Client Rights and Responsibilities: (Pursuant to CT General Statutes, Section 17a-540 to Section 17a-550, CT Public Act P.L. 93-369)

Name:_____ DOB:_____

Admission to Sunrise Therapy Services, LLC, is voluntary. Clients have a right to humane treatment, with full respect for personal dignity and right to privacy.

You will be treated in accordance with an individual treatment plan, which will be designed with your active participation. Informed consent for treatment from you or your legal guardian will be specified on the Contract for Financial Responsibility.

You will also participate actively in your treatment plan reviews, which will include a summary of your overall progress and rationale for any new problems, goals and objectives as well as a description of progress on each listed objective. You will also participate in your discharge plan, and in your aftercare plan.

If necessary, you will discuss your medication with your psychiatrist or APRN. Legal guardians will be asked to give consent in the event medication is prescribed for a child or adolescent. It will be explained how medication will be administered to the client. You shall not be forced to accept unwanted medication or treatment and you have a right to seek treatment elsewhere if you do not wish to accept Sunrise Therapy Services LLC's style of treatment.

In the event of refusing medications or treatment, it is the right of Sunrise Therapy Services, LLC to terminate the relationship with you, the client, if indicated. If the clinical director/team in consultation with a physician determines that your condition is of an extremely critical nature, then emergency measures may be taken without the consent stated above. All reports will be signed and placed in your chart.

As mental health professionals, staff are mandated by the State of Connecticut, pursuant to Section 17a-1 0 I of the Connecticut General Statutes, to report any suspected child abuse or neglect to the Department of Children and Families.

Sunrise Therapy Services, LLC is a smoke free environment. This applies to all those who are on the grounds, including staff, clients, and family members.

Sessions must be canceled at least 24 hours prior to appointment time. If not, Sunrise Therapy Services, LLC reserves the right to charge for this session.

Office hours are by appointment only. If you have a clinical emergency during non-clinic hours, please call 9-1-1 or go to your local hospital emergency room.

All treatment records are protected by the Health Insurance Portability and Accountability Act (HIPAA), Federal Regulation (42 CFR, Part 2), and State of Connecticut General Statutes (Chapter 899, 52-146c). The confidentiality of your treatment records will be outlined in the Notice of Privacy Practices that will be given to you upon admission to Sunrise Therapy Services, LLC.

For the purpose of treatment, clinical information may, when relevant, be shared with your psychiatrist or APRN.

I understand that in the event that I have a complaint concerning the quality of my care, I have available to me the following complaint procedure: Complaints may be addressed to the Primary Therapist and if not resolved, they may be taken to the Director. I shall submit my complaint in writing to the:

Director

Sunrise Therapy Services, LLC
580 Naugatuck Avenue
Milford, CT 06461
Phone: (203) 307-1123
Fax: (203) 283-7714

Services to be received:

Assessment
Individual Therapy
Family Therapy
Case Management
Medication Management

Attestation

This is to certify that I, the client, and/or I, the client's parent/guardian have received a copy of "Patient Rights", as defined in Section 17a-540 through 17a-550 of the Connecticut General Statutes. I agree that I have read and understood "Patient Rights" and that all of my questions regarding this information have been adequately explained to me.

I have been informed/educated and consent to all items described above.

Client Name: _____

Client Signature: _____

Date: _____

Welcome to Sunrise Therapy Services. We appreciate the opportunity to help you. This form includes information about therapy that we will go over together. It ensures that everyone is on the same page as to what to expect in our work together.

Information about Therapy

As with any powerful treatment, therapy includes risks and benefits. The main risk is that things may change in your life. This may seem obvious, but it is important to consider the discomfort that even positive change may cause in your life, relationships, and work. Things that were hidden may be discussed. Relationships may feel like they are getting worse before they get better. All of this is part of the change process. As this change occurs, please feel free to discuss your reaction to it as we proceed.

The benefits of treatment include growth in areas of your life in which you feel trapped. Relationships that you are dissatisfied with may take on new life, and your sense of yourself as a person may become stronger. You may become aware of why you make certain choices, and why those closest to you react the way they do. You may experience a broadening of options as you consider doing things you didn't think were possible before.

Confidentiality

Maintaining trust is important in any therapeutic relationship, and I will keep the information you share with me confidential, including the fact that you are my client. There are several limits to this confidentiality, and I ask for your understanding and agreement to these before we proceed.

First, I am a mandated reporter, so if you disclose any information about the possible physical or sexual abuse, or neglect of a child (any person under the age of 18), I am required by law to report that information to the Department of Children and Families (DCF).

