



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 (Tranlycypromine)			
Paxil (Paroxetine)			
Pristiq (Desvenlafaxine)			
Prozac (Fluoxetine)			
Remeron (Mirtazapram)			
Reboxetine			
Serzone			
Silenor (Doxepin)			
Tianeptine			
Trintellix			
Tofranil (Imipramine)			
Trazodone (Desyrel)			
Viiibryd (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 (Topiramate)			
Trilafon (Perphenazine)			
Trileptal (Oxcarbazepine)			
Vraylar			
Zyprexa (Olanzapine)			

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	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

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

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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BDI - II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully. And then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0. I do not feel sad.
1. I feel sad much of the time.
2. I am sad all the time.
3. I am so sad or unhappy that I can't stand it.

2. Pessimism

0. I am not discouraged about my future.
1. I feel more discouraged about my future than I used to.
2. I do not expect things to work out for me.
3. I feel my future is hopeless and will only get worse.

3. Past Failure

0. I do not feel like a failure.
1. I have failed more than I should have.
2. As I look back, I see a lot of failures.
3. I feel I am a total failure as a person.

4. Loss of Pleasure

0. I get as much pleasure as I ever did from the things I enjoy.
1. I don't enjoy things as much as I used to.
2. I get very little pleasure from the things I used to enjoy.
3. I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0. I don't feel particularly guilty.
1. I feel guilty over many things I have done or should have done.
2. I feel quite guilty most of the time.
3. I feel guilty all of the time.

6. Punishment Feelings

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self-Dislike

0. I feel the same about myself as ever.
1. I have lost confidence in myself.
2. I am disappointed in myself.
3. I dislike myself.

8. Self-Criticalness

- 0. I don't criticize or blame myself more than usual.
- 1. I am more critical of myself than I used to be.
- 2. I criticize myself for all of my faults.
- 3. I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- 0. I don't have any thoughts of killing myself.
- 1. I have thoughts of killing myself, but I would not carry them out.
- 2. I would like to kill myself.
- 3. I would kill myself if I had the chance.

10. Crying

- 0. I don't cry anymore than I used to.
- 1. I cry more than I used to.
- 2. I cry over every little thing.
- 3. I feel like crying, but I can't.

11. Agitation

- 0. I am no more restless or wound up than usual.
- 1. I feel more restless or wound up than usual.
- 2. I am so restless or agitated, it's hard to stay still.
- 3. I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- 0. I have not lost interest in other people or activities.
- 1. I am less interested in other people or things than before.
- 2. I have lost most of my interest in other people or things.
- 3. It's hard to get interested in anything.

13. Indecisiveness

- 0. I make decisions about as well as ever.
- 1. I find it more difficult to make decisions than usual.
- 2. I have much greater difficulty in making decisions than I used to.
- 3. I have trouble making any decisions.

14. Worthlessness

- 0. I do not feel I am worthless.
- 1. I don't consider myself as worthwhile and useful as I used to.
- 2. I feel more worthless as compared to others.
- 3. I feel utterly worthless.

15. Loss of Energy

- 0. I have as much energy as ever.
- 1. I have less energy than I used to have.
- 2. I don't have enough energy to do very much.
- 3. I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- 0. I have not experienced any change in my sleeping.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0. I am not more irritable than usual.
- 1. I am more irritable than usual.
- 2. I am much more irritable than usual.
- 3. I am irritable all the time.

18. Changes in Appetite

- 0. I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty

- 0. I can concentrate as well as ever.
- 1. I can't concentrate as well as usual.
- 2. It's hard to keep my mind on anything for very long.
- 3. I find I can't concentrate on anything.

20. Tiredness or Fatigue

- 0. I am no more tired or fatigued than usual.
- 1. I get more tired or fatigued more easily than usual.
- 2. I am too tired or fatigued to do a lot of the things I used to do.
- 3. I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0. I have not noticed any recent change in my interest in sex.
- 1. I am less interested in sex than I used to be.
- 2. I am much less interested in sex now.
- 3. I have lost interest in sex completely.

Total Score: _____

Patient Code: _____



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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

Patient Code _____

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 not 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