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

Name ____________________________ D.O.B: ______________________

Admission to Covenant Family 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 Covenant FS's style of treatment.

In the event of refusing medications or treatment, it is the right of Covenant FS 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-l 0 1 of the Connecticut General Statutes, to report any suspected child abuse or neglect to the Department of Children and Families.

Covenant FS 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, Covenant FS reserves the right to charge for this session.

Office hours are by appointment only. If you have a clinical emergency during non-clinic hours, call 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 Covenant FS.

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
Covenant Family Services, LLC
550 New Haven Avenue
Milford, CT 06460
Phone: 203-446-1848
Fax: 203-283-7714

Services to be received:
Individual Therapy
Family Therapy
Medication Management
Assessment
Case 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 Signature: ___________________________ Date: ______________

Client Name: ______________________________

SCHEDULE OF FEES AND CHARGES

CONTRACT BY AND BETWEEN: Covenant Family 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 Covenant FS 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

Covenant FS ask 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, which must be paid before we have another session.

Client: ____________________________ Date: __________________

Witness: ___________________________ Date: ___________________

Financial Agreement

THIS AGREEMENT, made this by and between _________________________ and Covenant Family Services, LLC. of Milford, Connecticut.

WITNESSETH THAT:

Covenant Family 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, Covenant FS, may turn my account over to attorneys for' collection after giving at least 30 days notice of its intention to do so.

Insurance Information

Insured 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 Covenant FS, LLC.________________________ Date: _____________

Acknowledgement of Receipt of Privacy Notice

I have been provided with and reviewed Covenant Family Services' Notice of Privacy Practices dated September 30, 2012 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 203-446-1848.

I also understand that I am entitled to receive updates upon request if Covenant FS's Notice of Privacy Practice is amended or changed.

Client Signature: ______________________ Date: ______________

Parent / Legal Guardian Signature: ________________ Date: _______________