CONNECTICUT CENTER
FOR PSYCHIATRIC WELLNESS

136 Sherman Avenue – Lower Level Suite #6 • New Haven, Connecticut 06511
(Phone) 203-680-0030 (FAX) 800-621-4166
www.CTMentalHealth.info

NEW PATIENT INFORMATION PACKET

Thank you for your trust in The Connecticut Center for Psychiatric Wellness. As an innovator in the practice of helping people manage their psychological wellbeing, the staff and your practitioner will work with you in the areas necessary for achieving your goals. We recognize that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The provider will strive to help you grow toward greater health and wholeness by providing counseling services and ask for your cooperation in seeing to it you maintain your course of care, keep your appointments, are honest with us, and work diligently as we administer appropriate and responsible psychopharmacologic, psychotherapeutic and psycho-social rehabilitation interventions. Completing the information here is the first step in this process.

In addition to gathering the information necessary to help you on your journey, this packet will also explain:

- ✓ Your rights
- ✓ Your expectations
- ✓ Your responsibilities
- ✓ And most of all… Treatment steps towards improving your quality of life.

CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT CLEARLY)

PERSONAL INFORMATION

Patient Name (First, Middle, Last):		Date of Birth:	Today's Date:
Street Address:		City, State, Zip Code:	
Sex at Birth: ❑Male ❑Female	Social Security Number:	Driver's License or Other ID Number:	State:
Home Phone Number:	Cell Phone Number:	E-mail Address:	
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed ❑Other		If Married, Name of Spouse:	
Employer Name and Location:		Employer Phone Number:	
Emergency Contact Name and Relationship:		Emergency Contact Phone Number:	

HEALTH INSURANCE

Name of Health Insurance Company:	Name of Insured:
Insurance Company Address (If Known):	City, State, Zip Code:
Group, Plan, or Patient ID Number (Please Present Insurance ID Card):	Insurance Company Phone Number:

Please List Any Medications You are Currently Taking:	Are you Capable of Making Your Own Medication Decisions?: ❑Yes ❑No
Please List Any Recurring Medical Problems You Have (Diabetes, High Blood Pressure, Cancer, Etc.):	
Please List Any Recurring Medical Problems Experienced by Your Immediate Family:	

Are You Pregnant? ❑Yes ❑No ❑Maybe		If Yes, How Far Along are You? ❑0-3 Mos. ❑3-6 Mos. ❑6-9 Mos. ❑Unknown	
Do You Smoke? ❑Yes ❑No	If Yes, How Often?	Do You Drink Alcohol? ❑Yes ❑No	If Yes, How Often?
Do You Currently use Recreational Drugs? ❑Yes ❑No	If Yes, Which Ones, How Often?	Are you in recovery from any Substance Addiction? ❑Yes ❑No	If Yes, Which, and How Long?

What areas concern you most that you'd like to address with your provider?
(This section is optional but answering honestly will help your provider begin to understand your concerns, or help match you with the right specialized provider, should you not have one in mind upon being accepted as a patient.)

Area of Concern	Intensity of Concern	How Often This Concern Impacts your Daily Life	Duration of Concern Months or Years
General Anxiety/Depression	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
ADD/ADHD	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Eating Disorder	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Sleeping Disorder	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Gender Related Issues	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
LGBTQIA+ Related Issues	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Stress/Trauma/PTSD	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Addiction:	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Headache or other Manifestations of Pain	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Other:	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.
Other:	1 2 3 4 5 6 7 8 9 10	Constant Frequent On/Off	_____Mos. _____Yrs.

→ My Preferred Pharmacy & Branch:_____

Please note that in addition to the information contained in this packet, you will also need to submit:

- ✓ Copy of the patient's official identification (If minor, copy of parent/guardian ID as well)
- ✓ Recent photo of the patient
- ✓ Copy of the front and back of patient's (or member's) insurance card
- ✓ Minor Consent Form, if the patient is under 18 years of age at the time treatment is beginning

YOUR RIGHTS

As a patient of CCPW, we want you to be comfortable with your experiences in our practice and be aware of your rights and responsibilities. At any time, you are free to confidentially discuss such experiences, positive or negative, with your provider and/or senior management without fear of judgment, retribution, or retaliation.

