STERLING INSTITUTE
Neuropsychiatry & Behavioral Medicine
100 Mill Plain Rd., Danbury, CT 06811

Patient Information, Policies and Permissions

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Hon.

First Name:_____ Middle Name/Initial:_____

Last Name:_____ Suffix:_____

Referred By:_____

Home Address

Address1:_____

Address 2:_____

City:_____ State:_____ Zip Code:_____

Work Address

Business Name:_____

Address1:_____

Address 2:_____

City:_____ State:_____ Zip Code:_____

Phones

(Please provide all numbers; check the phone we should use for appointment reminders)

☐ Home: (_____)_____-_____ (Voice Reminders)

☐ Cell: (_____)_____-_____ (Text Reminders)

☐ Work: (_____)_____-_____ (No Reminders, Emergency Use Only)

E-mail Address: _____

Birthday

Month:_____ Day:_____ Year: 19_____ **or** 20_____

Marital Status

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security Number: _____ -_____ - _____

Biological Sex: ☐ Male ☐ Female

Primary Care Physician: _____

City:_____ State:_____

Race And Ethnicity

(Section §170.314(A)(3) of the federal CMS "Meaningful Use" Regulations defines the terms and categories of these questions, obliges physicians to inquire, and also to let you know that you need not answer them. The government and delegated agencies may request statistical summaries of this data.)

Ethnicity: Hispanic, Latino, Spanish Origin? ☐ Yes ☐ No ☐ No Answer

Race (Select all that apply):

☐ American Indian or Alaska Native: A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliations or community attachment.

☐ Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam. (Note: Individuals from the Philippine Islands have been recorded as Pacific Islanders in previous data collection strategies.)

☐ Black or African American: A person having origins in any of the black racial groups of Africa.

☐ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

☐ No Answer

Insurance Information (Check all that apply):

Sterling Institute does not accept Husky nor other Medicaid Payors. You may still be treated if you wish on a self-pay basis. Your Husky/Medicaid prescription benefits will be honored by pharmacies regardless of prescriber.

N.B. You may have insurance that is underwritten by a major-name carrier whom we accept but in a dub-network that does not provide benefits to certain classes of providers who are otherwise contracted with that carrier. This most commonly happens with Providers.

☐ Self-Pay ☐ Medicare ☐ Commercial Insurance or Supplemental

Primary Insurance Carrier Name: _____

Network Name: _____

Identification Number: _____

Telephone Numbers (Back of Card):

☐ Provider Services: (_____)_____-_____

☐ Member Services: (_____)_____-_____

☐ Claims: (_____)_____-_____

Secondary Insurance Carrier Name: _____

Network Name: _____

Identification Number: _____

Telephone Numbers (Back of Card):

☐ Provider Services: (_____)_____-_____

☐ Member Services: (_____)_____-_____

☐ Claims: (_____)_____-_____

Emergency Contact

Name: _____

Relationship to Patient: _____

Address: _____

City:_____ State:_____ Zip Code:_____

☐ Home Phone Number: (_____)_____-_____

☐ Cell Phone Number: (_____)_____-_____

☐ Work Phone Number: (_____)_____-_____

Assignment of Benefits

I hereby authorize my treatment provider(s) to apply for benefits on my behalf for covered services rendered. I request that payments from my insurance company be made directly to the provider(s) or to Sterling Institute, LLC, who may in some cases accept assignment. If I receive any payments from my insurance company in error, I will notify Sterling Institute for further investigation. If claims are denied for any reason, I will be responsible for the full fee. I agree to obtain pre-certification from my insurance company for any initial appointment as required. I certify that the information I have reported with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. In writing only, this authorization may be revoked by either me or my insurance company at any time. I hereby authorize the use of this signature for billing my insurance company. I agree to be personally responsible (or where appropriate, allow my family/significant other to be responsible) for payment of all charges due Sterling Institute if they are not covered by my insurance carrier or if the provider is out-of-network.

Patient/Guardian Signature: _____

Patient/Guardian Name (Print): _____

Date: _____

Consent and Acknowledgement Form

I consent to medical psychiatric and psychotherapeutic evaluation and treatment by the licensed physicians and other behavioral health professionals of Sterling Institute for Neuropsychiatry and Behavioral Medicine, LLC. I have received a written copy of Institute policies, read them, and agree to comply with them as indicated by my signatures below.

I acknowledge receipt of the Patient-Professional Contract, understand the mutual obligations entailed therein and by my signature accept them. I understand that I am free to stop any recommended treatments, including medication, without forfeiting the right to be re-evaluated by the professional who recommended and/or prescribed the treatment. However, I also understand that it is not recommended that I stop any medication abruptly or without medical supervision.

I also understand that I am free to transfer my care to another care at any point without prejudice.

I understand that Sterling Institute will take all precautions to protect my confidentiality and privacy in accord with the Health Insurance Portability and Accountability Act (HIPAA). I authorize Sterling Institute to release protected health information concerning my evaluation and treatment as judged necessary only if such information is disclosed in accordance with Federal and Connecticut law.

