PATIENT INFORMATION SHEET

Patient's Name: _____ **Date of Birth:** _____

Address: _____

_____

Home Phone : _____

Cell Phone: _____ **Cell Phone:** _____

Email: _____ **Email:** _____

Family Members:

Name	Age	Gender	Relationship

Primary Care Physician: _____

Psychiatrist: _____

Who Referred you to us? _____

Anxiety Treatment Center, LLC

Farmington Office
10 Forest Park Drive
Farmington, CT 06032
Tel/Fax: 860-269-7813

Fairfield Office
501 Kings Hwy East, Suite, 200
Fairfield, CT 06825
Tel/Fax: 203-291-0458

FEE AGREEMENT FOR SERVICES

In-person Office Visits
Sessions conducted in the office will be 45-50 minutes long. Please try to respect that limit as therapists benefit from a few minutes for administrative duties and session preparation between clients.The time scheduled for your appointment is assigned to you and you alone. The last five minutes of each session will be used to set up future appointments and collect payment. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Please understand that payment of your bill is considered a part of your treatment. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. Any checks returned to our office are subject to an additional fee of up to $35.00 to cover the bank fee that we incur.

In-person, Out-of-Office Visits
Your treatment may involve meeting outside the office. If an out-of-office visit exceeds the 45-50 minute session, you will be charged for time spent traveling to and from the meeting location. Travel time is prorated based on your treatment provider's hourly billing rate.

Other Professional Services
You will be charged for other professional services that you require. Fees for these services are prorated based on your treatment provider's hourly billing rate.

Telephone Contacts
This includes time spent on your case via the telephone when the contact lasts longer than 15 minutes. This will include time your provider spends speaking to you, other health care providers, school personnel, legal representatives, and other people related to your/your child's case.

Letter and Document Preparation or Review
This includes time your treatment provider spends preparing letters and/or documents relating to your/your child's case when done outside of your/your child's scheduled session.

Cancellation Policies
If you need to cancel or reschedule a session we require a ***minimum of 24 hours notice***. If you miss a session without canceling or cancel with less than 24 hours notice, you will be charged the full fee for that session. Exceptions can be made at the discretion of the treatment provider. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Please help us serve you and others by keeping scheduled appointments.

If you cancel without sufficient notice more than three times for any reason (even if they seem legitimate but occur more frequently than with other clients) and do not pay the full fee for your missed session, your treatment provider can choose to discontinue treatment with you in order to work with clients who are waiting to receive treatment and show commitment to attendance and payment.

Inclement Weather Policy
If you have an appointment scheduled and the weather is affecting your ability to attend, please notify your treatment provider with ***one hour's notice*** to avoid a late cancellation charge.

Fee Adjustments
As a practice, we reserve the right to adjust our out-of-pocket fees at any time. You will be provided with at least one month advance notice of any rate increases. You have the right to continue to see your treatment provider for treatment at his/her new, increased rate or transfer your treatment to another provider. Your treatment provider will attempt to assist you in finding a new provider as needed.

Insurance
We are a fee for service practice. Therefore, we are not participating providers with any insurance companies. You will receive a receipt, detailing the appropriate diagnosis, the type of treatment received, and the amount paid, at each session. These receipts allow you to submit claims to your insurance company for reimbursement in accordance with your out-of-network benefit coverage.

It is your responsibility to contact your insurance company and be aware of your out-of-network benefits, reimbursement rates, and out-of-pocket costs for outpatient mental/behavioral healthcare. Prior to your first appointment we recommend that you call the mental/behavioral healthcare phone number on the back of your card to find out what your out-of-network behavioral health coverage includes.

I have read, understand, and agree to the financial policies outlined above.

_____ _____
Client's/Parent's Signature Date

_____
Printed Name

_____ _____
Treatment Provider's Signature Date

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ELECTRONIC COMMUNICATIONS PREFERENCES

While we recognize that email is not a secure form of communication, the use of e-mail and/or text communication can improve the ability to exchange information quickly and efficiently between you and your/your child's mental health care provider. Typically, this would include scheduling, rescheduling, or canceling appointments, or for other reasons to coordinate your/your child's care.

PLEASE BE ADVISED

- There is some risk that protected health information contained in email messages may be disclosed to, or intercepted by, unauthorized third parties. Our providers strive to use the minimum necessary amount of protected health information to respond to your email and text queries.

- E-mail and/or text messages or relevant information from the message may be filed in your/your child's health record by your/your child's health care provider.

