William Abrokwa, APRN | Jeannie Dilworth, APRN | Stacey Hansen, LMFT | Tracy Lewis, LCSW | Holly Monroe, LMFT

PATIENT REGISTRATION FORM

DATE:

PERSONAL INFORMATION:

Name: ____ Date of Birth: _____/_____/_____

Gender Identity: ☐ Identifies as male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male (FTM)

☐ Transgender Female/Male-to-Female (MTF) ☐ Gender non-conforming (neither exclusively male nor female)

☐ Additional gender category/ other, please specify ____________________ ☐ Choose not to disclose

Address: ____ Town: _____________________ State: _____ Zip Code: ________

Preferred Number: (_____) _______________ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No

Other Number: (_____) _______________ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No

Email: ____ Can we communicate via email? ☐ Yes ☐ No

Social Security #: _________________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: ____

If you are a student, are you attending: ☐ High School ☐ College ☐ Graduate School Highest grade completed: _________

Primary Language: ☐ English ☐ Spanish ☐ Other: __________________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

☐ Multi-Racial ☐ White ☐ Declined to Specify ☐ Other: _____________________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Pharmacy: ____ Phone Number: (_____) _______________

Primary Care Physician: ____ Phone Number: (_____) _______________

Emergency Contact: ____ Phone Number: (_____) _______________

In case of emergency, preferred hospital/ER: ____

Referred By: ____ Phone Number: (_____) _______________

Previous Psychiatric Services: ____

CENTER FOR
Behavioral Wellness

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INSURANCE INFORMATION:

Primary Medical Insurance: ____ Policy Number: ___________________________

Secondary Medical Insurance: ____ Policy Number: ___________________________

Insured Party: ☐ Self ☐ Spouse ☐ Parent

Party responsible for payment: ☐ Spouse ☐ Parent ☐ Other: ____

Please complete this section ONLY if someone other than the client is responsible for payment:

Name: ____ Date of Birth: _____/_____/_____

Address: ____ Town: _____________________ State: ______ Zip Code: _________

Preferred Number: (_____) _______________

BILLING CONSENT

I, ____, hereby give my consent for Center for Behavioral Wellness to bill my/my child's insurance carrier for the services rendered to me/ my child/family. In addition, I agree to pay Center for Behavioral Wellness any deductibles or uncovered charges in accordance with my health care plan.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

I,____, hereby give my consent for electronic billing statements by providing my email on the patient registration form and signing below.

____

Signature of Client/Parent/Legal Representative Date Print Name

*Please Note: If no email is provided, paper billing statements will be mailed to the address on file.

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POLICY STATEMENT

All clients or the client's legal guardian will have access to a copy of this written policy regarding the client's registration procedures, financial policies, and billing policies at the time of registration.

____ Appointments: All services are provided by appointment, in-person or telehealth. For in-person appointments, clients are required to check in with the front desk and make any payments due upon arrival for the appointment. For telehealth services it is the client's responsibility to maintain consistent payments for services rendered as notified by monthly billing statements. To make, change, or cancel an appointment, please call the office Monday-Friday 9:00 a.m.-5:00 p.m. If a receptionist is not available during hours of operation, you may leave a voicemail and your call will be returned as it is processed. Please note that voicemails can also be left outside of office hours as needed, and will also be responded to as they are processed during normal office hours.

____ Billing Policy: Your insurance policy is a contract between you and your insurance company; CBW is not a part of that contract. It is your responsibility to know and understand the provisions, limits, and requirements of your individual benefit plan(s). As a service to you, our office will file your insurance claim for you; however, we cannot guarantee benefits or payments. If your insurance carrier denies payment for services, you remain financially responsible for payment regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement. The responsible party agrees to provide all insurance information, at or prior to the first appointment. The responsible party also agrees to notify CBW of any changes in insurance coverage within 10 days.
**CBW is contracted with Lightning MD, an outside billing service company. Per HIPAA regulations, we have a formal business contract with Lightning MD company will adhere to all requirements of confidentiality as required by law.

____ Financial Policy: It is expected that fees for any professional services be paid when services are rendered. All co-payments and fees for services not covered by insurance are expected to be paid upon notification. CBW maintains the right to cancel and/or not schedule future appointments if balances are not paid consistently as agreed to in this policy statement. In-person clients are expected to make payments at the time of arrival for scheduled appointments. Telehealth clients are responsible for being aware of balances due and making payments by mail/phone before the time of scheduled appointments. All clients will receive monthly billing statements and can also inquire about balances during office hours.

We accept cash, personal checks, and all major credit cards. Clients will be responsible for covering any and all bank fees associated with returned checks. If a client fails to be responsible for the account, and it is necessary to refer a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all costs affixed by the court, collection agency, or attorney. A collections warning letter will be sent to any client who has not made a payment in 3 billing cycles. Failure to respond to this letter will lead to accounts being submitted to collections. Any clients with delinquent accounts sent to collections will no longer be considered for treatment with any provider at CBW.

