Sussex County Psychiatric Associates

Patient Registration Form

Please print clearly to assure proper documentation of information. We need a copy of your insurance card before your appointment. All co-payments will be collected before your session.

Patient's Full name:_____ **Today's Date:**_____

Date of Birth:_____**Social Security #:**_____

Sex:_____ **Age:**_____ **Referred By:**_____

Home Address:_____

City:_____ **State:**_____ **Zip Code**_____

Telephone Numbers: Home:_____ **Cell:**_____

Work:_____ **Ext:**_____

Emergency Contact:_____ **Phone #:**_____

Pharmacy Name and Number:_____

Primary Care Physician:_____ **Phone #:**_____

Address:_____

Employed By:_____ **Work #**_____

Address_____

Insurance Information:

Primary Insurance Co: _____

ID #_____ **Group #**_____
(Attach copy of insurance card)
Full Name of Insured:_____ **Relationship:**_____

Home Address:_____

SSN:_____ **Date of Birth:**_____

Secondary Insurance: Yes or No
Secondary Ins Co:_____ **ID #**_____

Group # _____ **Full Name of Insured**_____

EAP Related: Yes or No Company:_____

Sussex County Psychiatric Associates

Financial and Office Policy

I authorize use of this form on all my insurance submissions and the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I authorize direct payment to my service provider and hereby permit a copy of this form to be used in place of an original.
As the patient, you are responsible for contacting your insurance company prior to being seen to verify benefits and eligibility as well as obtaining pre-certification for your provider. The initial precertification is the patient's responsibility and you will be held responsible for any and all balances not paid by your insurance company.

WE MUST EMPHASIZE THAT AS MEDICAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.

1. Co-payments: It must be paid prior to being seen. Failure to do so will result in rescheduling your appointment.

2. Patient Balance: These must be paid before or at time of your next appointment unless otherwise arranged in advance by our billing staff.

3. Returned Checks: You will be responsible for the original amount of your check plus an additional charge of $ 25.00 and a $15.00 bank fee.

4. Collections: In the event your account goes to collection, there will be a 40% collection fee added to your balance.

5. Late Cancelations/ No- Shows: There is a 24 hour cancellation policy. Cancellations with less than 24 hours notice will incur a $50.00 charge, which will be billed to the Responsible party, as it is not billable to insurance.

6. Non-covered Services: Not all services, such as drug tests, are covered benefits in all contracts. In such cases, you will be asked to pay in full at time of your visit.

7. Medication refills: You must have an appointment to refill medication. We will not phone or fax in prescriptions without being seen for an appointment.

Please be advised that Sussex County Psychiatric Associates is a private out- patient mental health facility. We do not provide 24/7 answering service. Our providers are available during their scheduled office hours. In case of emergency, we suggest that you visit your local emergency room. For the Sussex County area we suggest Newton Memorial Hospital.

If for any reason you feel that your require more treatment than we are able to provide as an out-patient facility, it would be in your best interest to contact your insurance to find an in-patient facility that will better suit your needs. By signing below, you acknowledge that you have read the office policies and comply with its context.

Signature:_____ **Date:**_____

Patient's Guardian (if under 18 years old)_____

Sussex County Psychiatric Associates

Patient Consent for the Use and Disclosure of Protected Health Information

With my consent, Sussex County Psychiatric Associates (SCPA), may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. Please refer to the SCPA notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SCPA reserves the right to revise its notice of privacy practices at anytime. A revised notice of privacy practices may be obtained by forwarding a written request to:

Sussex County Psychiatric Associates
185 Route 183
Stanhope, NJ 07874

With my consent, SCPA may call or mail to my home or designated location any items that assist the practice in carrying out health care operations.

By signing this form, I am consenting to SCPA's use and disclosure of my PHI to carry out health care operations.

The office will sometimes call to confirm or reschedule future appointments. I give my permission to the staff and physicians to communicate, as described below.

1. **I can be reached at the following phone number(_____)_____**

2. ☐ **A message may be left as described below: (please check all that apply)**
   - ☐ **Home phone answering machine # _____**
   - ☐ **Cell phone answering machine # _____**
   - ☐ **Work phone answering machine # _____**
   - ☐ **Other preference#_____**

3. ☐ **I do not want SCPA to call**

I understand that I must write to SCPA to change or revoke any of my preferences indicated above. No verbal instructions will be accepted.