1. You have the right to be heard, respected, treated kindly with dignity in our practice at all times.
2. You have the right to privacy and confidentiality. Records that would identify your person, manner of treatment or your diagnosis cannot be given to any other person or agency without your written consent, except as permitted by law.
3. You have the right to receive humane and dignified treatment at all times, with full respect for your personal dignity and right to privacy. A specialized treatment plan will be developed in accordance with your needs. Any treatment plan will include, but not be limited to, reasonable notice of discharge.
4. You have the right to be actively involved in developing your own recovery plan and to get services that provide specialized treatment specific to your disorder. With your consent, you have the right to have a person of your choice advocate for you with CCPW.
5. Psychiatric medical records typically obtain sensitive material which may cause distress and an exacerbation of a patient's illness if reviewed by the patient. As is standard in practice, we do not release records to patients. Record forwarding is rare, and will be decided on a case by case basis, unless subpoenaed. All efforts will be made to assist other licensed health care professionals involved in your care. Your provider may refuse to disclose any portion of the record which the provider has determined would create a substantial risk that you would inflict a life-threatening injury to self or others, experience a severe deterioration in mental state or would constitute an invasion of the privacy of another.
6. You have the right to file a grievance if any of the CCPW Providers have:
    a. Violated your right provided by law;
    b. Been treated in an arbitrary or unreasonable manner;
    c. Denied services authorized by a treatment plan due to negligence, discrimination, or other improper reasons;
    d. Engaged in coercion to improperly limit your treatment choices;
    e. Failed to treat you in a humane or dignified manner.
        i. If you are aggrieved, you may petition the Superior Court within whose jurisdiction you reside for appropriate relief.
7. You always have the right to know your provider's credentials, you have the right to ask for a second opinion and you always have the right to question the focus of your sessions. You have a right to obtain a copy of your Protected Health Information (PHI), subjected to certain limitations prescribed by law. You have the right to end your counseling at any time, except when that treatment is required by law.
8. Throughout your treatment plan, you have the right to:
    a. Have you mental health questions answered.
    b. Know what medication, treatment or anesthesia will be given.
    c. Know the risks, benefits, and side effects of treatment.
    d. Know what alternative treatments may be available.
    e. Ask for changes in treatments if your mental health symptoms persists.
    f. Receive compassionate and sympathetic care.
    g. Receive required medication on a timely basis.
    h. Refuse treatment without prejudice from your provider.
    i. Include your family or caregiver(s) in decision-making.

YOUR RESPONSIBILITIES

CCPW considers you, the patient, a partner in your care. As such, you have some responsibilities as well. Among these responsibilities are to:

1. Respect the dignity and privacy of others including providers and other patients.
2. Give your provider information that they need to serve you better.
3. Work with your provider to develop a treatment plan and ask questions when you do not understand your treatment.
4. Follow the treatment plans you developed with your provider, including keeping appointments.
5. Tell your provider if you do not agree with your treatment plan.
6. Contact your provider if you want to stop your treatment.
7. Keep your appointments or contact the office if you need to cancel or reschedule your appointment, at least 24 hours in advance of the appointment.
8. Notify the office if you move and change your address/phone number.
9. Ask your provider if you have questions about your responsibilities.
10. Understand that you can be terminated from treatment if you miss an excess of appointments within a time period that your provider considers creates an unsafe situation and that your provider is under no obligation to refill prescribed medication.
    a. The aforementioned outcomes are based solely on the clinical judgment of the provider.
11. Inform CCPW if you are near the end of your medication supply and without a follow up appointment That will allow for adequate time to refill the prescription.
12. Understand that if prescribed, Medication prescribed needs to be taken as directed and if it is not, the prescriber of said medication needs to be informed of the nonadherence to prescription.
13. Understand that any prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, or accidentally destroyed), I may not receive a replacement from my provider. CCPW expects me to file a police report if my medication is stolen.
14. Permit CCPW staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.
15. Understand the following additional rules and policies related to medication prescriptions and refills:
    a. CCPW will not refill a prescription at the request of a pharmacy because such requests are not always based on clinical need or prescribed treatment plan.
    b. CCPW will only refill prescriptions at the request of the patient when clinically necessary and appropriate.
    c. You must call the office to request a refill and have an appointment scheduled for a future visit.
    d. Refills can take up to 48 hours during weekdays, and longer on weekends/holidays. It is therefore your responsibility to know when you will need a medication refill.
    e. Your provider may not honor a refill until the next available appointment.
16. Understand that Health Insurance is subscribed to by the patient and so it is the patient's responsibility to be informed of the insurance rules, copay and deductible amounts.
    a. Both parties agree that the provider will make every effort to consult as to patient cost for care however, this information is subject to source error and therefore ultimately the responsibility of you, the patient.
    b. Payment of copay and/or deductible is due in full at each visit.
    c. Further information on the payment policy is included in this packet.
17. During all visits your provider will provide an adequate amount of education as to the expectations of treatment, medication, referrals, administration, benefits and side effects of medications. If you have questions that you feel cannot wait until your next scheduled visit our office offers an "out of session" visit, usually available the same day at a fee of $75 which is not covered by insurance.