Second, I am required to take steps to safeguard your safety and the safety of others if you reveal any suicidal or homicidal ideation or intent. This may include, but is not limited to, contacting a family member to monitor you, taking you to the hospital, calling the police and warning the person you are threatening, or calling 911. Please provide the information for a contact below whom I can call in the event of an emergency.

Contact:_____ Phone: _____

Relationship to you: _____

Sunrise Therapy Services, LLC
580 Naugatuck Avenue Milford, CT 06461
P: (203) 307-1123 F: (203) 283-7714
4154 Madison Avenue Suite 102, Trumbull, CT 06611
P: (203) 612-4300 F: (203) 892-6873

sunrisetherapyservicesllc@sunrisetherapyservices.com www.sunrisetherapyservices.com

Third, like any professional, I may consult to ensure that I give you the best treatment possible. I also am required, if ordered by a judge, to release information about you and your treatment that may be relevant to a court case.

Payment and Fees

Our fees are outlined in the attached Scheduled of Fees and Charges. Forms of payment accepted are checks, cash, debit/credit cards, HSA (Health Savings Account) or FSA (Flexible Savings Account) cards. Payment in full is due by the end of each session. I will charge the full session fee even if you are late to a session, and I may not be able to extend the session due to other appointments. If for any reason you are unable to pay at the end of session, I must receive the full amount before the next session begins.

Cancellations/Missed Appointments

I ask that you provide **24 hours notice** of cancellations by phone, or **48 hours notice** if you inform me by email. If you do not give the required notice, or fail to attend your scheduled session, you will be charged a fee of **$70.00**, which must be paid before we have another session.

Ending Therapy

Therapy, like any relationship, has the best effects if there is closure at the relationship's end. Therefore, I would like you to agree that when you decide to stop therapy, you will inform me of your decision to terminate, and then come for one final session. This allows us both to be intentional about ending therapy, to review the progress you have made, and the work that we have done together.

I/We, _____ {print name(s)}, have read and agree to the policies above.

Client:_____ Date:_____

Client: _____ Date: _____

Therapist: _____ Date: _____

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Family's Information Form (p. 1 of 3).

Today's Date:_____

A. Identification

Your Name: _____ Date of Birth:_____ Age:_____

Nicknames or Aliases:_____

Home Street Address:_____ Apt:_____

City, State, Zip:_____

Phone Numbers: (H)_____(C)_____(W)_____

Preferred Contact Number (circle): H C W Email: _____

Spouse's Name:_____ Date of Birth:_____ Age:_____

Nicknames or Aliases:_____

Home Street Address (if different): _____ Apt:_____

City, State, Zip: _____

Phone Numbers: (H)_____(C)_____(W)_____

Preferred Contact Number (circle): H C W Email: _____

Date of Marriage:_____ Length of Marriage: _____

B. Referral: Who referred you to me?

www.therapytribe.com Yes No www.psychologytoday.com Yes No

Other Referral Source: Name: _____ Phone:_____

Address: _____

May I have your permission to thank this person for the referral? Yes No

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C. Your Medical Care: From whom or where do you get your medical care?

Clinic/Doctor's Name:_____ Phone: _____

Address:_____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Spouse's Clinic/Doctor's Name:_____ Phone: _____

Address:_____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

D. Your Current Employer

Employer Name and Address: _____

Spouse's Employer's Name and Address:_____

E. Your Education and Training

Your Highest Level of Education: _____

Spouse's Highest Level of Education:_____

F. Military Experience

Self Spouse None

Dates: From: _____To:_____

Branch of Service: _____

Job Title or Duties: _____

Reason For Leaving: _____

Spouse
Dates: From: _____ To:_____

Branch of Service: _____

Job Title or Duties:_____

Reason For Leaving: _____

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Family's Information Form (p.3 of 3).

G. Family-of-Origin History

Is your father still alive? Yes No If no, cause of death_____

Is your mother still alive? Yes No If no, cause of death _____

Do you have siblings? Yes No If no, cause of death _____

What position are you? _____

Spouse

Is your father still alive? Yes No If no, cause of death _____

Is your mother still alive? Yes No If no, cause of death _____

Do you have siblings? Yes No If no, cause of death _____

What position are you? _____

H. Children

Indicate which is/are from a previous marriage or relationship with the letter **P** and from whom (self or spouse) in the last column.

Name	Age	Sex	From a previous relationship

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SCHEDULE OF FEES AND CHARGES

CONTRACT BY AND BETWEEN: Sunrise Therapy Services, LLC, THE PROVIDER, and_____, THE CLIENT and THE FINANCIALLY RESPONSIBLE PARTY.

I understand that payment is expected at the time of service and that insurance coverage is not a substitute for payment. I understand that I, as the patient, parent or guardian, am ultimately responsible and liable for this bill, not my insurance carrier or any third party.