_____

Signature of Patient or Guardian Date

SUSSEX COUNTY PSYCHIATRIC ASSOCIATES

185 ROUTE 183, STANHOPE, NJ 07874 PHONE: 973|426|1640 FAX: 973|426|1641

Consent for Treatment

I do hereby seek and consent to take part in treatment by the therapist/ psychiatrist named below. I understand that developing a treatment plan with this provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this provider.

I am aware that I may stop my treatment with this provider at any time.
I know that I must call to cancel an appointment at least 24 hours before the time of the appointment.

I authorize my insurance company to make payments to Sussex County Psychiatric Associates for mental health services that are provided to me. SCPA may contact my insurance company regarding payments, authorization of services, and verification of benefits. SCPA may disclose limited information necessary for the purpose of reimbursement such as diagnosis, session type, dates of services, treatment goals and treatment progress.

My signature below shows that I understand and agree with all of these statements.

_____

Signature of client (or person acting for client) Date

_____

Printed Name Relationship to client (if necessary)

Consent for treatment of a minor

We/I, the undersigned_____, parent(s) and/ or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. We /I have legal power to consent to medical, and mental health assessment and treatment of said minor child.

_____

Parent or Guardian Date

Notice of Privacy Practices

This section of the Notice of Privacy Practices is to be removed from the rest of the pamphlet, signed by the individual and placed in their chart or record to be retained for a minimum period of 6 years or for the length of time designated to retain patient records.

Should a patient refuse to sign the acknowledgement, a note to that effect must be recorded in the individual's chart or record.

§ 164.520 Notice of privacy practices for protected health information.

(a) *Standard: notice of privacy practices.* (1) *Right to notice.* Except as provided by paragraph (a)(2) or (3) of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information.

(2) *Specific requirements for certain covered health care providers.* A covered health care provider that has a direct treatment relationship with an individual must:

(i) Provide the notice no later than the date of the first service delivery, including service delivered electronically, to such individual after the compliance date for the covered health care provider;

(ii) If the covered health care provider maintains a physical service delivery site:

(A) Have the notice available at the service delivery site for individuals to request to take with them; and

(B) Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered health care provider to be able to read the notice; and

(iii) Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements of paragraph (c)(2)(ii) of this section, if applicable.

Sussex County Psychiatric.
185 Route 183
Stanhope, New Jersey 07874

SUSSEX COUNTY PSYCHIATRIC

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

NOTICE OF PRIVACY PRACTICES

Telephone
973-426-1460

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and disclosures of health information

We use health information about you for treatment (diagnostic testing, prescription, referral, etc.) to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, and/or collection agencies, etc.) for administrative purposes (reporting, utilization management, quality improvement and surveys, etc.) and to evaluate the quality of care that you receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health -related benefits and services that may be of interest to you.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We will provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may apply a change to our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You may also request a copy of our notice at any time. For more information about our privacy practices, contact the Privacy Officer listed below.

Individual rights

You have the right, following a written request and agreed upon date and time, to look at, get a copy of or receive electronically protected health information about you that we use to make decisions about you. If you request copies, we will charge you at our cost for each page. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we amend the existing information.

You may request in writing that we restrict and/or not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access or amendment to your records, you may contact the person listed on the back page of this pamphlet. You may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. The person listed on the back page can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Questions or complaints may be addressed to:

Tina Marie Cooke

INFORMATION PRIVACY/SECURITY OFFICER

SIGNATURE OF PROVIDER

4/14/03.

EFFECTIVE DATE

HEALTH INSURANCEPORTABILITY AND

ACCOUNTABILITY ACT

[HIPAA]

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the PROVIDER NOTICE OF PRIVACY PRACTICE as required by the Health Information Portabil and Accountability Act.

I understand that upon completion of reading t notice, any questions I may have may be addressed to the PROVIDER PRIVACY OFFICER.

Signature

Date

Refusal to Sign— Patient has the right to refuse to sign and has decided not to sign.

Signature of Privacy Officer Date