WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date____________________ Birthdate ________________ Email Address______________________

Name____ Home Phone ______________________

Address ______________________________________ Cell Phone________________________

City ____ State______________ Zip __________

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer ____________________________________ Business Phone____________________

Business Address ______________________________ Occupation ______________________

Who should we thank for referring you? ____

In case of emergency, who should we contact? _____________________ Phone ____________________

PRIMARY INSURANCE

Subscriber ____

Relationship to Patient__________________ Birth Date_____________ Soc. Sec. # _______________

Address ______________________________________ Home Phone ______________________

City ____ State______________ Zip __________

Insurance Company ____

I.D. # _______________________________________ Group # __________________________

ADDITIONAL INSURANCE (IF APPLICABLE)

Subscriber ____

Relationship to Patient__________________ Birth Date_____________ Soc. Sec. # _______________

Address ______________________________________ Home Phone ______________________

City ____ State______________ Zip __________

Insurance Company ____

I.D. # _______________________________________ Group # __________________________

ASSIGNMENT AND RELEASE

I Hereby authorize directly to Landmark Center for Behavioral Health for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party___________________________________ Date ______________________

Landmark Center for Behavioral Health

1062 Barnes Road, Suite 207
Wallingford, Connecticut 06492
P: 203.265.4600 F: 815.717.7564

AUTHORIZATION TO OBTAIN/RELEASE/ EXCHANGE *HEALTH TREATMENT INFORMATION*

I, ______________________________hereby authorize Landmark Center for Behavioral Health to release to, receive from, or exchange with the names below (or you may decline and, write "NO".):

My Primary Care Physician (PCP) ____

Other Mental Health Provider(s) ____

Insurance Company/Managed Care Company

This authorization pertains to any portion of my medical record, including alcohol/drug treatment, and mental health information, and is intended to be used for insurance authorization, treatment planning, and follow-up care.

This authorization begins today and expires one (1) year from my last appointment with Landmark Center for Behavioral Health Inc. I understand I may revoke this authorization at any time by providing a written statement to the Office Manager *at the above office location.*

The information furnished is prohibited for any purpose other than that stated above AND the recipient is prohibited from disclosing this information to any other party, except as allowed or required by law or regulation. Therefore, information released by us may be subject to redisclosure and might no longer be protected.

A photocopy of this document has the same authorization as the original.

I understand if I have questions about disclosure of my health information, I can contact the Office Manager at the *above address or phone/fax numbers.*

Circle your answer about wanting Appointment Reminder Calls/Text Messages/EMail: YES / NO

These automated calls are generally made the day before your appointment, on Saturday for Monday appointments.

If YES, please use this email ____

If YES, please use this Phone # ____

Parent/Legal Guardian ______________________________ *Date* ______________

Patient Signature ______________________________ *Date* ______________

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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(Signature) **(Date)**

PATIENT INFORMATION/ CONSENT

This is to inform you of some of the important expectations and responsibilities regarding your outpatient care at Landmark Center for Behavioral Health Inc. After reading the form completely, please sign on the line below acknowledging your acceptance.

DUTY TO COOPERATE: As a patient seeking treatment, you have the duty to cooperate with your provider on your plan of care, including appointment scheduling.

APPOINTMENTS: We request notice of cancellation one business day prior to the scheduled appointment. If you fail to keep or cancel appointments, you will be charged a $75.00 fee which is payable before any additional time is reserved in our provider's schedule.

CONSENT: I voluntarily consent to all treatment by Landmark Center for Behavioral Health, its agents, employees, and contractors as deemed necessary by my attending provider.

NO GUARANTY OR WARRANTY: The practice of psychotherapy/counseling is not an exact science and diagnosis and treatment may involve risk. I acknowledge that no guarantees or warranties have been made regarding results of any evaluation and treatment.

PAYMENT FOR SERVICES: If you have insurance coverage, it is *your responsibility* to be knowledgeable and understand what your insurance plan will cover and your expected financial responsibility. Payment is expected at the time of your office visit for all charges if no insurance is to be billed or for your co-insurance and outstanding deductible amounts if the treatment is covered by insurance. If after two appointments, you have not paid your financial responsibility, your provider will have a discussion with you on the continuation of your appointments. If you have questions regarding our financial obligation, please discuss these with the office manager.

ATTORNEY OR LEGAL FEES: I the undersigned, patient, parent, or legal guardian hereby attests that my care is not related to an accident or injury. I understand that now or in the future if I require legal assistance, Landmark Center for Behavioral Health will require payment in full for all services rendered, past and future. I understand that Dr. Krulee's fees are $400.00/hr with a $5,000 retainer for continuation of service.

CONFIDENTIALITY: The patient information will be maintained in accordance with all applicable federal and Connecticut General Statutes. 20-7b, rules or regulations, which authorize disclosure in certain circumstances including but not limited to the following:

In the case of child or dependent adult abuse or neglect
In the case of insurance companies as required for billing and payment
In the case of survey requirements of accreditation and licensure agencies
In the case of subpoenas or court orders
In the case of any collection proceedings, if necessary

In the case of any circumstances where disclosure is permitted or required pursuant to the applicable federal or state laws, rules, and regulations.

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Signature of Parent, Patient, or Legal Guardian　　　　　　　　　　Date