GENPSYCH
Mental Health of the Future

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

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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

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AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

Client 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 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

NOTICE OF CLIENT FINANCIAL RESPONSIBILITY

Billing and Insurance
As a courtesy to our clients, GENPSYCH 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 insurance carrier directly with questions regarding benefits and participation.

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

Payment Options
GENPSYCH accepts cash, checks, money orders and major credit cards. Monthly payment plans may be arranged by calling the Billing Department at (908) 526-8370, extension 214.

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

Missed Appointments
We understand that there are rare exceptions when a client cannot make a scheduled appointment. However, we require 24 hour advance cancellation notice. If you give us less than 24 hours' notice or simply do not show for your scheduled appointment, you will be charged a missed appointment fee of $100.00

Self-Pay
To assist our self-pay clients, GENPSYCH 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 clients 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 services:

- $100.00 – Medical Management
- $300.00 – 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 services:

- $100.00 – Medical Management
- $200.00 – Program per day
- $300.00 – Evaluation

Collections
GENPSYCH will make every effort to assist clients with meeting their financial obligations. However, in the event that the client 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 collection agency fees directly to the client.
By signing below, I have read, understand, and agree to all of the above

_____ _____
Client or Parent / Legal Guardian Signature Date

_____ _____
Responsible Party Signature Date

_____
Responsible Party Printed Name

GENPSYCH
Mental Health of the Future

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_____ _____

Client or Parent / Legal Guardian Signature Date

_____ _____

Responsible Party Signature Date

_____

Responsible Party Printed Name

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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:** _____

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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: _____

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Adult Program Client Acknowledgement of Documents

I, _____,

PRINT NAME CLEARLY

do affirm that I have read, understood, and received copies of the following documents:

- Clients' Rights
- Compliant and Grievance Procedure
- Notice of Privacy Practices
- Medications and the Heat Advisory
- Client Handbook
- Psychiatric Advance Directives:

I have a psychiatric advance directive: Yes ___ No ____

If yes, I will provide GenPsych with a copy: Yes ___ No ____

If yes, additional copies are located:

_____

I have been given a copy of the Psychiatric Advance Directive form and understand that if I would like assistance with completing it, a member of GenPsych staff will assist me.

Signature: _____ Date: _____

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GenPsych Clients' Rights

All GenPsych clients have the right to:

1. Be informed of their rights and responsibilities, and to be notified of any rules and policies the program has governing client conduct in the facility.
2. Be free from unnecessary or excessive medication.
3. Not be subjected to non-standard treatment or procedures, experimental procedures of research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or an interested party of the client's choice. If a client is adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(3). *Note: this information is provided to you as legally required. None of these procedures are performed at GenPsych.*
4. Be free from corporal punishment and treated with privacy and dignity.
5. Treatment in the least restrictive conditions necessary to achieve the goals of treatment/services.
6. To be free from physical or pharmacological restraints, isolation, interference, coercion, discrimination or reprisal.
7. Be treated with courtesy, consideration, respect, and individuality.
8. Refuse participation in any research studies without jeopardizing the right to receive services.
9. Be informed of the services provided at GenPsych and the names and professional status of all personnel providing those services, and whether the program has authorized other health care and educational institutions to participate in his or her treatment.
10. Be informed of all fees for service and their responsibility for payment.
11. Be provided with an explanation of their medical condition, treatment recommendations, risks, options and anticipated treatment results.
12. Be assessed for physical pain and provided with an appropriate referral to address the diagnosis, treatment and management of identified pain.
13. Participate in their treatment plan, and to refuse medication and treatment at any time.
14. Voice grievances or recommend changes in policies and procedures to GenPsych personnel, the governing authority and/or outside representatives of the client's choice.
15. Be free from any form of abuse, exploitation, punitive or aversive interventions.
16. Confidential treatment of all protected health information, unless that right is waived through the signed release of information permitting disclosure to the designated party. Additionally, all clients have the right to adequate notice of the uses and disclosures of their confidential medical information.
17. Exercise civil and religious liberties, including the right to make independent personal decisions.
18. Be treated fairly and not deprived of any constitutional, civil or legal rights, regardless of age, race, religion, gender, nationality, sexual orientation, marital status, disability, or payment source. Be free from any obligation to engage in the provision of any employment or services to the treatment provider.
19. The right to be transferred or discharged only for medical reasons, their own welfare, that of other clients or staff or upon the written order of a physician or other LIP.
20. The right to have access to and obtain a copy of their clinical record in accordance with applicable federal and state regulations.
21. The right to be notified in writing and to appeal an involuntary discharge *(applies to clients in the Division of Addiction licensed programs only).*

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Consumer Grievance Procedure

It is the policy of GenPsych to ensure the rights of clients, family members, legal guardians, and/or significant others to submit a complaint to the organization or to an advocacy entity related to any aspect of their treatment experience. Clients, family members, legal guardians, and/or significant others are informed of this mechanism during the admission process and assured that a complaint does not compromise future access to care.

Anyone who has a grievance may present it to Gen Psych staff, Program Director and/or Medical Director. If the individual does not wish to present the grievance within the organization, he or she may present it directly to The County Mental Health Administrator or the Division of Mental Health Services, the Division of Protection and Advocacy, the Division of Youth and Family Services, as well as other entities listed at the end of this document.

PROCEDURE

Internal:

1. The individual may bring a grievance regarding any aspect of treatment or services to the attention of any staff member.
2. The staff member receiving the grievance will attempt to resolve it with the individual.
3. If the grievance is of serious concern, or if the staff member is unable to resolve it to the satisfaction of the individual, it will be immediately brought to the attention of the Program Director and/or Medical Director.
4. The Program Director and/or Medical Director will investigate all grievances within 24 hours of notification. This investigation will include meeting with any staff member involved in the grievance.
5. Results of such investigations are documented in an Incident Report. Any and all appropriate actions to resolve the grievance are taken.
6. The Program Director will meet with the individual to provide resolution. The results of this meeting are documented in the Incident Report.
7. If the individual disagrees with the method by which the Program Director addresses the grievance, the individual may bring the grievance to the Medical Director or to any of the external entities listed below. If the consumer brings the grievance to the Medical Director, he or she will meet with the individual to provide resolution. The results of this meeting are documented in the Incident Report as well as the consumer's clinical record.

GENPSYCH
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Consumer Grievance Procedure

External:

If the individual prefers to bypass the internal entities and bring the grievance to one of the external entities listed below, he or she is welcomed to do so without fear of any reprisal. The following advocacy agencies' contact information is provided to consumers at the time of admission and posted in a readily visible area in the facility:

Pam Mastro, Administrator
Somerset County Mental Health Board
Somerset County DHS
P.O. Box 3000
Somerville, NJ 08876-1262
(908) 704-6310
e-mail: mastro@co.somerset.nj.us

Division of Mental Health Services
800-382-6717
Capital Center
P.O. Box 727
Trenton, NJ 08625-0727

Division of Mental Health Advocacy
Justice Hughes Complex
25 Market Street
Trenton, NJ 08625
Phone: 877-285-2844

Community Health Law Project
South Orange - NJ 07079
Division of Protection and Advocacy

Disability Rights of New Jersey
210 So. Broad St., 3rd Floor
Trenton, N.J. 08608
800-922-7233 or 609-292-9742

Division of Youth and Family Services
Department of Children and Families
50 East State Street
P.O. Box 717
Trenton, NJ 08625-0720
CHILD ABUSE/NEGLECT HOTLINE
1-877-NJ ABUSE (652-2873)

Division of Addiction Services
877-712-1868 or 609-292-5760
1-800-835-5510 (TTY)
24 hours a day - 7 days a week

NJ Division of Children and Families
Office of Licensing
P.O. Box 717
Trenton, NJ 08625-0717
Phone: 877-677-9845

Division of Child Behavioral Health Services
P.O. Box 717
Trenton, N.J. 08625-0717
Phone: 609-888-7208

Division of Mental Health and Hospitals Ombudsperson
Attention: Lisa Ciaston
Division of Mental Health Services
P.O. Box 727
Trenton, NJ 08625
Phone: 609-777-0694

Adult Protective Services
Somerset County Board of Social Services Central Office
73 East High Street
Somerville, NJ 08876-0936
Phone: (908) 526-8800 (908) 526-8800
FAX: (908) 203-9991
Monday-Friday
8:15 a.m.-6:00 p.m.

Department of Children and Families
20 West State Street, 4th floor
PO Box 729
Trenton, NJ 08625-0729
DCF Office of Advocacy
877-543-7864

GENPSYCH
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NOTICE OF PRIVACY PRACTICES

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Protected Health Information ("PHI") is the collective term referred to any information about you, or used to identify you and that relates to your past, present or future physical or mental health or condition, the provisions of health care services, or the past present or future payment for the provision of health care, including demographic information. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information (PHI)** for treatment, payment and health care operations. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release, and we reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information (PHI) in confidence.** You have the right to request that we communicate with you in a certain way and in a certain location that ensures the utmost protection of your PHI.
4. **Inspect and obtain a copy of the protected health information (PHI).** You have the right to make a written request to inspect or obtain a copy of your medical and billing records used by us to make decisions about you. Such requests must be made in writing on an authorized release form. However, your right to view your record or obtain a copy may be restricted within the confines of NJAC 13:35-6.5(c)(3). In addition, a fee of $1.00 per page, not to exceed $100.00 for the entire record (inclusive of postage costs) may be charged for the reproduction of the record in accordance with NJAC 13:35-6.5.
5. **Request an amendment to your protected health information (PHI).** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth in number (4) above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information (PHI)** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;

- to correctional institutions or law enforcement officials as provided by law;
- for national security or intelligence purposes;
- that occurred prior to the date of compliance with privacy standards (April 14, 2003);
- incidental to other permissible uses or disclosures;
- that are part of a limited data set (does not contain protected health information that directly identifies individuals);
- made to patient or their personal representatives;
- for which a written authorization form from the patient has been received

7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization before revocation, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Kimberly L. Forino, Esq. at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Kimberly L. Forino, Esq. or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

GenPsych Privacy Officer
Kimberly L. Forino, Esq.
c/o Obanta
10 Findeme Avenue, 3rd Floor
Tel: 908-526-8370 x 104
Fax: 908-450-1136

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request.

PREVENTION OF HEAT RELATED ILLNESS

When in periods of high temperature and humidity, there are things everyone (and particularly, people at high risk) should do to lessen the chances of heat illness

❖ **TRY TO KEEP COOL**

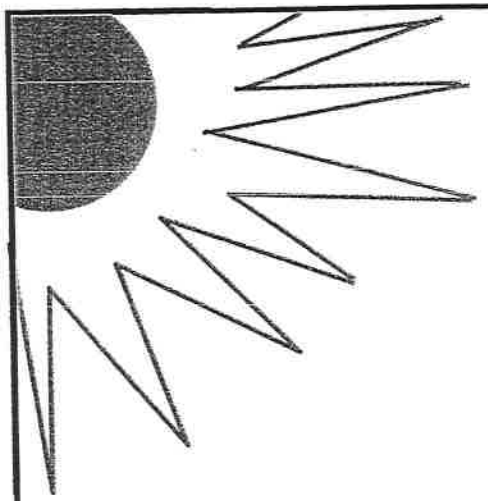
Keep windows shut, and draperies, shades, or blinds drawn during the heat of the day. Open windows in the evening or night hours when the air outside is cooler. Move to cooler rooms during the heat of the day

- Avoid overexertion, particularly during warmer periods of the day
- Apply sun screen lotion as needed.
- Drink plenty of fluids (Avoid coffee, tea & alcohol)
- Dress in loose fitting, light-colored clothing
- Lose weight if you are overweight
- Eat regular meals to insure that you have adequate salt and fluids

4/07

MAJOR ANTIPSYCHOTIC MEDICATIONS

Trade Name	Generic Name
Abilify	aripiprazole
Clozaril	clozapine
Geodon	ziprasidone
Invega	paliperidone
Risperdal	risperidone
Seroquel	quetiapine
Zyprexa	olanzapine
Haldol	haloperidol
Loxitane	loxapine
Mellaril	thloridazine
Moban	molindone
Navane	thiothixene
Prolixin	fluphenazine
Serentil	mesoridazine
Stelazine	trifluoperazine
Thorazine	chlorpromazine
Trilafon	perphenazine



Summer Heat and Sun Risks for Antipsychotic Medication Users

State of New Jersey
Division of
Mental Health Services

ANTIPSYCHOTIC MEDICATIONS AFFECT BODY HEAT

Antipsychotic medications may impair the body's ability to regulate it's own temperature. During hot and humid weather individuals taking antipsychotic medications are at risk of developing excessive body temperature, or hyperthermia, which can be fatal. Individuals with chronic medical conditions are especially vulnerable e.g. heart and pulmonary disease, diabetes and alcoholism, etc.

Heat exhaustion is the most common heat-related condition, which is most likely to occur in people who are involved in physical activity outdoors during heat waves.

Heat stroke is a more serious condition of dehydration and salt depletion which can be life threatening.

HEAT EXHAUSTION

This can occur in both active and sedentary individuals. It happens suddenly, and may be quite brief. **A doctor should be called.** Recovery may be spontaneous, or intravenous fluids may be needed to prevent unconsciousness.

Symptoms of heat exhaustion:

- Irritability or change in behavior
- Low or normal temperature
- Slight low blood pressure
- Rapid, full pulse and heartbeat
- Rapid breathing
- Cold, pale skin (may be ashen-gray)
- Profuse perspiration
- Dizziness, headache, and weakness
- Nausea, vomiting
- Cramps in the abdominal area or in the extremities

Treatment

If a person displays symptoms of heat exhaustion, he or she should be:

- Moved to a cooler place as soon as possible
- Given water or other liquids immediately (there is no need for salt)
- Encouraged to rest for a short time

HEAT STROKE

This occurs mostly during heat waves. Persons with chronic illnesses are most vulnerable. Heat stroke, the most serious heat illness, **can lead to death if left untreated.**

Symptoms of heat stroke:

- Agitation, confusion, seizures, lethargy, or coma (all may be first symptoms)
- High body temperature (102 degrees Fahrenheit or above)
- High blood pressure initially (shock may follow, resulting in low blood pressure)
- Rapid pulse and heartbeat
- Rapid, shallow breathing if person is moving about; slow and deep breathing if the person is still
- Hot, dry, flushed skin

Treatment

As soon as you recognize the signs of heat stroke, take immediate action:

- **Call 911 immediately**
- Loosen or remove outer layers of individual's clothing
- Move to a cool place
- Use CPR if needed
- Replace fluids and sodium only under medical orders

GENPSYCH

Mental Health of the Future

CLIENT HANDBOOK

Rev. 4-12

In order to gain maximum benefit from the services offered at GenPsych, please carefully review the following topics in this handbook so you may become more familiar with our services and expectations.

PROGRAM DESCRIPTION

GenPsych would like to welcome you. The goal of our program is to provide you with support in improving your mental health, substance abuse and/or your co-occurring psychiatric and substance-related disorders.

Our services are designed to serve adults and adolescents who require an intensive, structured treatment experience, but do not require 24-hour medically supervised inpatient care. The PC program operates five days a week and the IOP program operates three days per week.

GenPsych staff members consist of a team of professionals including board certified and board eligible Psychiatrists, LCSW's, LPC's, LCADC's, Psychologists, and Advanced Practice and Registered Nurses, who share a vision of helping people obtain and maintain optimal emotional and physical wellness. In some instances, services may be provided by a clinician who is not fully licensed, in which case the individual is supervised in accordance with law and regulation.

Our services provide clients with an opportunity to participate in a variety of groups focusing on skills and therapy. Each client will be assigned to a therapist with whom he or she will participate in weekly individual therapy sessions. Additionally, family therapy sessions are provided when agreed upon by the client and when clinically indicated.

Additionally, individuals attending the program will have weekly sessions with a prescriber (Psychiatrist or Nurse) for medication education, monitoring and counseling. During these sessions, you will receive a psychiatric evaluation, be offered prescriptions for clinically indicated medication, and educated and counseled regarding your medication. You are responsible to inform your prescriber of any problems you may be experiencing with regard to your medication, so he or she may assist you in the most effective manner.

An Individual Recovery Plan (IRP) will be developed for each client in collaboration with the treatment team. The IRP will be used as a tool to direct and establish goals for the treatment provided.

The length of time clients remain in the program will vary depending on their level of functioning and progress. When the treatment team, in collaboration with the client, establishes that the current level of services is no longer needed or beneficial, plans for continued care at a less intense level will be developed collaboratively with the client, treatment team, family members, and other community supports.

