Hockanum Valley Community Council, Inc.
27 Naek Road, Suite 4 Vernon, CT 06066

Patient Information *(Please print)*

Patient Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Date of Birth: ____/____/____ Soc Sec #: _____-_____-_____ Marital Status: S M D W Separated

Sex: M F

Language: _____ Race: _____ Ethnicity: _____

(White, Black, Asian, Amr. Indian/Alaskan, Natv. Hawaiian/Oth. Islander) *(Hispanic, Latino, Non-Hispanic)*

Employer: _____ Address: _____

Emergency Contact: _____ Relationship to Patient: _____

Telephone: _____ Referred to us by: _____

Primary Care Physician: _____ Telephone: _____

Insurance Information: *(Please present your insurance cards to receptionist)*

Primary Insurance

Name of Insurance Co. _____

ID# _____ Group# _____

Name: _____

Soc Sec# _____

D.O.B: _____

Employer: _____

Patient's Relationship to Policy Holder:

☐ Self ☐ Spouse ☐ Child

Secondary Insurance

Name of Insurance Co. _____

ID# _____ Group# _____

Name: _____

Soc Sec# _____

D.O.B: _____

Employer: _____

Patient's Relationship to Policy Holder:

☐ Self ☐ Spouse ☐ Child

Assignment and Release

I, the undersigned, assign directly to Hockanum Valley Community Council, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature: _____ Date: _____

Medicare Authorization

I request the payment of authorized Medicare benefits be made either to me or on my behalf to HealthWise Medical Associates for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or assigned cases the physician or supplier agrees to accept the change determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: _____

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Core Elements – Meaningful Use

In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about Race & Ethnicity because some groups are at higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Race:

☐ (American Indian or Alaska Native)

☐ (Asian)

☐ (Black or African American)

☐ (Native Hawaiian)

☐ (White)

☐ (Other Pacific Islander)

☐ (More than one Race)

Ethnicity:

☐ (Hispanic or Latino)

☐ (Not Hispanic or Latino)

Primary Language: _____

Name: _____

D.O.B: _____

Today's Date: _____

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Adult Health History Questionnaire

Name: _____ D.O.B: _____ today's Date: _____

Do you have any allergies, or have you had any bad reactions to any medicines or products? Please list:

_____

_____

Brief Medical History Review

Have you had or do you currently have any of the following?	Currently have	Had	Never
Diabetes			
Glaucoma			
Chronic infections			
Bleeding disorder or blood disease			
Asthma or hay fever			
High Blood Pressure			
Ulcer, stomach, or intestinal bleeding			
Weight problems			
Heart attacks or chest pain			
Heart murmur/Rheumatic fever			
Cancer treatment			
Seizures, convulsions, or blackouts			
Auto Immune Deficiency			
Angry, emotional, or abusive exchanges with your spouse or significant other			
Parenting difficulties			
Depression for more than one month			
Alcohol problems			
Drug abuse			
Anxiety or panic attacks			
Increased or uncontrollable anger			
Sleep disorders			
Suicide attempts/Thoughts			
Mental Illness			

LIFESTYLE	Y	N
Do you use tobacco?		
Do you drink alcohol?		
Do you have a special diet?		
Do you use "street drugs"?		
Do you wear a seatbelt?		
Do you have a regular exercise program?		
Please list any major surgeries:		
Females Only		
Are you currently pregnant?		
Are you currently breastfeeding?		
Are you currently taking birth control pills?		
Other medical problems Please list:		

_____

_____

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Please read and sign

Cancellation, Missed Appointment and Fee Policies

FEES:
All fees for services are due and payable at the time services are rendered unless other arrangements are made. No correspondence (court letters, release of records to another facility, letters to others on the client's behalf, etc.) will be sent if a client has an outstanding bill with HVCC.

MEDICAL RECORDS:
Per Hockanum Valley Community Council, Inc. LLP HIPAA Policy 0003- The charge for copying of Medical Records is $0.45 per page plus the cost of first class postage. If special mailing is required, an additional charge of $15.00 will be assessed.

CANCELLATION:
It is the policy of HVCC that all clients seen at this agency call and notify us at least twenty-four (24) hours in advance if they intend to cancel their scheduled appointment. Failure to give a 24 hour notice will result in the client being charged their normal and customary fee for the missed appointment. This fee, along with any regular fees, must be paid the next time the client comes to HVCC for counseling.

MISSED APPOINTMENTS:

1. If a client misses a scheduled appointment without calling to cancel, the client will be charged the normal and customary fee for the missed appointment (NO SHOW), payable their next visit to HVCC.

2. When an appointment is missed, your therapist will send you a letter. If you do not respond within two weeks, services will be stopped and you cannot request further services for at least three (3) months with approval of your therapist unless you have a psychiatric emergency.