Disclosure often requires Sterling Institute to request my consent which I understand I am free to withhold. I understand that Sterling Institute has the right to refuse treatment and to refer me elsewhere, if possible, if in the sole judgment of the Institute or its professionals my withholding of such consent prevents the Institute from providing me with high-quality treatment, reimbursement of the Institute for its services, or places my health or that of another in jeopardy. If my failure-to-disclose places my life or the life of another in imminent jeopardy, Federal and State law requires such disclosure immediately without my consent.

I understand that as is inherent in nature of health insurance, and as is stated explicitly in my health insurance contract, recipients of disclosed information may include my insurance company and other reimbursement agencies and utilization review companies with which they contract.

I understand that this consent is effective so long as Sterling Institute, LLC, maintains my protected health information in its records.

By signing below, I understand and acknowledge that I have read and understand this consent.

Print Name of Individual or Personal Representative:

_____

Signature of Individual or Personal Representative:

_____

Date: _____

If signed by the Individual's Representative, describe the legal authority of the representative to act on behalf of the Individual. (Sterling Institute may require proof of guardianship or power of attorney or of Conservatorship of Person for treatment and of Estate for reimbursement.):

_____

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Authorization to Release Information to Specified Individuals

Please complete if there is anyone you grant consent to receive information about either your clinical history or your billing status.

Without such permission, no one associated with Sterling Institute, LLC, may answer questions about you posed even by a family member (spouse, parent or other relative), neither about your medical status, your prescriptions, your billing nor even the fact that you are being, or have been, or intend to be treated here.
Custodial parent(s) of a minor child do not need authorization.

Authorization:

I understand that if I authorize the release of records, those records may contain information pertaining to my psychiatric, drug and/or alcohol abuse treatment, if any, and may also contain confidential HIV (AIDS) related information should it come into the possession of Sterling Institute either directly (in my discussions with my treating professionals) or indirectly (e.g., from other physicians' records).

I understand that I may withdraw this consent at any time in writing. However, should I withdraw consent after Sterling Institute has released information in accord with previously signed consent, then so long as Sterling Institute releases no further information it will have acted properly and shall be held harmless for such previously released information.

By this release I authorize Sterling Institute, LLC, to release or communicate written or verbal information as indicated to:

Name 1: _____

Relationship: _____

Name 2: _____

Relationship: _____

Name 3: _____

Relationship: _____

The information that may be shared is restricted to: (Please check all those that apply)

☐ Psychiatric Treatment / Psychotherapy Records

☐ Prescription Information, incl. pick-up of scripts

☐ Billing Information: Charges, payments, balance

☐ Appointment Information: Making / Changing Appointments

OR

☐ Check here if no information is to be shared except as mandated by HIPAA and State and Federal Regulations.

_____

Print Name of Patient

_____

Signature of Patient

_____

Signature of Parent (if patient is a minor child) or of Guardian

Date: _____

Billing and Financial Obligations

Missed appointments, including for longer initial evaluations, are unfortunately the bane of every medical practice and have become increasingly common in recent years. As was explained when you first booked an appointment, Sterling Institute, LLC, requires an initial booking fee of $50.00, charged against a credit card, that will be applied against your initial (today's) visit. We will maintain a valid credit card of yours on file and below we ask you to sign an authorization permitting us to bill that card for a variety of reasons. Most of these are the expected reasons – payment of co-pays, co-insurances and deductibles. There are other situations that may trigger an automatic charge – missing an appointment with less than 24 hours' notice, for example. Though allowed by, for instance, Medicare, these charges are almost never covered by insurance of any kind. We urge you to rigorously maintain your account and appointments in good order.

We will alert you in advance of posting the charge so that you will be able to make a reasonable payment arrangement. Situations that will trigger a charge to your credit card other than you decision to use to pay for co-pays, co-insurances, deductibles and self-pay charges include (please initial on each line):

_____ Balance overdue more than 30 days, per 30 days: Balance owed plus a late fee not to exceed the equivalent of a 12% APR per CT law.

_____ $75 per 15 minute time slot. Cancellation of an appointment with less than 24 hours advance notice *within business hours on working days*, Monday through Friday excluding Federal Holidays, 9 a.m. to 5 p.m. Notice given for example on a Friday night at 5:30 p.m. for a 9 a.m. appointment the Tuesday following a Federal three-day weekend is the equivalent of a ½ hour notice. (The answering service is for urgent medical matters only.) The principle behind this is simple: "Is it reasonable to expect the appointment slot to be filled?"

_____ $75 per 15 minute time slot: No appearance at a scheduled appointment.

Sterling Institute will make reasonable accommodations in the event of illness or emergencies. These charges represent the cost to Sterling so that when the cause is dire, we may agree to split the fee.

_____ Please note that *automated appointment reminders are a courtesy and may fail or transmit erroneous information*. Please be sure to take an appointment reminder card and record your appointment yourself. Please call if there is a discrepancy between the automated reminder and your own record.

□Visa □MasterCard □Discover □Amex

Name on Card: _____

Billing Address: _____

Card Number: _____

Expiration Date: _____ Security Code (CVV): _____

Signature: _____

Date: _____