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 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 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 my treatment records will be outlined in the Notice of Privacy Practices that will be given to me upon admission to Sunrise Therapy Services, LLC.

For the purpose of treatment, clinical information may, when relevant, be shared with the 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 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. I 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: __________________________________

Third, like any professional, I consult with my supervisor 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

My fees are outlined in the attached Scheduled of Fees and Charges. Payment is accepted by cash, check, or debit/credit card at the end of each session. I will charge my full 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:________________

— —

Sunrise Therapy Services, LLC
580 Naugatuck Avenue Milford, CT 06461

(203) 307-1123 (T)
(203) 283-7714 (F)

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: H C W E-mail: ___________________________________

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: H C W E-mail: ___________________________________

Date of Marriage:__________________ Length of Marriage:__________________

B. **Referral: Who referred you to me?**

www.theravive.com Yes No

Other: Name:____________________ Phone:___________________________

Address: _______________________

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

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

Self

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: _______________________________________

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 yes, how many? ______________________________________
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 yes, how many?___________.
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

This is a strictly confidential record. Re-disclosure or transfer is expressly prohibited by law.

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 me by email.** If you do not give the required notice, you may be charged **$70.00**, which must be paid before we have another session.

Client: ____________________________ Date:__________________________

Witness:___________________________ Date:__________________________

Financial Agreement

THIS AGREEMENT, made this by and between ___________________and
Sunrise Therapy Services, LLC. of Milford, Connecticut.

WITNESSETH THAT:

Sunrise Therapy Services, LLC agrees to provide: Outpatient Services to ___________________.

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:___________

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: _________________

RELEASE OF PROTECTED HEALTH INFORMATION

Client:__________________________ D.O.B:________________ Date:_______________
Address:__________________________ City:____________ State/Zip: _______________

PLEASE NOTE: THIS IS A LEGAL DOCUMENT AND IT 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
__Psychosocial Assessment __Laboratory Data __Other
__Psychological Testing __Medical History
__Limited to the following dates of service from______________________ 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) __Disability / Social Security
___Personal use/self (copy charges will apply) __Worker's Compensation
___Continuing care/follow-up care __Other________________

I understand my treatment records are protected by the Health Insurance Portability and Accountability Act (HIPAA), Federal Regulation (42 CA-R, Paid 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.

Information Released	By Whom	To Whom	Date

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