3. If you have two missed appointment in a row or three missed out of five: services will be suspended. You will be informed of such in writing and cannot request further services for at least three (3) months unless there is a psychiatric emergency. By missed appointments HVCC is referring to either a NO SHOW or CANCELLATION.

If you or your family is involved with services of the Department of Children and Families, Town Social Services, Family Relations, Probation or Parole, we will inform them of service termination due to missed or cancelled appointments.

Patient Signature: _____ Date: _____

Client Rights Statement

Hockanum Valley Community Council, Inc. is a multi-service agency, which provides a broad range of social services to the Tri-Town Area. These services include counseling/case management services to individuals, families and youth, outreach services, transportation services, emergency food and clothing, summer youth employment and intake for the energy assistance and commodities programs. As a facility providing counseling/mental health services, it is our responsibility to provide each of our clients with information regarding their rights as established by Connecticut General Statute #306. Although the language and emphasis of this statute may not be applicable to many clients of some programs of HVCC, it is the intention of this law to convey to all recipients of health and social services that they are entitled to specialized, quality care.

Records are confidential, and released only with the client's written permission, except under the following circumstances:

1. Subpoenaed under court order.
2. Review by public and private accrediting, funding and monitoring bodies.
3. Situations that are potentially life threatening to self or others, including situations involving child abuse and/or neglect.

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Drug Screen Participation Agreement

In an effort to maximize our clinical appointment time, a random urine screen rotation has been established as follows:

Each client in the CSSD program is subject to randomized screening. Notification of the screen will be done by phone in the evening. Once notified that the client is due for a screen, the client will have a pre-determined amount of time in which to attend their appointment. Please note that once you arrive at HVCC for a screen, there may be some wait time before a screener becomes available. To minimize wait time, it is best to arrive at the quarter of the hour of your assigned time block.

Please note that this information is confidential and not to be discussed with any party, internal or otherwise.

No one can take your screen for you nor can you trade appointments with another client or outside party. By signing below you are confirming that you agree to adhere to the process described to you above. Please note that arriving outside of the assigned time block forfeits your guarantee to be screened and the completion of your screen will be left at the discretion of Hockanum Valley Community Council staff. If you are unable to attend your appointment, it is your responsibility to make arrangements with the appropriate staff person(s) to be screened at another time. Attempting a screen outside of your assigned day and/or time block without prior approval will not be permitted and any screen done under such conditions will not be accepted.

It is the responsibility of the client to adhere to all above information; no reminders will be sent or verbally made to any clients under any circumstances.

By signing below *I, (please print)* _____agree to the terms above and understand that I am joining the randomized drug screening program. I acknowledge that it is my responsibility to observe the guidelines above and no one else's.

Client's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

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Signatory Page

Patient Name: _____

Cancellation, No Show and Fee Policy:

Initial Here_____ I have read the above Cancellation, No Show, and Fee policy of HVCC. I understand and agree to abide by it while I am receiving the services of Hockanum Valley Community Council, Inc.

Initial Here_____ I am aware that I may request a copy of the agency's Privacy Policies.

Payment of Services:

Initial Here_____ Should I become ineligible for insurance and/or the guarantor of my services determines I am no longer eligible for payment/coverage I understand that HVCC will conduct a financial assessment with me and a fee, based upon my income and family size, will be set and I will be required to pay for my services in full.

Enter your Name Here I, _____, have received a copy of the *Client's Right's* form, and a copy of Chapter #306 *Department of Health, Patients Rights*. I have discussed and do understand this document.

Privacy Policy: A copy of the Policy is posted in the Main Lobby. Upon request you may obtain a complete copy of the Agency's Policy.

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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Consent and acknowledgment form

I consent to the use or disclosure of my protected health information by Hockanum Valley Community Council, Inc. (HVCC) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by HVCC may include HIV/AIDS related information, psychiatric and other mental health information and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how HVCC will use and disclose my information can be found in HVCC's Notice of Privacy Practices. I understand that this consent is effective for as long as HVCC maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received HVCC's Notice of Privacy Practices currently in effect

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ❑ Individual refused
- ❑ Emergency treatment situation
- ❑ Individual not able to sign due to incompetence or other medical reason
- ❑ Other: _____

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Prescription Refill Policy

- No prescriptions will be refilled on Fridays, Saturdays, Sundays or Holidays.
- Require 2 days minimum to process prescription(s) renewal and/or pick-up requests.
- The patient is responsible for knowing when medication(s) will need to be refilled (no early refills).
- Prescription phone-in/pick-up: Monday-Thursday during 9:00 to 5:00.
- Prescriptions will not be filled for unauthorized "walk-in" patients. You must phone the HVCC office.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-4 months.
- Controlled-substances/narcotic prescriptions require a follow up appointment every 14-90 days.
- New symptoms and/or events require a clinic appointment. The Provider is unable to diagnose via phone.
- Signed "Controlled-Substance/Narcotic Policy" required if using narcotic/controlled medications.
- No early refills if medications are overused/abused/misused. Must follow prescription directions.
- No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc. (*treat like money*!!).
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- Patient must pick-up his/her prescription(s) in person, unless pre-authorized by staff.