SPECIAL CONSIDERATION FOR THE PRESCRIBING OF CONTROLLED SUBSTANCES

A controlled substance is a medication with a likelihood for physical and mental dependence, and fall into a category between Schedule I through Schedule V. This doesn't mean they are inherently dangerous or should be avoided, however they should be administered and used very responsibly. This responsibility lays with the prescriber (your doctor or provider) and equally as important, you - the patient. Pharmaceuticals (controlled and not controlled) are just one set of therapeutic tools available to your provider at CCPW. Your mental health well-being is paramount and if medications of any type are used in your therapy, it is done with the most judicious consideration of your individuality and potential for benefiting from such therapies. But as such, you must be aware of, and committed to the policies as it relates to using controlled medications.

The use of controlled medications such as opioids, stimulants, anxiolytics and benzodiazepines are effective to maximize treatment outcomes, improve a patient's level of functioning and are an important part of any medication regime recommended by your provider.

It's unfortunate that these medications have a history of being overused, misused, or even given or sold to people for whom the medication was not intended. Also, these medications have a considerable tendency towards dependency and addiction and can cause unpleasant and even dangerous withdrawal symptoms. CCPW recognizes that addiction is a very powerful disease, is somewhat unpredictable and can cause individuals to act differently than their own moral values and logic would normally cause them to. In order to assure proper utilization of all prescribed controlled medications and to maintain the highest degree of professional integrity as well as the safety of our patients, CCPW insists upon the need to agree that the following rules apply to the prescription of your controlled medication:

- You Understand that if prescribed, controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else, such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy, or am not thinking clearly.
- You agree to use one pharmacy for your controlled medication prescription and will notify CCPW in advance if you need to change pharmacy for any reason.
- All controlled medication must be used as prescribed only, without any adjustments or modifications.
- It is your responsibility to guard and protect your medication. If it is stolen, lost, or damaged it will be replaced by prescription one time only.
    - Reporting a stolen prescription will require a police report before refilled.
- The supply of controlled medication is largely dictated by statute and will be calculated by your provider in a fashion such that the medication will last until the next scheduled visit, in consideration of prescribed dosing frequency. If a visit is cancelled by you, your provider, weather, or other acts of God, an additional supply of medication will be prescribed to last until the next available visit.
- Repeated cancellations will result in dismissal from care.
- It is dangerous to have controlled medications prescribed by more than one prescriber/physician. Therefore, it is your responsibility to notify CCPW if you are prescribed controlled medication by any other medical professional.
- Failure to do so will result in dismissal from care.
- CCPW will verify with the Connecticut Prescription Monitoring Program, as required by standard of practice, to determine if you are prescribed controlled medications and use this information in forming a prescribing decision.
- You agree to the possibility of a random or scheduled submission of a urine sample as deemed necessary and/or appropriate.
    - Refusal will result in dismissal from care.
- You agree to the possibility of random medication counts as deemed necessary and/or appropriate.
    - Refusal will result in dismissal from care.
- Any noncompliance with treatment is a basis for immediate discontinuation of care which includes the discontinuation of medication prescription. Taper doses will be provided only if deemed clinically necessary by your provider.