- If you consent to the use of email, you are responsible for informing your/your child's therapist of any type of information that you do not want sent to you by email.

- You are responsible for protecting your password and access to your email account and any email you send to or receive from your/your child's provider to ensure your/your child's confidentiality. Your/your child's clinician cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.

- Any email that you send that discusses your/your child's diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must inform your/your child's clinician in writing that you are withdrawing consent to email information.

- Encrypted messages are the most protected form of communication; however, we do not presently use an encryption program. Our computers are password protected.

ELECTRONIC COMMUNICATIONS PREFERENCES

Client's Name: _____ Client's DOB: _____

Cell Phone 1: _____ Email 1: _____

Cell Phone 2: _____ Email 2: _____

Text Messaging Preference:

_____ Yes, I have been advised of the risks and consent to receiving text messages from my/my child's provider at the Anxiety Treatment Center.

_____ No, I do not consent to receiving text messages from my/my child's provider at the Anxiety Treatment Center.

Email Preference:

_____ Yes, I have been advised of the risks and consent to unencrypted email correspondence from my provider at the Anxiety Treatment Center.

_____ No, I am not interested in email correspondence from my provider at the Anxiety Treatment Center.

_____ _____

Client's/Parent's Signature **Date**

_____

Client's/Parent's Name (please print)

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Anxiety Treatment Center, LLC 's Responsibilities

The Center receives and generates certain Protected Health Information (PHI) about you especially for you. The following information explains your rights regarding this PHI and our practices and responsibilities to protect the privacy of your PHI.

- Federal and State law requires that we maintain the privacy of your PHI;
- Federal law requires that the Center provide you with this written Notice regarding its duties and practices in using your PHI;
- The Center is required to abide by the terms of this Notice;
- The Center is required to notify you if we cannot abide by a requested restriction on how your information is used or disclosed;
- The Center must accommodate reasonable requests that you make for it to communicate your PHI by alternative means or locations;
- The Center reserves the right to change this Notice and have the changes apply not only to PHI acquired after the change in Notice, but have it also apply to PHI received before the change in Notice. Should our Notice, be revised, you will receive a revised copy of our Notice.

Uses and Disclosures of Your Protected Health Information

The Center may use you PHI for the following purposes without obtaining your written consent:

- To provide ***treatment*** (e.g., discussions between caregivers for coordination and planning of your care). Treatment means the provision of health care and related services, including consulting between health care providers; and referring you to another health care provider to receive care; and
- To conduct our administrative and business ***operations***, which includes, but is not limited to, conducting quality improvement activities, reviewing the competence or qualifications of healthcare professionals, case management and care coordination, contacting patients with information regarding treatment alternatives, conducting or arranging for legal counsel, medical review and auditing functions, including fraud and abuse detection, business planning and development, management activities relating to compliance with State and Federal laws, resolution of internal grievances, and activities in connection with a sale of assets.

Federal law allows the Center to use and disclose your PHI for treatment, payment and healthcare operations without your consent. However, since State law continue to require that we obtain your consent for disclosure of PHI for **payment purposes,** coordination of care with other providers, and the disclosure of certain sensitive information protected under State law, we will request your consent for disclosure of PHI upon admission.

Unless the PHI is protected by State drug, alcohol, psychiatric, or HIV-related confidentiality laws, we may use and disclose your PHI without your consent or without providing you the opportunity to object as follows:

- If the use or disclosure of PHI is required by law and is limited to the relevant requirements of the law (e.g., reporting an adverse incident in our Center);

- Disclosures required by law to state and federal public health authorities; • Disclosures made to government authorities for the purpose of reporting suspected abuse and neglect of children, the elderly, and the mentally retarded;
- Disclosures to health oversight agencies authorized by law, in connection with audits, civil, administrative, or criminal investigations, licensure or disciplinary actions; or for monitoring compliance with quality, and program eligibility (e.g., Medicare, Medicaid, and State of Connecticut Department of Public Health);
- Disclosures to persons exposed to a communicable disease if authorized by law to make such disclosure;
- Disclosures in connection with judicial and administrative proceedings in response to an order of the court or administrative tribunal, or in response to a lawfully issued subpoena;
- Disclosures to law enforcement if mandate by law;
- Disclosures to persons reasonably able to prevent or lessen serious and imminent threat to the health or safety of a person or the public;
- Disclosures to comply with workers' compensation or other programs that provide benefits for work-related injuries without regard to fault.

The Center may make disclosures of your PHI to provide follow up contact to you regarding upcoming appointments, treatment alternatives, health-related benefits, programs and services which may be of interest to you.