____ Cancellation/No Show fees: It is important that clients attend all scheduled appointments. A missed appointment fee of $100 (or a $50 fee for a missed group session) will be applied if a client fails to cancel an appointment within 24hours advanced notice or provide proper documentation of an emergency. The missed appointment fee is due before the next scheduled appointment. This policy is aimed at minimizing the waiting time and ensuring availability of prompt care. Appointment reminder calls/texts are made 48hours prior to scheduled appointments as a courtesy and are not guaranteed. Clients are responsible for maintaining scheduled appointment times even if a reminder call/text is not received.
**CBW reserves the right to discontinue treatment for missed appointments with less than 24 hours notice on two occasions, as well as habitually cancelling/rescheduling appointments.
*Please note that insurance carriers cannot be billed for these fees and it is entirely client responsibility to make these payments promptly.

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____ Medical Records: Medical records created by our office shall only be released pursuant to signed authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with Connecticut law, we charge a photocopying fee of $.65 per page, and have up to 30 days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records. Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. CBW reserves the right to withhold records for clients who are actively engaged in treatment or that have been discharged from the practice.

____ Termination of Treatment: If a client is discharged from the practice, it means the client will no longer be able to schedule appointments, receive medication refills, or consider any provider at CBW an active treating practitioner. Treatment can be terminated if a client fails to keep scheduled appointments as per office policies, noncompliance or failure to follow the recommended treatment plan, abusive to staff, and failure to pay a balance. Treatment may also be terminated if an appointment has not been scheduled for a period of 90 days.
**If a client is discharged, a written notification letter will be sent to the address on file. Medical records may be sent to a new provider upon request following our record release protocol.

____ No Smoking Policy: CBW will not condone clients, staff, or providers smoking near and/or around the practice location. We care about your health, the health of others, and wish to promote healthy behaviors.

____ Professional Record Keeping: The laws and standards require that the psychological and behavioral healthcare providers maintain clinical records for all services provided. The following information may be included in a clinical record: reasons for seeking services; symptoms; diagnosis; treatment plan; session information and progress; medical, social, and family history; records from other providers; billing information; phone calls and other communications; information provided by other individuals; and other information related to the clinical services. Paper documents will be scanned into a digital format and saved within our electronical medical records system. All electronic medical records are maintained as a part of our EMR. The information is maintained as part of a HIPAA compliant on-line program.

____ Closings/Delays: In the event that our office needs to close during regular business hours, our practice will update our voicemail. In the event of inclement weather, we recommend calling the office prior to the scheduled appointment time to ensure knowledge of any changes. If appointments have been cancelled, the client is responsible for rescheduling.

CONSENT TO TREATMENT/ASSISNMENT OF BENEFITS: I hereby authorize Center for Behavioral Wellness and associated providers, through its appropriate personnel, to perform or have performed upon me, or the client, appropriate assessment and treatment procedures.

I consent to receive calls, text messages and/or emails from Center for Behavioral Wellness for my protected healthcare and other services at the phone number(s) provided on the Patient Registration Form. I understand that I may be charged for such calls and/or text messages by my wireless carrier and that such calls and/or text messages may be generated by an automated dialing system.

I hereby assume financial responsibility for and agree to make payment in full to Center for Behavioral Wellness and associated providers for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Co-payments and fees for services not covered by insurance are required at the time services are rendered. I understand and agree to inform Center for Behavioral Wellness of changes in my insurance within 10 days so that claims can be filed within the insurance carrier's deadline, and I will be responsible for the full fee for services rendered if not covered by my insurance carrier.

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I authorize Center for Behavioral Wellness and associated providers to release my information for all claims and payment purposes, as may be required by my insurance company or any third-party payer, and release Center for Behavioral Wellness and associated providers from any liability related to such release of information.

I authorize Center for Behavioral Wellness to disclose any information needed to confirm the validity of my prescription, as well as any information needed to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, and to third party payors. *This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I assign all benefits and rights to payment for services provided by Center for Behavioral Wellness and associated providers and authorize payment to be made directly to Center for Behavioral Wellness and associated providers by any third-party payer that provides benefits or payment for such services.

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their clients at their first visit. It also requires that we seek a written acknowledgement from our clients that we did, in fact, deliver that notice. Accordingly, Center for Behavioral Wellness asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form.

ACKNOWLEDGEMENT OF POLICY STATEMENT

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

*PLEASE NOTE THAT YOU MAY REQUEST A COPY OF THIS SIGNED STATEMENT FROM OUR FRONT DESK STAFF

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