CPC ASSOCIATES NEW PATIENT REGISTRATION PACKET

Please print out and complete the next five pages. When completed, you may

1. Fax to 203-792-0404 OR
2. Bring with you to your appointment OR
3. If there is sufficient time, you may certainly mail to
   CPC Associates; 84 Hospital Avenue; Danbury, CT 06810

The last page is our mutual professional commitment.

Page 2:

- Demographics, contact information, insurance information, pharmacy information, Responsible Party / Emergency Contact.
- How you heard about CPC? If referred by a physician/therapist, please provider his/her name.
- Assignment of Benefits: if covered by insurance, you understand that CPC will file claims and provide the necessary information to have them processed; furthermore, payment is assigned to CPC Associates.

Page 3:

- Summary of Office Practices
- Acknowledge and Consent

Page 4:

- Medical History
- Current Medications: both Over the Counter (OTC) and Prescription
  Please take this with you into the session with the Doctor, APRN, Therapist.

Page 5: Consent to Release Information within Families

- If a patient is 18 years or older, that patient must give consent for any other family member, including parents, for any information to be shared. Such information includes making/changing appointments, managing the payments to or from the account, as well as more detailed medical information.
- If the patient is under 18, then this form is not needed unless extended family members, such as grandparents or step-parents, are to be extended this courtesy. If there is a custodial issue, please be certain that this has been carefully explained and documentation, such as the court statement may be required.

Page 6: Credit Card on File
Having this on file facilitates payments authorized by phone, or payments against a card not carried by the patient.

Page 7: Our Mutual Professional Contract

CPC ASSOCIATES NEW PATIENT REGISTRATION FORM

Title: ______ First Name: ________________ MI: ____ Last Name: ________________________________

Home Address: ______________________________________ City/State/Zip: ____________________________

Home Phone: _________________ Cell Phone: _________________ ***Reminder Phone***: Home / Cell

Date of Birth: ________________ Sex M/F:____ Marital Status: Single Married Divorced Other

Social Security #: _________________________ Email Address: __________________________________

Primary Care Physician: _________________________________ City/State: _____________________________

Preferred Pharmacy: ___________________ Street ____________________ City/State:__________________

Race: Please check only one.
- □ American Indian or Alaskan Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ White
- □ Other
- □ Patient Declined to Answer

Ethnicity: Please check only one
- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Patient Declined to Answer

Preferred Language: Please check only one.

□ Arabic	□ Danish	□ Haitian	□ Italian	□ Russian
□ American	□ English	□ Hebrew	□ Japanese	□ Somali
□ Catalan, Valencia	□ French	□ Hindi	□ Korean	□ Spanish
□ Chinese	□ German	□ Hmong	□ Portuguese	□ Other

Employer: _________________________________ Work Phone: ___________________________

Insurance: (circle one) Self Pay or Insurance Coverage : Carrier ______________________

(Be sure to keep the office informed of any changes in coverage and its details in advance of appointments whenever possible.)

Policy Holder Name (if not self): ___________________________ PH Social Security #: _____________________

Responsible Party and/or Emergency Contact: (If responsible party is 'self', please give an emergency contact.)

Name: ____ Relationship: ____________________________

Address: ____ City/State/Zip: ____________________________

Home Phone: _________________ Cell Phone: _________________

Send bill to: Patient: ______ or Responsible Party: ______

How did you hear about our practice?: ____

ASSIGNMENT OF BENEFITS

I hereby authorize my treatment provider(s) to apply for benefits on my behalf for covered services rendered. I request that payments from my insurance company be made directly to the provider(s) or to CPC Associates Inc., who may in some cases accept assignment. If I receive any payments from my insurance company in error, I will notify CPC Associates for further investigation. If claims are denied for any reason, I will be responsible for the full session fee. I agree to obtain pre-certification from my insurance company for any initial appointment as required. I certify that the information I have reported with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by either me or my insurance company at any time in writing. I hereby authorize the use of this signature for billing my insurance company. I agree to be personally responsible (or where appropriate, allow my family/significant other to be responsible) for payment of all charges due CPC Associates if they are not covered by my insurance carrier and/or the provider is out-of-network.

