



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

**Please Print  
PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec #: \_\_\_\_-\_\_\_\_-\_\_\_\_ **E-mail Address:** \_\_\_\_\_

(\*Must sign below for consent to use\*)

Sex: M F (Please circle) Marital Status: S M D W Separated (Please circle)

Employer: \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Telephone: \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Telephone: \_\_\_\_\_

**\*\*Consent for E-Mail Notifications:** My signature indicates consent for H.V.C.C. to contact me via the above listed e-mail address, any non-clinical information regarding appointments, warnings, terminations, etc. it deems necessary in order to contact me.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**INSURANCE INFORMATION: (Please present your insurance cards to receptionist)**

**Primary Insurance**

**Secondary Insurance**

Name of Insurance Co. \_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_

ID # \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Relationship to Insured: Self Spouse (Please circle) Relationship to Insured: Self Spouse (Please Circle)

**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 that payment of authorized Medicare benefits be made either to me or on my behalf to Hockanum Valley Community Council, Inc. for any services furnished me by that provider. 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 release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## 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.

#### 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 a \$20.00 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 a \$20.00 fee for the missed appointment, payable on 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. Two missed appointment in a row: services are stopped. 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.
4. Three missed or cancelled appointments within eight (8) scheduled visits. Services will be stopped and you will be informed of such in writing. You cannot request renewed services for three (3) months unless there is a psychiatric emergency.

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.

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### 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.
-

**Patient Name:** \_\_\_\_\_

**Signatory Page:**

**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.

**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.**

- **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.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date



**HOCKANUM VALLEY COMMUNITY COUNCIL, INC.**  
**27 Naek Road, Suite 4 \* Vernon, CT 06066**  
**Phone (860) 872-9825 \* Fax (860) 870-9384**

***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: \_\_\_\_\_

# R<sub>x</sub> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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,i,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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