Hartford HealthCare
Ayer Neuroscience Institute
Headache Center

Patient Treatment Agreement

- I consent to treatment by my Headache specialist _____ in the _____ location.
- I agree to conduct myself in a courteous manner. I will treat Headache Center staff and providers with respect and dignity whether in the clinic or on the phone. Non-adherence will result in discharge from the practice.
- I will use a normal tone of speech and use appropriate language when speaking with Headache Center staff. Yelling, screaming or being discourteous will result in being discharged from the practice.
- I will adhere to my treatment plan and recommendations. If my treatment plan is not working, I will schedule an appointment to discuss treatment options with my Headache specialist. I will voice any questions and concerns regarding my treatment plan during a visit with my Headache specialist.
- I agree and understand that I will not be able to transfer to another headache specialist, unless there are extenuating circumstances which I will submit in writing. Such requests will be reviewed by appropriate management staff for approval.
- I understand that I can only transfer to another headache specialist or Headache center site once. If additional transfers are requested, I will need to seek future care outside of the HHC Headache Center.
- I agree to be on time to all of my scheduled appointments and understand that if I am more than 10 minutes late, my appointment may be canceled and/or rescheduled.
- I agree that I will not wear any perfumes or strong smelling soaps/lotions to my visit. I understand that perfumes or scented soaps/lotions can trigger headaches to other patients or providers. If I arrive wearing perfumes or lotions, I will be asked to reschedule my appointment.
- I will contact the clinic 24 hours in advance if I am unable to keep my appointment. I understand that keeping my appointment is essential to a positive outcome. A pattern of missed appointments, three in one calendar year, may result in The Headache Center discharging me from the practice.
- I agree to communicate any changes in insurance or financial coverage timely. I understand that not supplying changes in coverage prior to a visit or procedure can result in a cancellation of an appointment or non-coverage of services, which I am financially responsible for.

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- During Telehealth visits, I will give my Headache specialist my undivided attention. I will be prepared in advance in a private, well-lit room with a camera view of my person ready to discuss my care. I understand that my provider expects me to be respectful, treating this visit like I would a visit to the clinic. If I am not properly clothed, conducting the visit while driving or otherwise not in the moment, my Headache specialist will end the visit.
- I agree to adhere to the financial policy outlined by this office and Hartford Healthcare. It is my responsibility to understand my insurance coverage and financial responsibility of my treatment.

By signing this Patient Treatment Agreement, I acknowledge and agree to abide by its terms and agree to establish and/or continue care with Hartford Healthcare Headache Center.

_____ _____

Patient Name: Date:

_____ _____

MRN Date of Birth

▪ 65 Memorial Rd, Suite 508, West Hartford, CT 06107 ▪ 280 South Main St, Suite 103, Cheshire, CT 06489
▪ 100 Perkins Farm Drive Suite 303 Mystic, CT 06389 ▪ 1 Towne Park Plaza Norwich, CT 06360
▪ 300 Post Road West Suite 102 Westport, CT 06880

Tel 860.696.2925 Fax 860.696.2926 HeadacheCenter@hhchealth.org