Child and Adolescent Psychiatry
of Southern New Jersey LLC

Patient Demographic Information

Today's Date_____

Patient Information

Name_____
Last Name First Name Initial

Date of Birth_____Age_____ Email Address _____

Home Phone _____Work Phone _____Cell Phone_____

Can we leave you messages?_____Text?_____

Home Address_____City_____State_____Zip_____

Parents' Information/Emergency Contact Information

Responsible Party (for minors)_____Date of Birth _____Age_____

Person to Contact in Case of Emergency _____Relationship _____

Emergency Contact Home Phone _____Work Phone _____Other Phone _____

Reference for Provision of Care

Primary Care Physician_____ Phone_____

Pharmacy_____ Phone_____

How did you come to hear of the practice (check one)? ___Current client ___Psychology Today __Our Friends at Google

___Neighborhood Therapist (If so, who?_____) ___Treatment Facility ___Other:_____

1930 East Marlton Pike, Suite V-107
Phone (215) 806-5333
Cherry Hill, NJ 08003
www.childpsychnewjersey.com

POLICIES AND PROCEDURES

Welcome to Child and Adolescent Psychiatry of Southern New Jersey, LLC, serving children and adolescents and families. Our goal is to provide you and your family timely, respectful, quality service in a pleasant practice environment.

Decorum

"It's nice to be important but it's more important to be nice." We live by this motto here at the practice. We know that people are going through stressful life events and are being treated for emotional/anger issues. It is not, however, appropriate at any juncture to speak in a menacing, demeaning or disrespectful way/tone to staff. Folks here are only trying to help you; it's weird for you to act angry at them. Thus, it is the policy of this office that we can at any point refuse to serve individuals who speak harshly or treat our staff inappropriately. We only have one staff; we would like to keep them intact. Thank you for your kind cooperation!

HOURS

Child and Adolescent Psychiatry of Southern New Jersey, LLC is open by scheduled appointment only. We are always available by phone/voicemail.

APPOINTMENTS

Appointments can be scheduled through phone at 856-751-4127 or by email at info@childpsychnewjersey.com. We do not over-book or double-book; the time you schedule is yours. If you cannot or do not plan to keep your appointment, please let us know at least 24 hours in advance to avoid a late cancel/no show charge.

EMERGENCIES

If you have an immediate life and death emergency, **call 911** or go promptly to an Emergency Room or Urgent Care for assistance. During office hours, your clinician will return calls as soon as possible. If you feel your concern is urgent, please make this clear when you call or leave a voice mail message.

AFTER HOURS/HOLIDAYS

Calls/emails/any other form of communication received after hours or on holidays will be returned at the discretion of the clinician. While we make every effort to get back in touch with our clients, it may be the following business day that you receive a call/email back.

PRESCRIPTION REFILLS

The policy of the practice is to write a prescription(s) to cover your needs until your next appointment. There should be no need for additional refills if you keep scheduled appointments or reschedule promptly. If an exception occurs, please call (during business office hours at least five working days before you will run out). Prescriptions will be refilled during business hours, for active patients with scheduled follow-up at the discretion of the clinician. Patients are generally seen at least monthly at first, then up to every two months when well established, and occasionally up to every three months. Medication changes generally require appointments so they can be adequately considered, explained, and discussed. Controlled substances (Ritalin, Adderall, Klonopin, Xanax, etc.) will not be refilled by phone and will not be rewritten except during an appointment.

POLICIES AND PROCEDURES (CONTINUED)

RECORDS

There is generally no fee for copying or faxing records of fewer than five pages. Beyond this there is a charge of 50 cents per page plus postage, to cover costs and staff time. A completed, signed release of information is required.

PAYMENT

Full payment is due at the time of service. Personal checks, cash, and all major credit cards are accepted. Additionally, we may be able to use flexible spending accounts associated with your insurance. We cannot make change.

RETURNED CHECKS

There is $35 charge for returned checks.

MISSED APPOINTMENTS

There is a fee for appointments missed, canceled, or changed ***less than one business day (24 hours) in advance,*** except when, at the discretion of the practice, there exists dangerous weather conditions, serious illness, or a life-threatening emergency.

Please remember, this is fully your time. We do not over-book or double-book appointments. Please notify us promptly if you cannot make your appointment so that we can offer the time to someone else. Missed appointments will be billed equal to the total charge of the session.

