Psychological Services and Care, LLC
Address: 157 Church Street, 19th FL
New Haven, CT 06510
Phone: 646.902.4357
Email: april@psychservicesandcare.org

Be you + be well

A note from the offices of Dr. April M. Ries:

Hello + Welcome to PS+C,

I look forward to meeting you. Please complete documents in full and make sure to sign and date each form where this is indicated. You may attach your insurance card and driver's license or state ID. If someone other than yourself carries your insurance, they will need to sign the Authorizations for benefits and you will need to provide their driver's license, as well.

Please indicate what your desire to achieve as a result of our work together as completely as you can; this will allow us to be most effective together.

I very much look forward to getting to know your and support you in your journey of wellness.

Most Sincerely,

Dr. April Ries

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New Patient Information

Patient Name _____
First Middle Last

If under 18 y/o
Guardian(s) _____
First Middle Last

_____
First Middle Last

Date of Birth _____ Age _____ Gender _____ Grade/Occupation_____

Mailing Address: _____
Street City, State Zip

Phone: _____ Permission to leave voice mails [] Y [] N Texting ok [] Y [] N
Phone Primary Contact/Relationship

Phone: _____ Permission to leave voice mails [] Y [] N Texting ok [] Y [] N
Phone Secondary Contact/Relationship

Phone: _____ Permission to leave voice mails [] Y [] N Texting ok [] Y [] N
Phone In Case of Emergency Contact/Relationship

Email: _____ Do you wish to receive information from us? [] Y []N

Have you received services in the past year? []Y []N

Name of provider _____

Primary Insurance Information

Policy Holder Name _____ Relationship to Patient _____
Policy Holder DOB _____ Male/Female _____
Insurance Company _____ Insurance Phone _____
ID Number _____ Group Number _____

Secondary Insurance Information

Insurance Company _____ Insurance Phone _____
ID Number _____ Group Number _____

Authorization for Release of Information and Assignment of Benefits for Insurance

I authorize the use or disclosure of my health insurance information necessary to submit and process insurance claims. I understand that the service authorized to receive the information in not a health plan or healthcare provider. I authorize payment of medical benefits to my provider for services rendered.

Signed _____ Date _____

Note: Holder of Insurance MUST Sign here + provide driver's license of State ID card

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Reason seeking services: _____

_____

_____

I was referred by: _____

One big thing I hope to accomplish in therapy is: _____
Patient Grade/Occupation: _____
History of Education (FOR CHILDREN please include pre k-current grade):_____

_____

_____

Who does the patient live with (names/relationships, FOR CHILDREN include ages of siblings): _____

_____

_____

_____

Does patient have past history of treatment? [] Yes []No
Provide any past diagnosis and name of provider who diagnosed patient.

_____

_____

Does patient have current or past suicidal ideation? [] Yes [] No
Are guns or weapons in the household of patient? [] Yes [] No
Has patient ever had to go to the hospital for mental health concerns? [] Yes [] No
Does patient have any medical health concerns? [] Yes [] No
Has the patient lost a loved one? [] Yes [] No
Has the patient experienced abuse, neglect, or trauma? [] Yes []No

Provide any past diagnosis and name of provider who diagnosed patient as well as any other details here:

How do I feel?

[] anxious	[] Insecure	[] unsure	[] lost	[] inpatient
[] sad	[] Alone	[] afraid	[] jealous	[] hopeless
[] guilty	[] unable to sleep	[] angry	[] unfocused	[] drained

How do I want to feel?

[] peaceful	[] Energized	[] worthy	[] capable	[] patient
[] appreciated	[] Grateful	[] valued	[] optimistic	[] hopeful
[] confident	[] Present	[] strong	[] focused	[] energized

What are 3 things you like about yourself?

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Consent for Treatment

Welcome to Psychological Services and Care, LLC (PS+C). Upon your intake appointment, you will be asked to meet for one to six sessions in order to give appropriate time for assessment to address your concerns and treatment needs. During this time, your goals for seeking services and care will be addressed as well as collaborative goals and objectives for treatment will be outlined.

While it is my goal to be of help to the patient, I cannot guarantee treatment outcome. If you have concerns or questions about the services I provide, please feel free to discuss this with me. At any time you may seek an additional opinion and/or withdrawal from treatment services. I will make every effort to facilitate your consultation and/or transfer you to another clinician. I will offer that same referral assistance in the event that I find it necessary that the care you are in need of is outside of my area of competency.

