Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

The Center for Cognitive and Behavioral Health

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

Adult New Client Forms

Today's Date: ____/____/____

Client Name: _____ SS#_____

Home Address: _____

City, State, Zip _____

Date of Birth: _____/_____/_____ Age: _____ Birth Place: _____

Home #: _____ Mobile #: _____

Email Address: _____

Please answer the items that apply to your marital situation (Leave blank if never married):

Current Marital Status: M S D W

If Married: # years married: _____ Name of spouse: _____

If Separated: Date of Separation: ____/____/____

If Divorced: Date of divorce: _____/_____/_____

If Widowed: Date Widowed: _____/_____/_____

Previous marriages? Y N If yes, provide dates: _____

Children (if applicable) with names and ages: _____

PLEASE PROVIDE AT LEAST 24 HOURS NOTICE FOR ALL CANCELLATIONS
OUR PRACTICE DOES NOT PARTICIPATE WITH ANY INSURANCE PLANS

5 Sylvan Rd S, Westport, CT 06880 Tel 888-745-3372 Fax 203-307-5788 ccbhtherapy.com

Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

The Center for Cognitive and Behavioral Health

Payment Information

We require a credit card to be kept on file even if paying by check
Please select one payment option:

- o I/We elect to pay by credit card and would like the credit card debited for each session once per week.
- o I/We elect to pay by check or cash at the time of service and would like my credit card kept on file and debited only if my account becomes past due.

Please provide credit card information for: _____

Type of Credit Card (circle one): MASTERCARD VISA AMERICAN EXPRESS

Name as it appears on card: _____

Address of card holder: _____

_____

Credit card number: _____

Expiration date: _____/_____ Card Security Code (CSC): _____

Signature of card holder: _____

Date of signature: _____/_____/_____

Please circle one of the following for the preferred method of receiving invoices:

Email: _____

USPS Address: _____

5 Sylvan Rd S, Westport, CT 06880 Tel 888-745-3372 Fax 203-307-5788 ccbhtherapy.com

Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

The Center for Cognitive and Behavioral Health

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

CCBH Cancellation/Missed Appointment Policy

Cancellation of an Appointment:

In order to be respectful of the needs of other clients as well as our clinicians time, please let your clinician know promptly if you are unable to attend an appointment. This will allow us to accommodate another client. If it is necessary to cancel your scheduled appointment, we require that you provide us with at least 24 hours advanced notice.

How to Cancel Your Appointment:

To cancel appointments, please contact your clinician directly by phone or text.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

_____ _____

Signature Date

_____

Print Name

5 Sylvan Rd S, Westport, CT 06880 Tel 888-745-3372 Fax 203-307-5788 ccbhtherapy.com

Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

The Center for Cognitive and Behavioral Health

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Re: Client Name: _____

- I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices in effect for The Center for Cognitive and Behavioral Health, LLC.
- I acknowledge the I have received and reviewed a copy of the Practice Policies for The Center for Cognitive and Behavioral Health, LLC.

Signature of
Client/Guardian: _____

Date: _____

If signed by guardian,
Please note relationship to client:

_____

5 Sylvan Rd S, Westport, CT 06880 Tel 888-745-3372 Fax 203-307-5788 ccbhtherapy.com

Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

The Center for Cognitive and Behavioral Health

Practice Policies and Procedures

We offer comprehensive services for children, adolescents, adults, and families. Our practice is composed of specialists trained in different modalities who can effectively manage the diverse aspects of psychiatric needs. We offer a wide range of services including in-depth evaluations, parent guidance, Cognitive Behavioral Therapy (CBT, Dialectical Behavioral Therapy (DBT), individual, couples, and family psychotherapy, group therapy, and in-home services. Your practitioner will work closely with you to develop a treatment plan that meets your specific needs.

Appointments

All appointments must be scheduled directly with the provider. The session length will vary depending on the services required. If an appointment must be cancelled, 24 hours advanced notice is required (excluding weekends and holidays). Missed appointments and cancellations that occur within 24 hours will be charged to you unless there are exceptional circumstances involved.

Urgent Matters

In the event of an urgent psychiatric matter that cannot wait until the next business day, please follow the instructions on your clinician's voice mail. If you have agreed to text with your clinician (see 'text messaging' below), call your clinician as well as texting. If it is a true medical emergency and you have not heard back immediately, dial 911 or go to your nearest emergency room.

Confidentiality

The medical records of our clients are highly confidential. Information contained in the records will not be released without proper written consent. When treating a child or adolescent, parents are kept informed of the general progress of treatment but specific and personal information is kept confidential. In the case of a divorce situation where medical custody is shared, consent and authorization regarding disclosure of any information is required from both parents.

Phone Calls

All phone messages are responded to as quickly as possible. If we are not personally available, the confidential voicemail system will take your call. Please check with your provider regarding when his or her voicemail messages are checked. Be sure to always leave your name, phone number, and convenient times when you can be reached. Do not leave extensive voicemails; rather, leave key information you would like to discuss with your provider. Please be aware that extensive phone conversations may be billed as pro-rated sessions.

Email

We do not discuss clinical matters via the internet. We will occasionally send follow-up emails that pertain to scheduling, billing, or other administrative matters that do not include any sensitive medical information. If you have a clinical matter that needs to be discussed, please call your provider to schedule an appointment.