Patient/Guardian Signature: __________________________________ **Date**: _____________________

CONSENT AND ACKNOWLEDGEMENT of OFFICE PRACTICES FORM

I provide consent for psychiatric evaluation and treatment rendered by the provider(s) of CPC Associates Inc. in their practice of behavioral medicine. I have received a written copy of the office practices, read them, and agree to comply with their recommendations. I have particularly noted the policies regarding

- **the payment for services,**
- **the request for refills between appointments: five days in advance of need,**
- **late arrivals,**
- **timely notification of changes in schedule or insurance,**
- **and the no show/ late cancellation fee policy.**

I also acknowledge receipt of the Patient – Doctor Contract and understand the mutual obligations.
Highlighting three:
1. I understand that attempts are made to send reminder calls/texts, but for a variety of reasons, such messages may not actually be successfully sent. These reminders are a courtesy; appointment management is my responsibility. Not receiving a reminder is not a recognized reason for avoiding charges for missed appointments or those cancelled with less than 24 hours' notice.
2. I am free to stop taking any recommended medication without forfeiting the right to be re-evaluated by the provider. However, I also understand that it is not recommended that I stop any medication abruptly or without medical supervision. Continued lack of compliance with my doctor's recommended plan would be a concern and may result in a referral.
3. I also understand that I am free to transfer my care at any point without prejudice.

CPC will take precautions to protect my confidentiality and privacy. Some uses and disclosures are permitted. CPC may release protected health information concerning my evaluation and treatment as judged necessary for routine practice operations: carrying out treatment, obtaining payment, or conducting certain healthcare operations. Recipients of such information may include another physician treating me, my insurance company, and other reimbursement agencies identified by me. Protected health information disclosed by CPC Associates may include HIV/AIDS related information, psychiatric and other mental health information, alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut law. Other disclosures may require you to provide specific authorization.

I am responsible for providing all insurance information and establishing the proper sequencing of primary and secondary coverage (coordination of benefits) before each visit. CPC will send a bill to my primary insurance company. After my visit, I should receive an Explanation of Benefits (EOB) from my insurance company, stating how much the insurance company paid and how much is my responsibility. I am responsible to verify that my insurance company pays in a timely manner. Fulfilling this responsibility may require that I contact my insurance company. My coverage is between my and my insurance company. CPC will present my claim, but I have ultimate responsibility for my account. **If my insurance changes in any way, it is my responsibility to inform the Office and provide the new insurance information.** If there is an unavoidable delay in providing the new information, it still must be done within 60 days of the date of service. Failure to do so will probably result in claims being denied and payment for services will become my responsibility.

I understand that information regarding how CPC Associates will use my information can be found in CPC Associates Notice of Privacy Practices: posted in the office and soon to be available at www. cpcassociates.org. I understand that this consent is effective as long as CPC Associates maintains my protected health information.

By signing below, I understand and acknowledge that I have read and understand this consent.

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. (CPC Associates may request proof of guardianship or power of attorney.)

MEDICAL HISTORY

Would you please complete the following, noting N/A, meaning not applicable, for anything that does not apply to you? The questions are arranged by general topic. Please bring it into your session with the doctor. Some answers will require follow-up by the doctor to ensure proper documentation or planning. ***Thank you!***

Name: ___________________________________ **Date:** ___________________

Coordination of Care:

Are you seeing another doctor / therapist for behavioral health care including any assistance with addictive behavior? ______

Have you been diagnosed with diabetes, stroke, kidney disease, cancer hypertension, heart disease or congestive heart failure? ______

Have you been discharged from a hospital or other inpatient facility within the last 30 days? ______

Medical History: (if more space is needed, please write on back of this page)

____

____

____

Please list medications you are taking now: from any doctor or Over-the-Counter (OTC).

Over the Counter Medications or Supplements:

____

____

Prescribed Medications: (if more space is needed, please write on back of this page)

____

____

____

Smoking/ Using Tobacco:

Have you ever used tobacco? ______

If you no longer do, for about how long? ______

If you still do, have you tried to quit? ______

Are you willing to try another program? ______

Alcohol:

How many times in the past year have you consumed four or more drinks in the same day? ______

Has there been a recent change in the frequency or quantity? ______

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? ______

CPC Associates Inc.

84 Hospital Avenue
Danbury, CT 06810
Telephone (203) 792-0400

AUTHORIZATION TO RELEASE INFORMATION WITHIN FAMILIES

To be completed if there is any other person you wish to be able to inquire about either your clinical history or your billing status. Without permission, no member of CPC Associates should answer questions posed even by a family member (spouse, parent, other relative) about your medical status, your prescriptions, or your billing. Custodial parent(s) of a minor child do not need authorization.

