GENPSYCH
Mental Health of the Future

Adolescent Program

DEMOGRAPHIC AND INSURANCE INFORMATION

***** Please complete all questions on both sides of this form *****

Date	Social Security Number

Demographic Information – Please Print

First Name	Middle	Last Name
Address		
City	State/ZIP	Home Phone ( )
Cell Phone ( )		Work Phone ( )
OK to leave a voice mail at home? Yes ___ No ___ OK to leave a voice mail at work? Yes ___ No ___ OK to leave message on cell phone? Yes ___ No ___		OK to leave a message with a family member ? Yes ___ No ___ Family member's name(s): _____
Email		
Date of Birth _____/_____/_____	Gender: Male ____ Female ____	Marital Status (ex. single, married, divorced, separated, etc.)
Age	Legal Guardian (if applicable)	

INSURANCE POLICY INFORMATION

Insurance Company/HMO	Patient ID Number/Member ID
Group Number	Policy Holder's Name
Policy Holder's DOB _____ Policy Holder's S.S. # _____	Relationship to Policy Holder (ex. spouse, child, guardian, etc)
Claims Mailing Address	

City	State/Zip	Phone

GENPSYCH
Mental Health of the Future

Secondary Policy Information (if applicable)

Insurance Company/HMO		Patient ID Number/Member ID
Group Number		Policy Holder's Name
Policy Holder's DOB		Relationship to Policy Holder (ex: spouse, child, guardian, etc)
Claims Mailing Address		
City	State/ZIP	Phone

Pharmacy Information

Pharmacy Name
Address
Phone Number

Signatures

_____ _____
Client or Parent / Legal Guardian Signature Date

_____ _____
Responsible Party Signature Date

_____
Print Name

GENPSYCH
Mental Health of the Future

AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

Office Copy

The paragraphs below contain several agreements.

Please read carefully and sign the ***Client Copy*** and the ***Office Copy.***

Client Name _____

Medical Insurance

I authorize the medical insurance company to pay directly for GENPSYCH services. I, however, understand that the person who signs below is responsible for all my fees, including any fees not paid by the insurance company.

Release of Information

I authorize GENPSYCH to release/receive verbal and written information about me to/from the medical insurance company and the referring physician. This authorization will end if I give written instructions to GENPSYCH to that effect, which I may do at any time.

Financial Responsibility

We understand and agree that each of us is responsible for the client's fees to GENPSYCH, including any fees not paid by medical insurance; that if the account is not paid when due, reasonable collection and court costs will be paid by the undersigned; that we are responsible for the cancellation and "no-show" fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for outpatient services must be paid at the time services are rendered.

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation and "no-show" policy. This policy enables us to better utilize available appointments for our clients in need of medical care. Please be courteous and call the appropriate office in which you scheduled your appointment promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave a phone number and let us know the best time to return your call.

A $100.00 fee will be applied to your account for cancellations not made in the 24-hour time frame or "no-shows."

For those clients who may be receiving GENPSYCH, P.C. transportation services, as consideration for our lengthy van waiting list, a fee of twenty-five dollars ($25.00) will be charged for every cancellation of transportation without proper notice.

CONTINUED ON NEXT PAGE

GENPSYCH
Mental Health of the Future

AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

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CONTINUED ON NEXT PAGE

GENPSYCH
Mental Health of the Future

981 Route 22 West, Bridgewater, NJ 08807
31 East Darrah Lane, Lawrenceville, NJ 08648
940 Cedar Bridge Ave, 2nd Floor, Brick, NJ 08723
5 Regent Street, Suite 518, Livingston, NJ 07039

Program

NOTICE OF CONSUMER FINANCIAL RESPONSIBILITY

Billing and Insurance
As a courtesy to our consumers, GenPsych, PC will verify your mental health benefits with your insurance carrier. In order to do so, we must obtain a copy of your insurance card and obtain the name, address and birth date of the subscriber. The information that we receive is not a guarantee of payment. We recommend that you reference your mental health benefit policy or consult your carrier directly with questions regarding benefits and participation.

In addition, GenPsych, PC will bill your insurance carrier for services provided. All co-payment amounts are due at the time of service. Co-insurance, deductible and nay outstanding balances will be due upon receipt of our billing invoice.

Payment Options
GenPsych, PC accepts cash, checks, money orders and major credit cards. Monthly payment plans may be arranged by calling the Billing Department at (908) 526-8370.

Returned Checks
A fee of $35.00 will be added to your balance due for all returned checks.