Text Messages

In the event your provider agrees to communicate with you via text message, the following guidelines apply:

1. Text messages are not the primary method of communication; in emergency situations, please call your provider.
2. Text messages should be sent only Monday through Friday between 8am and 6pm, or as agreed by you and your provider. Please do not expect your provider to respond to messages sent nights or weekends.
3. If your provider does not respond to your text messages right away, please call his or her cell phone or confidential phone extension, and be sure to listen to any messages indicating that your provider is away from the office. Follow the instructions on the voicemail.
4. Keep it simple. If a matter is complicated, text is not the preferred method of communication.
5. We do not discuss medical information via text.

Billing

Professional fees are based upon the type and duration of the session. Please refer to our "Services and Costs" form for further information. If paying by check, payment is expected at the end of each session. If paying by credit card, your card information will be kept on file and charged once per week for the previous week's session(s). Our policy is to maintain a current credit card on file so that payments may still be processed if your account becomes past due.

CCBH does not participate with any insurance plans; however, our experience has been that most insurance plans have an out of network mental health component that will reimburse you directly. These benefits and reimbursements vary greatly depending on the insurance company and individual plan. Because the practice is not contracted with any insurance plans, you are responsible to know your benefits, and authorization requirements, and to follow up regarding payment. Payment for our services is not contingent upon third-party reimbursement.

As of August 1, 2015, An individual invoice for each session will be mailed or emailed to you for submission to your insurance. The statement includes all of the information your insurance company requires for processing. If you use a HCFA claim form, please **DO NOT** sign box 13 authorizing payment directly to the practice. If we receive payment directly from an insurance company, we will return the check to the company with a request to please reissue directly to you, the subscriber. If your insurance company requires additional information, we will be happy to provide it, within reason. However, we cannot accept responsibility for collecting your claim or for negotiating a settlement on a disputed claim. If at any time financial difficulties present a problem in keeping your account current, please discuss the situation with your provider immediately.

Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Nardozzi, LCSW
John Lieberman, LPC

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Alexandra Fernandez, LCSW
Lakshmi Kandel, LCSW

The Center for Cognitive and Behavioral Health

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and your child maybe used and disclosed and how you can gain access to this information please review it carefully if you have any questions please write to our privacy officer at the address noted at the end of this notice.

I) Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills and or other payment information that we maintain related to your case.

This notice describes how we handle your health information and your rights regarding this information. We are required to:

1) Maintain the privacy of your health information as required by law
2) Provide you with our current notice of privacy practices
3) Follow the terms of the notice of privacy practices currently in effect.

II) Uses & disclosure of information.

Under federal law we are permitted to use and disclose PHI without prior authorization for treatment, to obtain payment for treatment, (including the use of collection services) and to support our healthcare operations (however the American psychiatric Association's principles of medical affects may require us to obtain your express consent before we make certain disclosures regarding your PHI)

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options alternatives health-related benefits or services that may be of interest to you.

We may use or disclose medical information about you without your prior authorization for several other reasons subject to certain requirements.

We may give our medical information about you without your prior authorization for public health purposes, abuse and neglect, reporting health oversight, audits or inspections, medical examiners, funeral arrangements, and organ donation.

We also disclose medical information when required by law such as in response

to request from law-enforcement and specific circumstances or in response to valid judicial or administrative orders or other legal process.
Under certain circumstances we may use and disclose health information about you for research purposes. Subject to a special approval process we may also allow potential researchers to review information that may help them prepare for research so long as the help information they review does not leave our group, and so long as to agree to specific privacy protections.
We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.
In any other situation not covered by this notice we will ask you for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure you can later revoke the authorization by notifying us in writing of your decision.

III) PHI Rights
Under federal law you have certain rights regarding the PHI we collect and maintain about you:
1) Request that we restrict certain uses and disclosures of your PHI we are not however required to agree to a requested restriction.

2) Request that we communicate with you by alternate means such as making records available for pick up or mailing them to an alternate address if we are unable to satisfy your request we will tell you in writing the reason for the denial and your right if any to request a review of our decision.

3) Request that we amend the PHII about you that is maintaining your files your request must explain why you believe our records about you are incorrect or otherwise require amendment if we are unable to satisfy your request we will tell you in writing the reason for this denial and how you may contest the decision including your right to submit a statement disagreeing with the decision, this statement will be added to your record.

4) Request an accounting log of requests for your PHII including date of request information requested mailing name and address.

5) Request that medical information about you be communicated to you in a confidential manner such as sending mail to an address other than your home.

6) Request a copy of this notice.

IV) To request information or to file a complaint:
If you believe your privacy has been violated you must file a written complaint by mailing it or delivering it in person to:
Michelle Feeney, LCSW
CCBH
5 Sylvan Road South
Westport, CT 06880

You may also file a complaint with the Secretary of Health and Human Services by writing to the office of civil rights, US Department of Health and Human Services 200 Independence Ave. SW room 509F HHH building Washington DC 20201 or by calling 800-368-1019 or by emailing OCRprivacy@HHS.gov.
We will not make you waive your right to file a complaint as a condition of receiving care from us or penalize you for filing a complaint.