HK SH LG EM MK LA CF FORENSIC___ UPDATE___ DX:_____

Patient:_____Date of Birth:___/___/___

Address: _____

City:_____ State: _____ Zip: _____

Home#: (____) _____Work# (____) _____ Cell Phone #(___)_____

Sex: ❑ Male ❑ Female S.S.#: _____-_____-_____

E-mail address for correspondence only_____

Employer/School: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Emergency Contact:_____ Telephone:(____) _____

Guardianship Information (if relevant):

Name:_____ Address:_____ Contact #:_____

Relevant medical conditions (history, current condition, changes in condition):

_____

Medications (dosage, name of prescribing professional)

_____

Primary Care Physician Name: _____

Address:_____ City_____
Zip_____ Telephone: (____) _____

**Are you currently under the care of any other behavioral health provider yes no

Briefly state reason for your visit today:

_____

_____

DEAR PATIENT:

BEFORE YOU RECEIVE SERVICES AT CONNECTICUT RESOURCE GROUP, WE WILL CHECK OUTPATIENT MENTAL HEALTH BENEFITS FOR YOU. OUR OFFICE STAFF WILL KNOW WHAT COPAY NEEDS TO BE PAID AT THE TIME OF YOUR OFFICE VISIT. **HOWEVER**, THE CUSTOMER SERVICE REPRESENTATIVES AT THE INSURANCE COMPANIES ARE NOT ALWAYS ACCURATE WITH THEIR BENEFIT ESTIMATIONS, WHICH MAY IN TURN PUT THE FINANCIAL RESPONSIBILITY ON YOU.

PLEASE CHECK YOUROWN OUTPATIENT MENTAL HEALTH BENEFITS TO MAKE SURE THE APPROPRIATE COPAY HAS BEEN QUOTED TO YOU HERE IN THE OFFICE.

PLEASE BE CERTAIN TO FIND OUT IF THERE ARE ANY DEDUCTIBLES THAT NEED TO BE MET AS WELL.

SHOULD YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT ME.

SHAWNA
OFFICE MANAGER FOR
CT RESOURCE GROUP

PLEASE INITIAL THAT YOU HAVE READ THIS _____.

CONNECTICUT RESOURCE GROUP, LLC
*Psychological Services for Children, Adolescents & Adults*
133 SCOVILL STREET - SUITE 211
WATERBURY, CONNECTICUT 06706
(203) 573-9521 FAX (203) 573-8708

Sidney S. Horowitz, Ph.D.
Howard M. Krieger, Ph.D.
Leonard I. Goldstein, Psy.D.
Eric D. Margolies, Psy.D.

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Lauren K. Ayr, Ph.D.
Michaela Kauffmann Psy.D.
Chris Fletcher, Ph.D.

# 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.

### Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important information. This notice will serve this purpose.

We will use this information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations.** After you have read this Notice of Privacy Practices (NPP), we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers' Compensation and similar benefit programs.

**Your rights regarding your health information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at your health information we have about you such as your medical and billing records. You can obtain a copy of these records but we may charge you.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our office You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this Notice of Privacy Practices, we will post it in our waiting room and you can always get a copy of it.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our office and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Practice Coordinator.

## ACKNOWLEDGEMENT FORM

**I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.**

**NAME:** _____ **DOB** _____

**SIGNATURE** _____ **DATE** _____

# CONNECTICUT RESOURCE GROUP, LLC

## OUR FINANCIAL POLICY

We accept assignment of insurance benefits. However, you must clearly understand and agree that:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, and not with your insurance company.

2. All charges incurred are charged directly to you and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payment and deductible according to your policy. We do not in any way guarantee that your insurance will pay this amount.

   Please be aware that your mental health benefits may be different from your medical benefits.

3. If the insurance company does not pay within a reasonable amount of time, the balance is your financial responsibility.

4. When you make an appointment, that scheduled time is reserved and set aside for you. We do not double book our appointments. If you need to cancel an appointment, the office must receive notice 48 hours before your scheduled visit. **Missed appointments or late cancellations will be subject to a fee of $50.00,** which cannot be billed to your insurance company. Exceptions are made for medical emergencies or extreme weather conditions.

---→ INITIAL PLEASE _____

## SIGNATURE ON FILE

I authorize the release of medical or other information necessary to process any claims. I request that payment of authorized benefits, government or otherwise, be made to **Connecticut Resource Group.**

Date:_____ Signature:_____