In the event that I am successful at a later date in finding third party payment, I remain personally obligated to the initial agreed upon fee. If the third party commits to a retroactive payment it will be reimbursed to me up to the agreed upon rate.

Unless an agreement between Sunrise Therapy Services, LLC and a third-party payer stipulates otherwise, from the date of responsibility for payment by a third party, where the third-party payment is lower than the agreed upon fee, I remain obligated only for the difference between the initial agreed upon fee and the third-party payment. Where the third-party payment is higher than the agreed upon fee that rate remains in effect during the time period for which it applies. When a third party assumes payment of the fee the remainder of this agreement remains intact.

Fees for services rendered are as follows:
Diagnostic Intake—$220
Family Session With Client—$180
Family Session Without Client - $150
Individual Session—$120
Group Session—$50
Consultations - $200
Court Appearance (if necessary)-$400 per hour

Cancellations/Missed Appointments

Sunrise Therapy Services, LLC asks that you provide **24-hour notice of cancellations by phone, or 48-hour notice if you inform us by email.** If you do not give the required notice, you will be charged **$70.00,** which must be paid before we have another session.

Client: _____ Date:_____

Witness:_____ Date:_____

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Financial Agreement

THIS AGREEMENT, made this by and between _____ the client, and Sunrise Sunrise Therapy Services, LLC.

WITNESSETH THAT:

Sunrise Therapy Services, LLC agrees to provide: Outpatient Services to _____ the client.

These services will be provided to myself and/or members of my family.

I understand that I will be responsible for the full amount of the fees for these services, less the amount collected from insurance or third-party agents, and that these fees are due at the time of the session.

I further understand that if my account is in arrears, Sunrise Therapy Services, LLC may turn my account over to attorneys for collection after giving at least 30 days notice of its intention to do so.

Insurance Information

Insurance Name:_____ Name of Insurance Carrier:_____

Insured SSN:_____ Insurance Group Number:_____

Insured D.O.B:_____ Member ID:_____

Client Name:_____ Client D.O.B:_____

Client SSN:_____

For the Family/Client:_____

Date:_____

For Sunrise Therapy Services, LLC:_____

Date:_____

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Acknowledgment of Receipt of Privacy Notice

I have been provided with and reviewed Sunrise Therapy Services' Notice of Privacy Practices dated September 17, 2018 and been given an opportunity to have any questions about it answered. I understand that if I have further questions or complaints concerning the use and disclosure of my health information or about my privacy rights, I may contact the Privacy Officer at (203)-307-1123.

I also understand that I am entitled to receive updates upon request if Sunrise Therapy Services' Notice of Privacy Practice is amended or changed.

Client Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date: _____

Sunrise Therapy Services, LLC.
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Phone: (203) 612-4300
Fax: (203) 892-6873

RELEASE OF PROTECTED HEALTH INFORMATION

Client: _____ D.O.B:_____ Date: _____

Address: _____ City: _____ State/Zip: _____

PLEASE NOTE: THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS COMPLETED IN FULL

I hereby authorize: _____ of _____ _____ To release information to _____ of Sunrise Therapy Services, LLC.	I hereby authorize Sunrise Therapy Services, LLC. to release information to: Name: _____ Agency:_____ Address: _____ Phone: _____ Fax: _____

The information to be disclosed was explained to me and consent was given of my own free will. I understand the treatment record to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, or confidential (HIV) AIDS related information.

Specific Information to be released from my (or my child's) treatment record: (Check all that apply)

__ Discharge Summary __Treatment Plans __ Consultations: written and/or verbal
__ Psychiatric Evaluation __ Medication Records __ Communications
__Other_____
__ Psychosocial Assessment __ Laboratory Data _____
__ Psychological Testing __ Medical History
__ Limited to the following dates of service: _____ to _____

The information for which I'm authorizing release will be used for the following purpose(s) and All other use is prohibited:

__ Pending legal action (copy charges will apply)
__ Personal use/self (copy charges will apply)
__ Continuing care / follow-up care
__ Disability / Social Security
__ Worker Compensation
__ Other _____

I understand my treatment records are protected by the Health Insurance Portability and Accountability Act (HIPAA), Federal Regulation (42 CFR, Part 2), and State of Connecticut General Statutes (Chapter 899, 52-146c). I understand under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or continued treatment by Wellspring is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that I may revoke this consent at any time by written notification to the Clinical Director, except to the extent that action has been taken. I understand that I may inspect or copy the information to be used or disclosed. Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization. Unless otherwise revoked, this authorization will automatically expire one year from its signing.

Signature of Client or Legal Representative: _____ Date: _____

Witness_____ Date: _____

Information Released	By Whom	To Whom	Date