This release is to authorize CPC Associates Inc. to release or communicate written or verbal information about my account to/with:

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

The information that may be shared is indicated below:
(Please check all those that apply

____ Psychiatric / Psychotherapy Records
____ Prescription Information, incl. pick-up of scripts
____ Billing Information: charges, payments, balance
____ Appointment Information: Making/Changing Appointments

or check here if no information is to be shared ☐.) (except as provided for by HIPAA)

I understand that if I authorize the release of records, those records may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information.

I understand that I may withdraw this consent at any time. However, should that withdrawal occur after information has been released, CPC will have acted properly as long as no further information is released.

____
Signature of Patient

____
Signature of parent of guardian
(If patient is under 18 years of age)

Date: ____________________

____
Print Name of Patient

84 Hospital Avenue, Danbury, CT 06810
Telephone (203) 792-0400

Credit Card on File Authorization

CPC Associates requests that you keep your credit card on file for future payments. You may elect to present your credit card for each service or authorize CPC to charge the card on file, by phone or in person.

Patient Name(s): ______________________________________

____

Information to be completed by the card holder:

Cardholder Name: ______________________________________

Card Number: ______________________________________

Card Type: Visa Mastercard American Express Discover
(Please circle one)

Expiration Date: __________________ (MM/YY)

Security Code: __________________ (usually 3 digits; 4 digits for AMEX)

Billing Zip Code: __________________

Phone: __________________

I, __________________________, authorize CPC Associates to charge the above card account for payments owed to the listed patient accounts for services rendered at their office. I agree to update any information regarding this account(s) – credit card, insurance, address, etc. The above information is complete and correct to the best of my knowledge.

________________________ __________________
Cardholder Signature Date

CPC Associates Inc.

PATIENT – DOCTOR CONTRACT

There are expectations and obligations that need to be understood and observed in the doctor-patient relationship. On both sides, courtesy is to be extended and expected in return.

Doctor:

- Honor patient confidentiality.
- Adhere to schedule as much as possible, realizing that emergencies arise that may require more time with some patients.
- Monitor medication treatment and adjust as situations change and/or appropriate product information comes available.
- Return calls – either personally or via Coordinator – to answer concerns about medical status.
- Prescriptions are written as a result of appointments. The only exceptions are for very short term extensions to accommodate a necessary schedule change that results in running out of medication. Such extensions are measured in days, not weeks or months. Extensions may not be repeated.
- If a controlled substance medication is lost, stolen, or destroyed, the doctor will only prescribe enough to taper the patient down and off that medication until the next regularly scheduled appointment.
- If stimulants are prescribed, re-evaluation will be done at least every three months.
- This is an outpatient facility. Excessive phone calls, in lieu of appointments, may lead to the conclusion that a higher level of care is required in which case the patient will be referred out of CPC Associates.
- This is an outpatient facility with a working relationship with area resources providing emergency or more intensive care. As need indicates, such referrals can and will be made.

Patient:

- CPC Associates runs by appointments; it is not a drop-in office. Efforts will be made to accommodate need and last-minute cancellations are available for re-assignment, but appointments are necessary.
- Make appointments on the recommended schedule. Keep those appointments, or re-schedule close to the original date to maintain the treatment plan.
- Plan to arrive a few minutes early to allow for unexpected trafficdelays. Late arrivals of fifteen (15) minutes or more may be asked to re-schedule or wait for the next break in doctor's schedule.
- Medication is only prescribed at visits; establishing the correct regimen is a key part of those appointments.
- Be sure to call the Office and alert the doctor to problematic reactions being experienced with medication.
- Do not cancel appointments and then request refills.
- There is one instance where calls for refills ARE expected.
  The time between appointments is greater than one month AND the medication prescribed is a controlled medication, such as a stimulant. Local pharmacies will only accept a maximum of a 30-day script. It is incumbent on the patient to call the Office to request the next planned refill. Please give **five (5) days notice**.
- If patient wishes to try a new medication, mentioning this at a visit is the appropriate time, not between visits by telephone.
- If ADD/ADHD seems to be the indicated diagnosis, the doctor may request additional information from other sources in order to better document and verify this diagnosis. The patient's understanding and support in this is requested and appreciated.
- Only medications relevant to the practice of psychiatry will be prescribed; medications appropriate to other disciplines, e.g. pain management, must be acquired from physicians in those disciplines.

Thank you for your full attention and the privilege of participating in your care!