In order for therapy services to be most beneficial, we will meet, on a once-per-week basis unless otherwise arranged. For patients under the care of a parent/guardian, parent sessions may be necessary. It is preferable to have regularly scheduled appointments. In the event of a missed appointment it will be assumed that the patient will attend the upcoming scheduled appointment unless otherwise communicated. Occasional rescheduling and cancellations, if necessary, must be made at least **48 hours** in advance. Missed appointments or cancellations within less than 48 hours, will be a charged a fee of $150.00. In the case of an emergency, it is your responsibility to notify the practice within 48 hours of the reason for the missed appointment. Please understand that missed appointments may also result in losing your regular appointment time.

In addition to direct services for psychotherapy, it may be necessary to provide a range of indirect case management services. The charge for office-based case management services is $100.00 per half hour. Specific case management services may include but are not limited to letters and or reports written on your behalf regarding psychotherapy, travel to and attendance at any meetings in person or by phone to offer advocacy and care, communication with providers for consultation and/or collaboration for the patient's treatment and care.

Please note that legal and court related services are not provided. This includes custody related services, such as assessment and or custody evaluations. If you have such needs, you will be referred to a practitioners and/or agency specializing in this area.

It is your responsibility to have a card on file for all payments and fees. If your card and expires and you do not provide a new card to cover fees, this will result in a fee of 150.00 per week until a payment is made. All co-payments and payments are made on the date of service at the start of session of each session. You may place a Health Savings Account (HSA) or any major credit card. You will receive an immediate receipt via text or email for your payment. You may also request detailed receipts if need be.

Medical records will be retained for a period of seven years from the last date of service unless otherwise specified (i.e., in the case of a youth).

My signature indicates that I have read and understand the notice of practice and policies and have been given a copy. I am voluntarily requesting services from this provider. I give consent for disclosure of protected health information for purposes of treatment, referrals, payment, and healthcare operations. I understand that there are charges for late cancellations and missed appointment. I agree to abide by treatment, payment, and cancellation policies. I understand my medical record will be available for up to seven years.

Print Name(s) _____ Sign Name: _____ Date: _____
Print Name(s) _____ Sign Name: _____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable of law and the APA Code of Ethics. I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices.

HOW I MAY USE AND DISCLOSE HEALTH INFORMAIOTN ABOUT YOU

FOR TREATMENT Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are the following: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or undertaking utilization review activities. If it becomes necessary to use collection process due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (i.e., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.

REQUIRED BY LAW Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

WITHOUT AUTHORIZATION Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are the following: 1) Under the Connecticut Mandated Reporting Law, I must report to the Department of Children and Families Services, the Office of Protection and Advocacy for Persons with Disabilities, or the Protective Services for the Elderly, any disclosures of physical or sexual abuse or neglect of a minor, a disabled person, or an elder; 2) If you are in danger of hurting yourself and you refuse to accept appropriate treatment, I will have to notify appropriate authorities and possibly your emergency contact to protect your safety; 3) If you are threatening to harm someone else and I believe this person is in danger,

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I will have to notify appropriate authorities and the person being threatened; 4) If I am required by Court Order I may have to disclose information in your record.

VERBAL PERMISSION I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies (standard rate $.45 per page).
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the APA addressed to American Psychological Association Attn: Office of Ethics 750 First Street., NE Washington, DC 20002-4242 or by calling (800) 374-2721 or (202) 336-5580. I will not retaliate against you for filing a complaint.

The effective date of this notice is April 1, 2016.

I have read this notice of privacy practices and understand how the practices relate to my treatment.

Patient Name _____ DOB: _____

Print Name(s) _____

_____

Signature(s) _____ Date _____

_____ Date _____

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Acknowledgement and Consent for Electronic Communication and Crisis Events

CONTACTING ME BETWEEN APPOINTMENTS

The best way to reach me is by phone at 646.902.4357. You may call me at any time and leave a message on my confidential voicemail and/or send a text message. Do not use email (more on this below). Most calls are returned in a 24-hour period. It is not possible for me to respond to an emergency at times. As such, if you are experiencing a clinical emergency call 211 from a mobile phone you can use 800-203-1234 and speak to a Emergency Mobile Psychiatric Service (EMPS) clinician, call 911, or take yourself to the nearest Emergency Department. To protect your confidentiality, your contact will be saved into my business phone using an encrypted series of letters. This allows me to make your call a priority, while protecting your name from being known to anyone else that may see the caller ID on my phone. This being said, please only identify yourself or family members by using initials when sending text. Anything you send that contains personal info will be saved to your chart, if need be, and promptly deleted to protect your personal information. Receiving text message reminders of appointments, the day before have been found as useful by most patients. Be reminded this is a courtesy not to be used as a time to cancel as you will need cancel 48 hours prior to your appointment please and thank you.