Self-Pay
To assist our self-pay consumers, GenPsych, PC has developed a Self-Pay Fee Schedule Discount Program. Designed to help defray the cost of medical care for the uninsured, the program offers a discount to uninsured consumers only. For more information, please call the Billing Department at (908) 526-8370.

Estimated Fees
The fees associated with your care may include, but are not limited to the following service:

- $100.00- Medical Management
- $350.00- Psychiatric diagnostic evaluation exam
- $525.00- Intensive Outpatient Program Per Diem
- $800.00- Partial Hospitalization Program Per Diem

The self-pay fees may include, but are not limited to the following service:

- $100.00- Medical Management
- $350.00- Psychiatric diagnostic evaluation exam
- $195.00- Intensive Outpatient Program
- $295.00- Partial Hospitalization Program

Collections
GenPsych, PC will make every effort to assist consumers with meeting their financial obligations. However, in the event that the consumer does not respond to our billing invoices or neglects to make arrangements, we reserve the right to transfer the outstanding balance to a collection agency. We also reserve the right to report delinquent accounts to credit bureaus and charge applicable collections agency fees directly to the consumer.

I understand and agree to the above:

Patient Name (Print) _____

Patient or Parent Signature: _____ Date: _____

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I understand and agree to the above:

Patient Name (Print) _____

Patient or Parent Signature: _____ Date: _____

GENPSYCH
Mental Health of the Future

EMERGENCY CONTACT RELEASE

I authorize GenPsych to contact the following person(s) in the event of an emergency. Please provide ***at least one*** emergency contact.

EMERGENCY CONTACT(S): (Please Print)

Name	Relationship	Phone Number

I understand that this request will remain in effect until I am discharged from GenPsych PC unless I submit a written request for a change.

Client Name: (Please print) _____

Client Signature: _____ **Date:** _____

GENPSYCH
Mental Health of the Future

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ DOB: _____

I, _____, request and authorize GenPsych PC to release confidential health information protected by U.S. Federal and State privacy laws to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: (check all applicable)

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

_____ *** Marketing purposes (please define the type of information that may be released and how it may be used)

_____

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I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services upon my signing this form.

Client Signature: _____ Dated: _____

Legal Rep's Signature*: _____ Relationship to Client: _____ Dated: _____

* If Client is aged 14-17, both client and legal representative must sign release form

GENPSYCH
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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: (check all applicable)

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

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Mental Health of the Future

981 Route 22 West, Bridgewater, NJ 08807
31 East Darrah Lane, Lawrenceville, NJ 08648
1610 Route 88, Suite 202, Brick, NJ 08648
5 Regent Street, Suite 517/518, Livingston, NJ 07039

PRIMARY CARE PHYSICIAN LETTER

To: _____

_____

_____

Re: _____

Dear Dr. _____

Your client recently participated in a Psychiatric evaluation. They have enrolled in GenPsych's Intensive Outpatient/ Partial Care Program.

Please feel free to contact us at 908-231-0511 with any questions. We look forward to collaborating in this patient's care with you.

Sincerely,

GenPsych Bridgewater Physicians:
Indira Shah, M.D.
Blessing Nwele, APN
Jobin Kallacheril, APN
Caren Polonsky, APN-BC

GENPSYCH
Mental Health of the Future

PRIMARY CARE PHYSICIAN

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ DOB: _____

I, _____, request and authorize GenPsych PC to release confidential health information protected by U.S. Federal and State privacy laws to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

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Client Signature: _____ Dated: _____

Legal Rep's Signature*: _____ Relationship to Client: _____ Dated: _____

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GENPSYCH
Mental Health of the Future

PSYCHIATRIST

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ DOB: _____

I, _____, request and authorize GenPsych PC to release confidential health information protected by U.S. Federal and State privacy laws to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

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THERAPIST

GENPSYCH
Mental Health of the Future

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

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GENPSYCH
Mental Health of the Future

SCHOOL CONTACT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: (check all applicable)

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

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Client Signature: _____ Dated: _____

Legal Rep's Signature*: _____ Relationship to Client: _____ Dated: _____

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GENPSYCH
Mental Health of the Future

REFERRAL SOURCE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ DOB: _____

I, _____, request and authorize GenPsych PC to release confidential health information protected by U.S. Federal and State privacy laws to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: _____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____ HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

_____ *** Marketing purposes (please define the type of information that may be released and how it may be used)

_____

*** 'Marketing is defined as "any communication about the organization, its products or services that encourages recipients to purchase or use the product or service."

*** GenPsych, its employees and patients are strictly prohibited from receiving any renumeration by GenPsych or its affiliates as a direct result of this release. However, the release of protected health information for marketing purposes may encourage recipients' use of the organization's products or services.

***Pursuant to NJAC 13:35-6.5, Genpsych reserves the right to charge $1.00 per page for medical record reproduction or $100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, the cost for the record reproduction may be up to $10.00 to cover postage and the miscellaneous costs associated with the record retrieval.

I understand and authorize the exchange of information as requested above. I also understand that this request will remain in effect until _____ or until I am discharged from GenPsych PC.

I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.

I understand that if the above named person or entity is not a health care provider or part of a health plan covered by federal privacy regulations and this form authorizes the release of my health information, **my health information may be re-disclosed** by the person or entity I have named above and will no longer be protected by these regulations. However, the person or entity named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services upon my signing this form.

Client Signature: _____ Dated: _____

Legal Rep's Signature*: _____ Relationship to Client: _____ Dated: _____

*** If Client is aged 14-17, both client and legal representative must sign release form**

GENPSYCH
Mental Health of the Future

INFORMED CONSENT FOR TREATMENT

I, _____ (print name of client), agree and consent to participate in behavioral health care services offered and provided by GENPSYCH, PC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client. I understand that these services may include individual, group, and/or family therapy, medication management, and urine, blood, or other tests for substances. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____

GENPSYCH
A New Generation of Behavioral Health

Notice of Clinical Supervision

It is the policy of GenPsych to fully disclose the licensure status of therapists that individuals may work with individually or within a group setting. New Jersey law mandates that partially licensed therapists practice under the supervision of fully licensed therapists. GenPsych conducts an extensive qualification review of all staff and ensures that our staff practices in full compliance with New Jersey law.

- Please note that the following clinical supervision is conducted as required by New Jersey law. As defined by the NJ Division of Consumer Affairs, the state agency responsible for licensure, a "Qualified Supervisor" is an individual who holds a clinical license to provide mental health counseling services for a minimum of two years (obtaining at least 3,000 hours work experience subsequent to holding the license in a minimum of 2 years but no more than 6 years) in the state where the services are being provided, and who has: a Clinical Supervisor's Certificate, or is designated as an Approved Clinical Supervisor by the respective healthcare licensing board, or has completed a minimum of three graduate credits in clinical supervision from a regionally accredited institution of higher education.

Intern is a student currently enrolled in an accredited Master's Program for Counseling or Social Work who practices under the supervision of a fully licensed practitioner-either a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW).

Licensed Associate Counselor (LAC) is a Master's level practitioner who practices under the supervision of a Licensed Professional Counselor (LPC).

Licensed Social Workers (LSW) is a Master's level practitioner who practices under the supervision of a Licensed Clinical Social Worker (LCSW).

Certified Alcohol and Drug Counselor (CADC) practices under the supervision of a Licensed Certified Alcohol and Drug Counselor (LCADC).

Non-licensed Psychologist is a Ph.D. level practitioner who practices under the supervision of a Licensed Practicing Psychologist

I, (Print Name) _____, acknowledge that I have received and understand GenPsych's Clinical Supervision Policy. I understand that I may address any questions or concerns with regard to a therapist's licensure status to my assigned therapist.

By signing below you are acknowledging you have been informed of this information:

_____ _____

Client Name Date

_____ _____

Client Signature Date

_____ _____

Parent / Guardian Signature Date

GENPSYCH
Mental Health of the Future

GenPsych, P.C. Adolescent Clients Program
Parental Informed Consent Procedures for Prescriptions

Client Name: _____

GenPsych Providers (prescribers) may prescribe medications for your child. Below is a procedure delineating the mechanisms in place to ensure that you are fully informed about any and all medications prescribed for your child.

Please carefully read the procedure and indicate your agreement by signing below.

1. I understand that the prescriber will call me regarding any medications prescribed for my child or any significant dosage changes in medications currently prescribed.

2. I understand that a medication fact sheet and informed consent signature form will be provided.

3. I understand that it is my responsibility to read the fact sheet and contact the prescriber regarding any questions or concerns I may have about the medication(s).

4. I understand that I have the option not to fill the prescription or administer the medication to my child until all of my questions and concerns are satisfied.

5. I understand that by filling the prescription and administering the medication to my child, I am giving my consent for the medication and dose prescribed.

6. I agree to sign the informed consent form as soon as I receive it if I intend to fill the prescription.

7. If my child requires medication dosing while at the program, I understand that this will be closely supervised by a member of the medical or nursing staff. Further, I agree to bring the medication in to the program in the originally labeled prescription bottle and hand it in to a member of the staff for safe keeping.

_____ _____
Parent / Guardian Signature Date

_____
Parent / Guardian Printed Name

_____
Witness

Rev. 4-12