REPORTS, EXTENDED CALLS, LETTERS

Due to the additional time and costs incurred, there is a charge for extended or complex phone calls, and for letters, reports, medication authorizations, or extended calls done on your behalf to other clinicians or insurance companies/agencies.

FEE AGREEMENT

I understand that I am financially responsible for services received at Child and Adolescent Psychiatry of Southern New Jersey, LLC.

I understand that full payment is due at the time of appointment.

I understand that I am responsible for the full cost of missed appointments, any lab services and medications that I might receive.

Patient Bill of Rights

You have the right to be treated with respect and dignity, free of abuse or exploitation of any kind.

You have the right to receive services which are suited to your individual needs and in the least restrictive setting in keeping with available resources.

You have the right to be informed of the care that is provided or recommended to you. You have the right to have the clinician in charge of your treatment explain the therapeutic procedures and medications that will be used, including the benefits, any risks and side effects. This is also known as informed consent.

You have the right to consult with a specialist about your service plan and to seek a second opinion.

You have the right to refuse the services offered to you, unless an emergency exists.

You have the right to have your treatment and clinical records be kept confidential except when release of such information is authorized by law.

You have the right to see your records or have them shown to any person that you designate in writing according to New Jersey law. You may be denied access to your records in limited circumstances. If you are denied access to your records, you have the right to know why and the right to appeal this decision.

You have the right to be given the names and professional status of the staff member(s) responsible for your care.

Child and Adolescent Psychiatry of Southern New Jersey, LLC also retains the right to terminate providing services to you.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients (under age 14) have the right to access the clients' records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under age 14) _____

Today's Date _____

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RELEASE OF INFORMATION

Most patients have family members and friends that occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; **OR** your adult child calls with questions about your medication; **OR** a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone that you would allow us to communicate with, please list them below. Due to privacy regulations, we cannot speak to anyone but the patient unless we have your written permission.

I give Child and Adolescent Psychiatry of Southern New Jersey, LLC staff my permission to speak with the following individuals regarding my care: (If you prefer that we not speak with ANYONE, please write NONE across the lines)

Person to whom confidential treatment information may be disclosed:

_____

Information to be Disclosed: Medical Records, session notes, lab results, general clinical impressions or all (circle)

Restrictions to Communications:_____

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize Child and Adolescent Psychiatry of Southern New Jersey, LLC staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____

Signature of Patient /Legal Guardian (Minors 12-17 must sign) Date

_____ _____

Printed Name Date

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

_____ _____

Signature of Patient /Legal Guardian (Minors 12-17 must sign) Date

Child and Adolescent Psychiatry
of Southern New Jersey LLC

Consent to Treat/Insurance Waiver

I, _____, have been informed of the policies, procedures and
(Printed Name here)

treatment modalities of Child and Adolescent Psychiatry of Southern New Jersey, LLC and I consent to treatment and to abiding by these policies and procedures.

In addition, I understand that Child and Adolescent Psychiatry of Southern New Jersey, LLC

- does not accept insurance
- that my payment is due in full at the time of service
- that I am not allowed to carry a balance and payment for services rendered must be provided before I can be rescheduled for my next appointment
- that written reports that cannot completed during my session are subject to same rate as my session (per 15 minute increment) and that payment is due prior to receiving this paperwork
- that missed appointments/late cancellations will be billed at the scheduled rate of the session missed.

Please supply a credit card number below. This card will be kept on file for the purposes of billing no-shows or late cancellations consistent with our above policies. This card can also be charged for regularly scheduled in-office sessions as well as telepsychiatry sessions, should you wish.

Credit Card # _____ Expires on _____

Security Code ____ Zip Code for billing address of card _____ Charge for sessions? __ Yes __ No

By signing below you are attesting that you have been informed about treatment, that you consent to treatment and that you are authorizing the automatic charging of your card in the event of late cancellations and/or not showing up for your appointment.

_____ _____

Patient's signature Date Responsible party's signature if patient is a minor

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Master Copy List

I have received a copy of the following documents, have reviewed them, had a chance to ask questions about them and understand them fully. Please initial by each form received:

_____Policies and Procedures

_____Patient Bill of Rights

_____Patient Rights and HIPAA Authorizations

_____Consent to Treat/Insurance Waiver Form