EMAIL

Email will be utilized only by your request to collaborate with your treatment team and/or to share documents per your request. Use of email/electronic communications between patients and their clinicians has risks regarding protection of your private health care information. Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. No technology is 100% secure and I cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Emails and other means of electronic communication should NEVER be used to communicate emergency, urgent, or other time sensitive information. Do not email me content related to your therapy sessions, as an email is neither completely secure nor confidential. Any emails I receive from you and responses I send to you may become a part of your medical record.

SOCIAL MEDIA

I am committed to maintaining proper boundaries that include, but are not limited to, protecting the privacy and confidentiality of our therapeutic relationship. As such, I do not accept "friend" or contact requests from current or former clients on any social networking sites. Please, do not attempt to contact me by using sites such as Facebook, Twitter, Linked In. It is my practice not to respond to such contact from patients and/or former patients. If you chose to use emails or electronic communication as a way to communicate with this organization, please read and sign below:

- I have read and understand the information provided regarding emails or electronic communication. I have had my questions regarding this answered to my satisfaction.
- I understand that Psychological Services and Care is required by Federal and State Law to try to protect my private health care information, which is the reason I am being informed of the risks involved with emails or electronic communication.
- I understand that I am not required to participate in email or electronic communication, but if I do consent, I may withdraw this consent at any time by notifying Psychological Services and Care in writing.

With knowledge of the risks and limitations of electronic communication, I give my informed consent to participate in email or electronic communication with Psychological Services and Care:

Client Signature_____ Date_____
Guardian Signature_____ Date_____
Clinician Signature_____ Date_____

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Telehealth Informed Consent Form

I _____ (patient name/guardian) herby consent to engage in telehealth with Dr. April Ries as a part of my treatment and care with Psychological Services and Care, LLC. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communication. I understand that telehealth may also involve the communication of my medical/mental health info, both verbally and visually, to healthcare professionals.

I understand I have the following rights with regard to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment
2. The laws that protect the confidentiality of my medical information also apply to telehealth care and treatment. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and/or dependent abuse; expressed threats of violence towards an ascertainable victim, and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychologist, that; the transmission of my medical information could be disrupted or distorted by technical failures.
4. I understand that if I am in need of emergency mental health services, I should contact my local emergency room. Additionally, I can utilize the state 211 line if I need assessment immediately.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with the law.
6. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent. I.e., this includes in group or individuals' sessions there is no coping or taking photos of screens for any form of use. The same confidentiality applies and should be uphold.
7. Additionally, in any group session you have the right to know your peers are in a private setting with no family members or children present. If need be arrangements can be made (as in the issue of being a primary childcare provider during COVID19) to utilize headphones in order to ensure that others words and images are not shared with anyone other than the identified patient.

I have read and understand the information provided above. I have discussed in with my psychologist, and all of my questions and/or concerns have been answered to my satisfaction.

_____ _____

Signature of patient/guardian Date

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Working Collaborative Treatment Plan

Date: _____

If you had three wishes to be granted right now, what would you wish for? Why? What would those wishes do for you personally?

_____
_____
_____

List 3 Goals for Therapy:
1)
2)
3)

Give a word or sentence to describe how you are feeling about each area below currently in your life:

I am _____ The world is _____
Family_____ Fitness_____
Friends_____ Intimacy_____
Fun_____ Faith_____
Finances_____ Life Purpose_____

Name as many feelings below in 60 seconds:

What is the biggest dream of your life that you will not allow other humans to ever talk you out of?

_____
_____
_____

Sign: _____ Date: _____
Clinician Sign: _____ Date: _____

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Use this space to create NOTES TO YOURSELF ABOUT YOU FOR YOUR FIRST VISIT
(i.e., questions you have or anything you want to remind yourself about to share with the doctor on your visit)

Notes: