

# Connecticut Psychiatric & Wellness Center

1 Bradley Rd

Suite 404

Woodbridge, CT 06525

Phone: (203) 285-6769 Fax: (203) 298-9453

## CLIENT REGISTRATION FORM

<b>Client Name:</b>		
<b>Intake Date:</b>		
<b>Date of Birth:</b>		
<b>*SSN:</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Email:</b>		
<b>Home Phone:</b>	<b>Cell Phone:</b>	
<b>Parent(s)/Guardian:</b>	<b>Phone:</b>	
<b>Emergency Contact:</b>	<b>Phone:</b>	
<b>Pharmacy Name:</b>	<b>Pharmacy Number:</b>	

### Consent for Treatment:

I, \_\_\_\_\_, give consent to be treated as a client by \_\_\_\_\_.  
(Parent if under the age of 18)

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Connecticut Psychiatric & Wellness Center

2446 Whitney Avenue, 2<sup>nd</sup> fl

Hamden, CT 06518

Phone: (203) 298-9005 Fax: (203) 535-0023

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## FEES & ATTENDANCE

If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be charged \$75.00. In the rare case of an emergency situation, cancellations made later than 24 business hours before the session may be accepted.

Payment is due at the time of service. We accept cash, personal checks and all credit/debit cards.

*For medication services, appointments that are missed or cancelled with less than 24 hours notice will NOT be rescheduled. There is a high demand for prescriber services and we cannot accommodate no shows or cancellations. For established patients if two appointments are missed we will not reschedule a third appointment or provide medication refills.*

We sincerely appreciate your cooperation and at any time you have questions regarding fees or payments please feel free to ask. You will be provided with a copy of this form. By signing below, I/We agree to comply with the above statements.

**Client:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(If under 18 years of age)

## TRANSFER PLAN

In the event of your clinician's death, disability, retirement or inability to provide counseling services, Connecticut Psychiatric & Wellness Center will possess and maintain your clinical records for a period of 7 years. After 7 years all records will be shredded and destroyed. By signing below, I/We agree to comply with the above statements.

**Client:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(If under 18 years of age)

# Connecticut Psychiatric & Wellness Center

2446 Whitney Avenue

Hamden, CT 06518

Phone: (203) 298-9005 Fax: (203) 535-0023

## Authorization for Access/Release/Exchange of Information

Patient Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

I hereby authorize Connecticut Psychiatric & Wellness Center to:

Release information to: \_\_\_\_\_  Obtain information from:

Name of person/Agency/Entity: \_\_\_\_\_

Address/Phone/Fax: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Information to be released or obtained; (*This consent authorizes the release of mental health information*)

VERBAL Format  WRITTEN Format

Information Requested: Please mark appropriate item(s):

Medical Records  Psychiatric and/or Medical Info including diagnosis

Psychological assessments and reports  Current Overall Plan of Service

Billing Records  Treatment  Medications

Psychosocial History  Progress Notes  School Records

OTHER (Please Specify) \_\_\_\_\_

I request access to my health information covering the dates \_\_\_\_\_ through \_\_\_\_\_. This consent, if not withdrawn, will expire on \_\_\_\_\_ or six (6) months from the date of signature. I understand that this permission can be revoked by me at any time upon written request, except to the extent that action has already been taken.

Signature of Patient or Patient's Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

\*If signed by the patient's representative, please print name and describe relationship to patient:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Connecticut Psychiatric & Wellness Center**

**2446 Whitney Avenue**

**Hamden, CT 06518**

**Phone: (203) 298-9005 Fax: (203) 535-0023**

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**Acknowledgment of Receipt of Notice of Privacy Practices**

I hereby acknowledge that I received a copy of Connecticut Psychiatric & Wellness Center's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

If not signed by the client, please indicate relationship:

- Parent/Guardian of minor
- Guardian or Conservator of an incompetent person
- Beneficiary or personal representative of deceased patient

Name of client: \_\_\_\_\_

Notice of Privacy Practices

Connecticut Psychiatric &  
Wellness Center  
1 Bradley Road Suite 905  
Woodbridge, CT 06525  
(703) 298-9005

**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.**

**A. How CPWC May Use or Disclose Your Health Information.**

CPWC collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of CPWC, but the information in the record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help when you are sick or injured.
- Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
- Health Care Operations.** We may use and disclose medical information about you to improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health information is prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications, and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

- Or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization to that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
- Required by law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to be relevant requirements of the law. What the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
- Public health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder, or dependent adult abuse or neglect; with products and reactions to medical devices; reporting to the Food and Drug Administration when we report suspected elder or dependent adult abuse or domestic violence; inform you or your personal representative about abuse or domestic violence; or report information you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
- Health oversight activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and Connecticut law.
- Judicial and administrative proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
- Law enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
- Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
- Organ or tissue donation.** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- Public safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

- 13. **Specialized government functions** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- 14. **Worker's compensation** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.
- 15. **Changes of Ownership** In the event that this medical practice is sold or merged with another organization, your health information/reCORD will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**B. When CPWC May Not Use or Disclose Your Health Information.**

Except as described in this Notice of Privacy Practices, CPWC will not use or disclose health information which identifies you without your written authorization. If you do authorize CPWC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**C. Your Health Information Rights.**

- 1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
- 2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a post office box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
- 3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Connecticut law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
- 4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or

incomplete. We are not required to change your health information, and will provide you with information about CPWC's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. **Right to an Accounting or Disclosure:** You have the right to receive an accounting of disclosures of your health information made by CPWC, except that CPWC does not have to account for the disclosures provided you or pursuant to your written authorization or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 4 (notification and communication with family), 13 (specialized government functions), and 15 (minors) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent CPWC has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices

**D. Changes to this Notice of Privacy Practices.**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment. We will also post the current notice on our website [www.cipsychwellness.com](http://www.cipsychwellness.com)

**E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of the Secretary  
200 Independence Avenue, S.W.  
Washington, DC 20001

You will not be penalized for filing a complaint.