STATEMENT OF UNDERSTANDING REGARDING THE USE OF TELEMEDICINE

Telemedicine (Telemed, Telehealth) involves the use of electronic communication to enable patients to access patient care without having to attend sessions in their healthcare providers office. This service is allowable and effective for psychiatric and mental health services and is performed by live two-way audio and visual communication. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of the patient identification and data and will include measures to safeguard the data and to ensure integrity against intentional or unintentional corruption.

The benefits of telemedicine are recognized by CCPW and include such things as:

- Providing ease of access to care by mitigating such obstacles as transportation, childcare, work schedules, etc.
- Improving access to medical care by enabling a patient to remain in their home while the provider performs the consultation and obtains necessary results to make decisions and assist the patient with their mental health needs.
- Obtain the expertise of a distant specialist.
- Improve efficiency of healthcare evaluations and management.

CCPW has identified some potential risks associated with telemedicine that patients should know:

- Inadequate or unpredictable technology and/or connectivity between provider and patient.
- Insufficient transmission such as poor resolution of images to allow for appropriate medical decision making by the physician or nurse practitioner and consultant.
- Delays due to failures of the equipment or in rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In extremely rare cases a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

You have the right to decline telemedicine services at any time and opt to visit your provider in any of the CCPW offices.

Through signature affirmation on the last page of this packet, you as the patient consent to engage in telehealth with a CCPW provider part of your psychotherapy. You understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. You understand that telehealth may also involve the communication of my medical/mental information, both orally and visually, to health care practitioners.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, you understand that any information disclosed or disseminated through the course of evaluation and treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. The dissemination of any personally identifiable images or information from the telemedicine interaction shall not occur without your written consent.

You further acknowledge and understand you have the right to inspect all information obtained in recorded in the course of the telemedicine interaction and may receive copies of this information for a reasonable fee. There are a variety of alternative methods of psychiatric care that may be available, and such alternatives have been explained by the provider to your satisfaction. You further agree to inform my healthcare provider of electronic interactions regarding my care that I may have with other healthcare providers. And finally, you understand that there is an anticipated benefits from the use of telemedicine, but as is the same with non-telemedicine services, no results can be guaranteed or assured.

PAYMENT POLICY

To help provide the most efficient and reasonably priced health care services, it is necessary for CCPW to have a financial policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by CCPW.

We will assist you in any way we can to facilitate the settling of your account. It is essential for you to provide us with accurate and up-to-date insurance information upon **each encounter**. It is your responsibility to notify us of any changes in insurance so that claims can be filed correctly. Any error causing a delay in processing and payment, puts the burden of the bill on you. Although highly unlikely, approval from your insurance company does not guarantee payment. The patient is ultimately responsible for payment of the services rendered.

Health Insurance

It is our policy to file insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within the contractual time frame.

We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

Financial responsibility

Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier. CCPW accepts credit/debit cards through the online payment portal. An administrative re-billing charge of 10% of the balance owed will be assessed to each account over 30-days past due. 90-day past-due balances are subject to third party collection and/or litigation.

Co-Payments

Copayments for visits are due at the time of service. If you are unable to make your copayment at the time of service, CCPW reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Balances and payment plans

For patients who need financial arrangements, we will offer counseling and options that would fit their needs and capabilities. Balances need to be resolved before the next visit, unless a payment plan has been arranged. Payment plans need to be in good standing before each visit.

Self-pay

If you do not have health insurance, or if your health insurance will not pay for services rendered by our practice, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from management). Self-pay patients are expected to make payment in full at the time of service.

Scan to access your Patient Portal and Payment Options

APPOINTMENT POLICY

We understand that life happens… work, kid, transportation, even changed dinner plans happen. CCPW will work with you to make sure you keep your appointments at the most convenient time(s) for you. Particularly with mental health wellness, it's important to keep your appointments as scheduled for the continuity of care and maintenance of your treatment plan. Gaps in care can negatively impact your road to wellness. Additionally, if treatment includes the use of prescription medication, such medication may be prohibited from being refilled in the absence of a patient/provider encounter.

Appointments

Once accepted as a CCPW patient, all your encounters will require an appointment. All follow-up appointments will be clearly communicated and you will be reminded. However, you can always call the office if there are any questions regarding your treatment plan.