I understand and accept the protocol listed above. Failure to comply may result in immediate termination of prescriptive medications.

Patient Name: _____ Date: _____

Patient Signature: _____

HOCKANUM VALLEY COMMUNITY COUNCIL has adopted strict rules regarding addictive medications for your safety and to comply with the Drug Enforcement Agency regulations:

NEW PATIENTS: Under no circumstances will our office refill these medications without records received directly from your previous doctor's office. NO EXCEPTIONS!

Patients picking up refill prescriptions must provide photo identification. Those that attempt to fraudulently receive addictive medications will be fired from our practice and prosecuted.

We strive to offer the best services and care for each patient in a timely manner. The above "rules" are necessary to efficiently manage a busy clinic. Thank you in advance for your cooperation and understanding.

These protocols are per recommendations of the Connecticut Board of Medical Examiners & DEA

Patient's Copies Attached

Department of Health Service

Hospital and Medical Care Division
Mental Health Facilities Licensure Section

PATIENTS' RIGHTS

Chapter 3306

Sections 17-206 b,c,d,e,j,k

Section 17-206b. Deprivation of rights of patient prohibited. Exception

No patient treated in any public or private facility for the treatment of the mentally disordered shall be deprived of any personal property or civil rights, including the right to vote, hold or convey property, and contract except in accordance with due process of law, and unless he/she has been declared incompetent pursuant to chapter 779. Any finding of incompetence shall specifically state which civil or personal rights the patient is incompetent to exercise.

Section 17-206c. Humane and dignified treatment required.

Every patient treated in any facility for treatment of the mentally disordered shall receive personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his/her disorder.

Section 17-206d. Procedures governing medication and treatment.

(a) Voluntary patients may receive medication or treatment, but shall not be forced to accept unwanted medication or treatment, except in accordance with procedures set forth in subsection (b) of this section. No medical intervention may be undertaken without the patient's written informed consent, except in accordance with subsection (b) of this section.

(b) If the head of the facility, in consultation with a physician, determines that the condition of a patient, either voluntary or involuntary, of an extremely critical nature, then emergency measures may be taken without the consent otherwise provided for in this section.

(c) No public or private facility shall request or require blanked consent to all procedures as a condition of admission or treatment.

Section 17-206e. Medication not be used as substitute for habilitation.

(a) Medication shall not be used as a substitute for a habilitation program.

Section 17-206j. Denial of employment, housing, licenses, because of history of mental disorder restricted.

(a) No person shall be denied employment, housing, civil service rank, any license or permit, including a professional license, or any other civil or legal right, solely because of a present or past history of mental disorder except as so provided by the general statutes.

(b) The burden shall be on the person or agency denying any such right to prove that the person so denied is not suitable solely because of his/her present or past history of mental disorder.

Section 17-206k. Remedies of aggrieved persons.

Any person aggrieved by a violation of sections 17-206a to 17-206j, inclusive, may petition the superior court within whose jurisdiction the person is or resides for appropriate relief, including temporary and permanent injunctions, or may bring a civil action for damages.

Addendum: Section 17-206a: Definitions.

As defined in Section 17-206 a, b, c, d, e, f, j, k inclusive:

Section 17-206a. Definitions. When used in sections 17-206a to 17-206k, inclusive, unless otherwise expressly stated or unless the context otherwise requires:

a) "Facility" means any inpatient or outpatient hospital, clinic, or other facility for the diagnosis, observation or treatment of the mentally disordered;
b) "Patient" means any person being treated in a facility;
c) "The Mentally disordered" means those children and adults who are suffering from one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorder";
d) "Family" means spouse or next to kin;
e) "Head of the hospital" or "head of the facility", means the superintendent or medical director of a hospital or a facility, or his/her designated delegate;
f) "Informed consent" means permission given on the basis of knowledge of the implications, consequences or possible complications of affects of such permission;
g) "Medically harmful" means capable of inflicting serious mental or physical injury on the patient, or producing in the patient a disturbed mental state or impaired judgment which may be grossly detrimental to his/her physical or mental well being.

Criteria for Involuntary Termination:

Any mental health services client will be involuntarily terminated if:

a) The client comes to sessions under the influence of drugs or alcohol.
b) The client becomes threatening or assaultive.
c) The client has the ability to pay the established fee and has not paid for two consecutive sessions, or has an ongoing pattern of non-payment.
d) The client misses two (2) consecutive appointments without arranging with the Therapist.

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