All other uses or disclosures will only be made with your specific written authorization, which may be revoked, except to the extent it has already been relied upon. Special rules for Psychiatric, Drug and Alcohol and HIV-related protected information:

Protected Psychiatric Information: State law provides special protections when it comes to psychiatric information. Except for treatment, or healthcare operations, psychiatric communications will not be disclosed, without your specific written consent, unless the disclosure is made: (i) to another health care provider for the purpose of treatment and diagnosis (with notice to You); (ii) when there is substantial risk of imminent physical injury to you or others and the disclosure is necessary to place you in a treatment facility; (iii) to a court as part of mental condition as an element of a claim or defense; (v) after your death, when your condition is introduced by a party claiming or defending through or as a beneficiary of you and a court finds it to be in the interests of justice to disclose such psychiatric information; (vi) to the Commissioner of the State Department of Public Health or the State Department of Mental Health and Addiction Services in connection with an inspection or investigation; (vii) to the family or legal representative of a victim of a homicide committed by you; (viii) to individuals or agencies involved in the collection of fees for psychiatric services; and (ix) to the State Department of Mental Health and Addiction Services in connection with the center receiving payment funded by such agency with notice to you.
Protected HIV-Related Information: Special rules under State law also limit the disclosure of HIV-related information. According to the rules, the Provider may not disclose such information without your specific written authorization, unless such disclosure is: (i) made to a public health official as required or allowed by State or Federal law: (ii) a health care Provider for the purpose of treatment; (iii) a medical examiner to determine the cause of death; (iv) to a hospital committee or another organization for the purpose of oversight or monitoring of the hospital; (v) to a health care worker experiencing a significant occupational exposure to HIV infection; (vi) pursuant to a court order; (vii) life and health insurers; (viii) to your partner by a physician caring for you and your partner if it is believed by the physician that your partner is at significant risk for transmission; and (ix) if you are a minor, to your parents or legal guardian, unless the physician determines there is cause (as defined by law) not to disclose to them.
Protected Drug and Alcohol Information: Federal law establishes certain protections for any patient identifiable information relating to drug and alcohol treatment. As a general rule, protected drug and alcohol information is confidential and may not be disclosed without your authorization or pursuant to Federal law. Exceptions for disclosure of protected drug and alcohol information without your authorization are as follows: (i) to medical personnel to the extent necessary to meet a bona fide medical emergency; (ii) to qualified personnel for the purpose of conducting research, management audits, program evaluation, provided that you are not identified in any report; (iii) pursuant to a court order where good cause for such disclosure has been established; (iv) communications between a program and an entity and an affiliated covered entity having direct administrative control over our program; (v) to a business associate performing services on our behalf; (vi) limited communications with law

enforcement regarding a crime committed or threatened by you on our premises; (vii) the reporting of incidents of suspected child abuse and neglect to the appropriate state authorities; and (viii) to the FDA when they assert that your health may be threatened by an error in manufacture, labeling, or sale of a product under FDA jurisdiction.

Your Rights Relating to Your Protected Health Information.

• You have the right to request certain restrictions on the use of your PHI for treatment, payment and our operations, disclosures to notify family and friends of your location, general condition and/or death, and disclosures to notify others involved in your care or payment of your care. However, we are not required to honor such restrictions;

- The right to receive communications of PHI from the Center by other means or locations;
- The right to inspect and subject to a copying charge, copy PHI, except psychotherapy notes, information collected for use in a court proceeding, or certain other information protected by Federal law governing clinical laboratories.
- The right to request to amend PHI so long as the amendment is accurate and complete in writing;
- The right to revoke you Authorization and Consent except to the extent relied upon;
- The right to receive an accounting of disclosures of PHI made by the center in the six years prior to the date on which the accounting is requested;
- The right to receive a copy of the Center's Notice of Privacy Practice; and
- The right to file a complaint with the Center or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.

For more information on how to exercise any of your rights regarding your protected health information, please send a written request to:

Nicholas Maltby, Ph.D.
Anxiety Treatment Center, LLC
10 Forest Park Drive
Farmington, CT 06032

If you believe your privacy rights have been violated, you may file your complaint by any means of communication by contacting:

Nicholas Maltby, Ph.D.
Anxiety Treatment Center, LLC
10 Forest Park Drive
Farmington, CT 06032
You will not be retaliated against for filing a complaint.

If you believe the Anxiety Treatment Center, LLC has violated your privacy rights, you may file a complaint with the Secretary of the Department of Health and Human Services.