RANDALL DWENGER, MD
PO Box 718, 3 Brook Street, Lakeville CT, 06039
(860) 435·8863 Fax: (860) 435·8864

www.RandallDwenger.com
RD@RandallDwenger.com

Client Information Form

(This is a fillable PDF Form. It may be completed on-screen or else printed and filled out by hand.)

Name		Today's Date	/ /
Date of Birth	/ /	Age	
Home Phone	( ) -	Cell Phone	( ) -
Work/Other Phone	( ) -		
Email			
Home Address		For Students/Minors	
		Parent Name	
		Parent Phone	( ) -
		Parent Email	
Emergency Contact Information			
Name		Relationship	
Phone	( ) -		
Referred By		Phone	( ) -
Medical Provider (MD, Nurse Practitioner, etc.)		Phone	( ) -
Allergies	☐ None Or List:		
Medications	☐ None Or List:		

RANDALL DWENGER, MD
PO Box 718, 3 Brook Street, Lakeville CT, 06039
(860) 435·8863 Fax: (860) 435·8864

www.RandallDwenger.com
RD@RandallDwenger.com

PAYMENT AGREEMENT/AUTHORIZATION - RELEASE of INFORMATION

Patient Name		Date of Birth	/ /

I agree to be responsible for the entirety of my bill. I agree to pay for all services when rendered (or as agreed to with Randall Dwenger, MD.)

I understand that Dr. Dwenger does not "take" insurance, but he will provide me with a paid invoice containing the necessary information for me to submit to my insurance company for out-of-network reimbursement

I understand that Dr. Dwenger has "opted-out" of Medicare, and that I am not permitted to submit claims or expect payment from Medicare for his services

☐ I certify that I have active insurance coverage with:

Primary Insurance	*Insurance # (If Applicable)*
Secondary Insurance	*Insurance # (if Applicable)*

- I request that payment of my insurance benefits be made to me.
- I authorize Randall Dwenger, MD to act as my agent in helping me obtain payment from my insurance company(s).
- I authorize Randall Dwenger, MD to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- I permit the use of a copy of this authorization to be used in place of the original signature on all insurance submissions. - *This "Signature on File" is valid until it is revoked or treatment is terminated.*
- I hereby authorize and give my consent to Randall Dwenger, MD to discuss any confidential and private health information related to any claims, such as: psychiatric, substance use and medical history, diagnoses and treatment with my insurance company in order to facilitate the payment for my mental health care.

_____ _____

Signature *of Patient (or parent if patient is a minor)* *Date*

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken; it shall be effective only long enough to answer the purpose for which it is given, and no further confidential information will be released without the execution of an additional written statement of my consent. This document authorizes Randall Dwenger, MD to release information to the party(s) listed for the purposes described. The recipients of the confidential information are legally obligated to maintain the information confidential, are restricted from re-disclosure without further written consent from you unless otherwise permitted under law.

RANDALL DWENGER, MD
PO Box 718, 3 Brook Street, Lakeville CT, 06039
(860) 435·8863 Fax: (860) 435·8864

www.RandallDwenger.com
RD@RandallDwenger.com

TREATMENT COLLABORATION AGREEMENT

Psychiatric treatment involves a cooperative and collaborative effort between the patient and the psychiatrist. It is my obligation to offer you the most comprehensive and safest care to help you to make the change or gain the relief that you seek. Based upon the Initial Evaluation and Assessment, we will discuss the various treatment options, and together we will formulate a Treatment Plan (which may include psychotherapy and/or medication, or other behavioral plan). Your **active involvement and participation** in your treatment is vital in reaching a therapeutic plan and optimal outcome.

There can be some unintended **negative effects** with any treatment – this includes both therapy and medication. **Psychotherapy** sometimes raises difficult issues or painful memories. **Medications** often will have side effects. I will discuss the potential side-effects of any medication I prescribe. It is very important that you report any negative symptoms that you are experiencing or that you believe might be caused by your medication. **You should not stop, increase or decrease your medication without discussing it with me.** Treatment – whether medication or therapy – will often require time (and patience) to achieve a positive result.

Telephone Calls: I encourage you to call me whenever you have questions or problems. For non-urgent matters you should leave me a voicemail on my office phone (860-435-8863). I check messages daily (and my voicemail messages are also routed to my cell phone) and I will return your call within 24 hours. I generally do not charge for brief telephone calls with patients (or with family members for whom you have signed consent). Lengthier calls and scheduled "telephone sessions" will incur a charge (based on my prorated hourly rate).

Email and Text Communication: E-mail can be appropriately used to communicate information about scheduling, medication refills, transmitting articles or forms, as well as other non-sensitive matters. However, not all email is secure, and confidential/sensitive items should not be sent or received via e-mail. I do not do "therapy" on-line or via email or "Skype." Further, email should not be used for emergencies or other urgent communications. The best e-mail address for me is: RD@randalldwenger.com I am happy to communicate via **text messages** about appointment scheduling/rescheduling and medication refills, etc. I will give you my cell phone number at our initial session.

Emergencies: Emergencies may arise during our work together. At our initial session together, I will give you my cell phone to reach me for urgent matters (which should not be used for things such as prescription refills or appointment changes). In the case of a medical or psychiatric emergency and/or if you can not reach me, you should go to your nearest emergency room – or call 911.

Payment: Payment is expected at the time of service – either by check, cash, or credit card. For students, as this is not generally practical, parents often will provide a credit-card number for me to keep on file – or I will bill them monthly

It is important for you to know that I do not "accept insurance," but I will provide you an invoice with the appropriate diagnostic and CPT codes – for you to submit to your insurance company for reimbursement. You will need to sign a specific consent permitting me to communicate with your insurance company on your behalf.

Attendance: If you need to cancel your appointment, please call at least 24-hours in advance. I will generally charge a flat-rate charge of **$100** for any No-Show or Late-Cancellation. Frequent No-Shows or Late Appointments will be discussed in sessions, and may ultimately result in the need to terminate our treatment together

Confidentiality: I am bound by and I follow HIPAA privacy rules.

In general, all communications between a patient and his/her psychiatrist are **confidential**, and this confidentiality is protected by law. I can only release information about you with your permission. There are a few exceptions, however. There are some **circumstances when I am required to breach confidentiality without a patient's permission**. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate state agency. If I believe that a patient is threatening serious harm to another person, or if a client threatens to harm himself or herself, I may be required to contact family members, the police or to seek hospitalization.

If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment, and I will need consent from your parents before initiating or changing medications. If you are at one of the boarding schools – and especially if you are started on medications – I will need to communicate diagnosis, medications and prescriptions, and other concerns appropriate to your treatment to representatives from the Health Center office at your school.

RANDALL DWENGER, MD
PO Box 718, 3 Brook Street, Lakeville CT, 06039
(860) 435·8863 Fax: (860) 435·8864

www.RandallDwenger.com
RD@RandallDwenger.com

I have received a copy of Dr. Dwenger's **Treatment Collaboration Agreement**, and give consent for Dr. Dwenger to provide treatment to:

☐ Me

☐ My child

Patient Name _____

_____ _____
Signature [or Parent Signature] Date