date of Birth: ___________________ Subscriber's Social Security #: ___________________

Client's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Employer: _________________________________ Effective Date: _____________________

Insurance Company: _____________________________ Insurance Company Phone: _________________

Insurance ID#: ____________________________________ Group #: ____________________________

Bills should be sent to (if other than client):

Name: ____ Relationship to client: ___________________

Address: ____ City: ___________________________

State: _____________ Zip Code: ______________________ Date of Birth: _______________________

Email: ____ Social Security #: ______________________

Home Phone: _________________ Cell Phone: __________________ Work Phone: _________________

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

I authorize Connecticut Behavioral Health Associates, P.C. 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 ALR: ____ Date: _____________________

Connecticut Behavioral Health Associates, P. C.

NEW PATIENT PAPERWORK

Client Name: ____ DOB: ____________________

FINANCIAL POLICY

We, the staff at Connecticut Behavioral Health Associates, P.C. (CBHA) 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 clients' financial responsibility is vital to that provider-client 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 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-client 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. **Also, a service fee of $15.00 will be charged for all copayments not paid at the time of service.**

Collection Fees
Collection fees of 29% will incur if a balance is sent to our collection agency.

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 clients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect clients 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 client's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate client 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.

Miscellaneous Forms, Additional Information and Authorizations
We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extra-curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments
We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another client. 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 ALR: ____ Date: ______________________

Client Name: ____ DOB: ____________________

CONTROLLED MEDICATIONS ADHERENCE POLICY

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

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

While we believe that the vast majority of our clients 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 CBHA 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. In case that visit does not take place because of prescriber or client related reasons, an additional amount of the medication can be prescribed until the date of the new appointment.
- 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 the prescriber may deem necessary and appropriate. Avoidance or refusal to submit a urine sample when requested shall be interpreted as providing a dirty urine.
- 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.

Signature of Client or ALR: ____ Date: ______________________

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NEW PATIENT PAPERWORK

GENERAL OFFICE POLICY

Clients should always try to contact the office they are seen in for any questions before contacting other office locations.

New London	**(860) 437-6914**	**Norwich**	**(860) 823-1399**	**Pawcatuck**	**(860) 572-8834**
Groton	**(860) 449-0200**	**CSS**	**(860) 552-7305**	**Plainfield**	**(860) 564-2242**
Old Saybrook	**(860) 391-8661**	**New Britain**	**(860) 223-1111**	**Southington**	**(860) 276-9295**
Hamden	**(203) 691-7634**	**Glastonbury**	**(860) 780-2262**		

Confirmation calls:

- Confirmation calls are a courtesy. It is the clients' responsibility to keep their appointments or cancel them. We require 24 hours notice when canceling an appointment. CBHA charges for all missed or late canceled 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.
- Clients who are not seen in more than a six month period of time, without provider approval will be considered discharged from the practice. In order to reschedule any further appointments the client will be directed back to intake to assess client appropriateness. *It is not guaranteed that the client will be accepted back or that they will be scheduled with their previous medical provider.*

Medication Refills:

- We require 48-72 hours notice prior to your medications running out.
- Please contact the pharmacy to request a refill of your medications and speak with a pharmacist directly to confirm that no previous scripts are remaining on file before contacting the office.
- Controlled substances will only be sent to the pharmacy for a quantity that will be enough medication until the next scheduled appointment.
- No medication will be called in if a client has not been seen in the office for over three months.
- No medication will be called in if a client does not have a scheduled follow-up appointment.
- Lost or miss-utilized medications will not be replaced until client is seen by the prescriber and a valid/verifiable reason is given. A police report may be required.

Paperwork/Forms:

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

Medical Records Request:

- If you request records of any kind, we have 30 days to complete your requests.

Exceptions to any of the above rules can be made only by the prescribing physician or APRN.

Connecticut Behavioral Health Associates is proud to be a SMOKE FREE Establishment.

- There is absolutely no smoking of any products on company grounds.
- Clients are also asked not to loiter before or after office hours.

This copy is for the client to take home and to keep for their records. Page one of the new patient paperwork has been signed, confirming that the client or authorized agent is aware of and understands CBHA's company policies, and is in agreement to follow said policies.