Late arrivals

We understand that there are times when you are late for an appointment due to emergencies or obligations for work or family. If you are running late, please call the office. In this case, we will make every effort to see you but you may have to be re-scheduled for another day.

Cancellations

If you are going to be late or have to cancel an appointment, you are urged to notify the office or your provider with as much time as possible. We will gladly reschedule you in the earliest available slot that would fit your schedule. Be advised that, due to the nature of our practice, we can only prescribe medications after a meaningful patient encounter, either in person or Telemedicine. This means if an appointment has to occasionally rescheduled, there may be a brief gap in the continuity of care.

No-Shows

We take all our patient encounters seriously and strive to offer each patient the best quality care they deserve. A "no-show" or a cancellation without 24-hour notice as a new patient may result in reduced access and the inability to reschedule an appointment. Therefore, in these cases, you may be responsible for an administrative cancellation fee of $75.

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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

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 that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of CCPW, and any other use required by law.

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 a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of CCPW. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical personnel that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law: Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

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 healthcare 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

By affirming with your signature on the next page, attesting to each clause in this packet, you are also acknowledging that you have read and understand this office's privacy policy and adherence to the HIPAA Ombibus Rule. You acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare organization. A copy of this document shall be as effective as the original. YOUR SIGNATURE WILL ASLO SERVE AS A PHI DOCUMENT RELEASE SHOULD YOU REQUEST TREATMENT NOTES OR OTHER DIAGNOSTIC REPORTS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. You also acknowledge and authorize that this office may recommend products and/or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

You consent to receiving appointment confirmation(s), healthcare information/records, treatment information, billing information, special services, and announcements related to your care by means of SMS messages, phone calls to your indicated primary contact number (including cellular), email, and/or fax. You may opt out of any of these communication methods by contacting your provider or the front office.

You may designate any party you wish to additionally receive information regarding your healthcare by alerting your provider or contacting the front office.

INFORMED CONSENT AND AGREEMENT FOR TREATMENT

Please review all the pages in this packet carefully and sign this document. If you do not understand any of the information contained on any of these pages or require additional clarification on the policies of this office regarding privacy practices, the prescribing of medications, or administration of therapies, please ask your provider or management.

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the provider I will be seeing at CCPW to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third-party payer to obtain reimbursement, unless I direct otherwise. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through a provider at CCPW at any time. I also understand that there are no guarantees that treatment will be successful. By signing this Acknowledgment of Informed Consent to Treatment, I acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this packet. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or a ward with a court approved guardian is the client I am signing on behalf of the minor or the ward as the authorized parent/guardian. (Information on minor rights will be shared with the minor, as appropriate.)

I have read the above Informed Consent, as well as all pages in this packet. I have had all my questions concerning this packet and/or my evaluation and treatment answered to my satisfaction. I agree to abide by the terms specified in this packet and further agree to abide by the special considerations listed on page 5 of this packet if I am prescribed controlled substances (including, but not limited to narcotic analgesics). I acknowledge having received a copy of this packet in its entirety, including information on federally-mandated privacy rights. By signing below voluntarily, I give my consent for the treatment in consideration of having all my concerns and questions addressed.

Please note, incomplete or inaccurate information provided by you in this packet may delay or adversely impact your care and treatment plan. You have a right to refuse to sign this acknowledgement and authorization but in doing so, we may not be able to administer some regulated therapies such as prescribing medication, nor will we be able to process insurance claims for payment on your behalf.

Patient's Signature_____ Date:_____

If the patient is a minor (<18 y/o) a minor-consent form must be addended to this new patient packet.

It is important this packet is submitted to your provider in enough time for your first appointment. You will also need a copy of your ID, Insurance card, and recent photograph.

Methods of Submitting this Completed Packet and additional required documentation:

- Drop off to your provider in person
- Fax to: 800-621-4166
- Scan and Email to your provider's ctcenterforpsychwellness.com email address
- Scan and Email to: office@ctmentalhealth.info
- Mail to: CCPW, 136 Sherman Avenue LL #6, New Haven, CT 06511-5238
- Electronic Signature Capturing Initiated by CCPW Front Office
    - Read and Understand the contents herein, before agreeing to Electronic Signature Capturing