

OFFICE USE: Check page 2 for signature of patients aged 5 and older prior to scanning
 _____ PAR initials



BEHAVIORAL HEALTH DEPT.

AGREEMENT BETWEEN OUTPATIENT AND PATIENT OR PARENT/GUARDIAN

Patient Name _____ DOB _____

| | |
|----------------------|--|
| Parent/Guardian Name | |
| Address | |
| Telephone Number(s) | |

Person who will transport the client to and from appointments: _____
 (☐ If same as above, check here.)

Parent/guardian understands that they must remain in the Behavioral Health Dept. while the child is attending an appointment.

Children at the School-Based Health Center will be escorted by SBHC clinician from the school's main office to the clinic, then escorted back to the main office when service is completed.

I understand that there are not any medical procedures conducted by the behavioral health staff. Should medical assistance be required I will assume responsibility for seeking such treatment. Should an emergency occur, an ambulance will be called for me.

I understand that the only medications administered by the behavioral health staff are long-term, injectable psychiatric medications that are brought to the appointment by the person receiving the injection.

I have received a paper copy of the Patient Rights and Responsibilities. I have been instructed to contact the site manager if I have any questions.

I have been given a paper copy of the Notice of Privacy Practices.

I understand that all staff are mandated reporters and are required to report suspected child abuse and neglect (as described by CT statutes 17a-28; 17a-101; 46b-120). I understand that my confidentiality may be waived if I express an intention to harm

PLEASE REVIEW, SIGN AND DATE THE BACK OF THIS SHEET 

myself, harm another, commit a crime, or if I am experiencing child or elder abuse, or am gravely disabled.

Information will be released after signing a release of information form. If I sign a release of information form, I will do so of my own free will. The release will expire within one year; however, I may withdraw the release at any time without prejudice.

I have been given information about other Generations services during my meeting with the patient access representative.

I understand that to file a complaint I must register my complaint in writing with the Behavioral Health Site Manager or the Privacy Officer. A complaint form will be provided to me by Behavioral Health staff when requested. I understand that my complaint will be investigated within five days, and I will receive a response within 30 days.

I understand that I am responsible for payment of my session at the time of each session. If I have made payment arrangements, I understand that I am responsible to make such payments. I understand the fee which I will be charged for each session.

I have been provided with the business hours of the behavioral health clinic at Generations. I understand that there are not any medications prescribed after business hours, although I may contact a clinician if I require assistance by dialing 860-450-0585. I also understand that if I am experiencing an emergency, I should call 911 or go to the closest hospital emergency room.

I understand that when I arrive for my appointment I must check in at the front desk and make a payment (if applicable), and when I am leaving I must check out at the front desk to make a future appointment.

I understand that if I need to cancel an appointment after hours, I will leave the information with the answering service at 860-450-0585.

All of the above information was reviewed with me by clinic staff.

Patient Signature (age 5 and older must sign) and Date

Parent/Guardian Signature and Date

Generations Representative and Date

Generations Family Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Generations does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Spanish ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-808.9008.

Haitian ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-808-9008.