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Child/Adolescent New Client Forms

Today's Date: ____/____/____

Client Name: _____ SS#_____

Home Address: _____

City, State, Zip _____

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

Home #: _____ Mobile #: _____ Email: _____

Current School: _____ Grade/Year: _____

In the next section please provide information for parent(s)/guardian(s):

1) Name: _____ Relationship: _____

Address if different from above: _____

Date of Birth: _____/ _____/ _____

Preferred Contact #: _____ Email: _____

2) Name: _____ Relationship: _____

Address if different from above: _____

Date of Birth: _____/ _____/ _____

Preferred Contact #: _____ Email: _____

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

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

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Payment Information

We require a credit card to be kept on file. Please select one payment option:

- I/We elect to pay by credit card and would like the credit card debited for each session once per week.
- I/We elect to pay by Venmo 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: _____

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CONSENT FOR TREATMENT

Client Name(s): _____

_____

_____

I am (we are) the sole guardian(s) for the client(s) listed above, by signing below, do hereby grant, The Center for Cognitive and Behavioral Health, LLC and its providers my (our) medical permission and informed consent for the mental health evaluation and treatment for the client(s) listed above:

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

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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

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CONSENT FOR VIDEO/ONLINE SESSIONS

I understand and consent to having selected individual sessions by video/online programs with my CCBH practitioner. These programs include Facetime, Skype and all other video/online programs. I understand that these programs are not encrypted or HIPPA compliant. I understand that the CCBH team will take all necessary precautions for confidentiality but any internet based communication is not 100% guaranteed to be secure/confidential.

The CCBH team does offer encrypted and HIPPA compliant online programs. If interested, please discuss with your CCBH practitioner. I understand that if I choose to use one of these programs, I will need to download the app and create an account. As stated above, I understand that no internet based communication is 100% secure/confidential.

Client Name (Please Print): _____

Signature: _____ Date: _____

Parent/Guardian/Family Member (Please Print):_____

Signature: _____ Date: _____

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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:

_____

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AUTHORIZATION TO DISCLOSE/EXCHANGE INFORMATION

I, _____(hereinafter "Client") hereby authorize The Center for Cognitive and Behavioral Health, LLC (hereinafter "Provider") to disclose / exchange mental health treatment information and records obtained in the course of treatment including, but not limited to, doctor or therapist's diagnosis to:

Name: _____

Address: _____

Telephone: _____ Fax:_____

The specific uses and limitations of the types of health information to be released are as follows (check all that apply):

- o Treatment Coordination
- o Treatment Planning
- o Diagnostic Refinement
- o Other: _____

Such disclosures shall be limited to the following types of information:

- o Full Treatment Record (can include any or all of the information below)
- o Psychiatric Diagnosis (es)
- o Dates of Treatment
- o Treatment Summary
- o Treatment Plan
- o Psychiatric Evaluation
- o Psychotropic Medication Record
- o Discharge Summary
- o Psychological Testing
- o School Reports
- o Medical Reports
- o Other: _____

This Consent to Disclose/Exchange Information expires on _____or one year from the date of signature, whichever comes first.

_____ _____ _____

Date Signature of Patient/Parent or Guardian Relationship to Child