84 Hospital Ave, Danbury CT 06810 –
81 Holly Hill Lane, Greenwich CT 06830
Ph: 203.792.0400,
Option 1 for New Patients Option 2 for Prescriptions
Option 3 for Billing
and Option 4 for Prior Authorization
Fax: 203.792.0404

PATIENT INFORMATION:

Name: _____ _____**Date:**_____

Address: _____ **City:**_____ **State:**_____

Date of Birth: _____ **Gender:** _____

Occupation: _____ **Employer/School:** _____

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

Email Address: _____

What is your preferred pharmacy? _____

Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier:_____ **Phone Number**_____

Insured Name: _____ **Insured Employer** _____

Insured DOB: _____ **Member ID:** _____

Secondary Carrier: _____ **Phone Number** _____

EMERGENCY CONTACT

Name:_____**Relationship:**_____**Phone:**_____

Address: _____

HOW DID YOU HEAR ABOUT US?

Referred by: _____ **Phone:** _____

Google _____ **Friend/Family** _____ **Social Media** _____ **Other** _____

Primary Care Doctor: _____ **Phone:** _____

Psychiatrist: _____ **Phone:** _____

Therapist: _____ **Phone:** _____

CURRENT MEDICATIONS: Please List all Medications and Dosage

_____

_____

REASON FOR VISIT/ CHIEF COMPLAINT:

_____

_____

_____

PAST HOSPITALIZATIONS:

_____

_____

_____

HAVE YOU SEEN A PSYCHIATRIST OR THERAPIST BEFORE? _____

IF YES, PLEASE PROVIDE PAST PSYCHIATRIC DIAGNOSIS:

_____

_____

TELEHEALTH CONSENT

I grant permission and request to receive Telehealth services with my provider at Contemporary Care, LLC via HIPAA compliant, real time audio/video interaction. The telehealth service complies with all CMAP requirements and is clinically and medically appropriate as per section 17b-259b of the CT General Statues. I understand all cancellation and standard policies apply with Telehealth services. I further understand I am responsible for payments of Teleheath services if my insurance does not cover. I will notify Contemporary Care if at any point if I chose to revoke consent.

Name:_____ Signature:_____ Date:_____

FINANCIAL POLICY FOR COMMERCIAL INSURANCE AUTHORIZATION

Patient is responsible for all fees and legal costs incurred by Contemporary Care regarding bill collection.
Please initial each item below:

_____ No show and cancellations with less than 24 hours notice are billed at $150.00 per session
_____ Returned checks will be assessed an additional $30.00 fee
_____ Patient balances (deductible , coinsurance, copay, no show, late cancellation) will be automatically charged each week to the credit card on file.
_____ There will a charge to prepare letters and forms if not done at the appointment

Patient Signature	Patient Name	Date
_____	_____	_____

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE OF HIPAA PRIVACY PRACTICES

(Please find a copy of the HIPAA Privacy Practices at our website www.contemporarycarecenters.com)

Patient Name (Print):_____ Date of Birth:_____

I acknowledge that I have received a copy of the Privacy Practices of Contemporary Care, LLC

Patient Siganture:_____
Date: _____

Past and Current Medication Trial

Antidepressants

Medication	Dosage	Approximate Dates/Years	Outcome, Side Effects
Anafranil (Clomipramine)			
Celexa (Citalopram)			
Cymbalta (Duloxetine)			
Desipramine			
Effexor (Venlafaxine)			
Elavil (Amitriptyline)			
Ensam (Selegiline)			
Fetzima			
Lexapro (Escitalopram)			
Luvox (Fluvoxamine)			
Marplan			
Nardil (Phenelzine)			
Pamelor (Nortriptyline)			
Parnate (Tranylcypromine)			
Paxil (Paroxetine)			
Pristiq (Desvenlafaxine)			
Prozac (Fluoxetine)			
Remeron (Mirtazapram)			
Reboxetine			
Serzone			
Silenor (Doxepin)			
Tianeptine			
Trintellix			
Tofranil (Imipramine)			
Trazodone (Desyrel)			
Viibryd (Vilazodone)			
Wellbutrin (Bupropion)			
Zoloft (Sertraline)			

Past and Current
Adjunct Medications

Medication	Dosage	Approximate Dates/Years	Outcome, Side Effects
Abilify			
Buspar			
Cerefolin			
Clozaril (Clozapine)			
Cytomel (T3/Liothyronine)			
Depakote (Valproate)			
Deplin (Methylfolate)			
Geodon (Ziprasidone)			
Horizant			
Lamictal (Lamotrigine)			
Latuda			
Lithium (Lithobid)			
Lyrica			
Neurontin (Gabapentin)			
Rexulti			
Risperdal (Risperidone)			
Saphris			
Seroquel (Quetiapine)			
Symbiax			
Synthroid (T4) (Levothyroxine)			
Tegretol (Carbamazepine)			
Topamax (Topiromate)			
Trilafon (Perphenazine)			
Trileptal (Oxcarbazepine)			
Vraylar			
Zyprexa (Olanzepine)			

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

A2663B 10-04-2005

Patient Code: _____

CONTEMPORARY CARE

84 Hospital Ave, Danbury CT 06810
81Holly Hill Lane, Greenwich, CT 06830

Phone: (203) 792-0400
Fax: (203) 792-0404
www.contemporarycarecenters.com

CREDIT CARD ON FILE – AUTHORIZATION

Contemporary Care, LLC 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 **Contemporary Care, LLC** to charge the card on file, by phone or in person. In the event that a card on file is charged, a receipt for services rendered and payment submitted will be provided to you upon request.

Please note that it is the policy of **Contemporary Care, LLC** to protect all of your information at all times. All credit card information will be entered into a secure credit card portal.

Name on Card: _____

Type of Card _____

Credit Card # _____

Exp. Date _____ Security code _____

I, _____, authorize **Contemporary Care, LLC** to retain the credit card I have submitted on file and to charge for payments owed to the named patient accounts, _____, for services rendered at **Contemporary Care, LLC**.

I agree to update any information regarding this account(s) – credit card, insurance, address, etc.

_____ _____

Cardholder Signature Date

CONTEMPORARY CARE
Psychiatric Centers of Excellence

AUTHORIZATION TO RECEIVE HEALTH INFORMATION

Please allow up to 30 days to process your request.

Patient Name: _____ Date of Birth: _____

I hereby authorize __ Attorney __ Physician __ Therapist __Psychiatrist __ other _____

Name: _____ **Address:** _____

Telephone#: _____ **Fax #:** _____

To release my personal health information to:

Name: Contemporary Care, LLC Address: 84 Hospital Avenue, Danbury, CT 06810

Telephone #: 203-792-0400 **Ext 830** Fax #: 203-792-0404

I authorize the use or disclosure of my personal health information as described below:

- Mental Health Medical Records: I understand that the records to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information or psychiatric disabilities.
- Psychotherapy Notes
- Psychological or education evaluations, possibly including school records
- Medication History
- Other or Exceptions: _____

The information is being disclosed for the following purpose(s): Please check all that apply.

- o Changing physician
- o Coordinating care
- o Second opinion
- o Legal, Insurance, School, Other: _____

This authorization is valid until _____ (up to one year). I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information. However, if this information is protected by the Federal regulations (42 CFR & 2.32), then further disclosure is prohibited except with the specific written consent of the person to whom it pertains.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.

X_____ _____ _____

Signature of patient Signature of parent or guardian (if patient is under 18 y/o) **Date**

*If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____

E.g. Parent, Guardian (relation), Conservator

Patient Code _____

CONTEMPORARY CARE
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AUTHORIZATION FOR THE RELEASE OF INFORMATION TO FAMILY MEMBERS

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 Contemporary Care should answer any questions posed even by a family member (spouse, parent, other relative) about your medical status, your prescriptions, or your billing. Custodial parents(s) of a minor child do no need authorization.

I, _____, direct Contemporary Care LLC and payers to disclose and release my protected health information described below to:

Name/Relationship: _____/
_____

Contact information: _____

Name/Relationship: _____/_____

Contact information: _____

Health Information to be disclosed upon the request of the person(s) named above

☐ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

☐ Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
____Mental health records Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment
____Other (please specify): _____

☐ Form of Disclosure (unless another format is mutually agreed upon between my provider and designee): ____An electronic record or access through an online portal ____Hard copy

☐ This authorization shall be effective (Check one):
_____All past, present, and future periods
_____Until date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization (print) Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date