CLIENT RESPONSIBILITIES

It is the policy of GenPsych to promote client involvement in all aspects of treatment. Client responsibility is fundamental for successful treatment and reinforces the principles of self-care. GenPsych clients are responsible to:

- Treat all clients and staff with dignity and respect.
- Participate in the development of their individual recovery plan and to follow the plan.
- Ask questions about their care and communicate any information requested by the program so the best possible care can be delivered.
- Attend scheduled sessions and call the program with any unscheduled absences.
- Follow the agreed upon medication plan.
- Report any medication side effects or other issues related to their medication.
- Tell their provider and primary care physician about medication changes, including medications prescribed by others.
- Abide by prohibition of violence, alcohol, drugs, firearms, weapons, and other contraband items while on the premises.
- Adhere to any agreed upon financial arrangements and advise the staff of any problems with paying fees.
- Report any concerns about the quality of care promptly.
- Report any safety concerns promptly.

GROUP PARTICIPATION

Guidelines for Group Participation

The purpose of group therapy is to provide a safe, supportive environment where clients can learn tools for recovery, share challenges, concerns, and feelings, and practice new behaviors and coping skills. The following are guidelines to help all group members achieve their individual treatment goals:

- Arrive on time for groups.
- Do not use cell phones or any electronic devices during groups. Actively participate in groups using "I" statements. Do not speak for anyone else. State your own thoughts and feelings.
- One person speaks at a time.
- Respect the confidentiality of others by not sharing what is said in group with any third party.
- Be honest and respectful when sharing your thoughts and feelings
- Listen to others. Good communication requires listening with empathy and speaking with respect.

SUBSTANCE USE

During participation in this therapeutic program it is GenPsych's goal to provide education, treatment and support to assist all clients in making the informed decisions regarding the use of alcohol, illicit drugs, or the abuse of prescribed medication. We encourage clients to be open and honest about any urges to use any of the above mentioned substances. We also encourage clients to speak with staff if the urge to use becomes overwhelming so we may assist you in maintaining abstinence. If over time a client is unable to maintain abstinence, the GenPsych Staff may refer that client to more intensive services.

Clients who are suspected of being under the influence of alcohol, illicit drugs or using more than a prescribed dosage of medication while at the program may be removed from group for testing. In the event of ongoing substance abuse, the treatment team may ask that you enter into an abstinence contract. This contract is a tool to assist clients with remaining abstinent. It encourages openness and honesty, and provides for assistance with thoughts, feelings, and urges to use substances.

DRESS CODE

In order to maintain a therapeutic treatment environment, GenPsych has established guidelines for appropriate dress. While your freedom in choice of attire is respected, you are expected to be appropriately and modestly dressed while at the program, in clothing appropriate for the season. Shoes or other appropriate foot covering must be worn at all times. Staff reserves the right to prohibit the wearing of any garment deemed inappropriate and will provide a full explanation of the reason. Clothing that may be deemed inappropriate includes but is not limited to:

- Short shorts (length must be mid-thigh)
- Bare chest or midriff garments
- Transparent or otherwise revealing garments
- Muscle shirts or tank style undershirts
- Clothing with inappropriate or drug/alcohol related sayings or images are prohibited

SMOKING

There is no smoking anywhere inside of the building or in any GenPsych vehicle. Individuals under the age of 18 are prohibited from smoking on program property. Adult clients who wish to smoke during breaks will be directed to the designated smoking areas outside of the building. Smoking materials are to be extinguished and disposed of appropriately in the designated receptacles. Clients are asked to report to staff immediately if the receptacle is missing, overflowing, or unsafe in any way.

ATTENDANCE POLICY

Because regular attendance is vital to successful therapy, clients are responsible for adherence to the attendance policy as follows:

- Attend all scheduled sessions
- If an absence is unavoidable, contact the program as soon as possible to report absence and provide the reason
- Be aware that any client who does not attend 3 consecutive program days without an excused absence may be discharged from the program with a referral
- Be aware that any client who attends less than 2 groups per week for 3 consecutive weeks may be discharged from the program with a referral

If you need to schedule an appointment with a prescriber, you are responsible for scheduling the appointment with the provider's support staff.

INCLEMENT WEATHER

In case of inclement weather (i.e. snow, ice, flood), all clients are asked to call the main GenPsych office to receive information regarding program cancellation. As safety is our primary concern, no client will be financially penalized if for staying home from program due weather related transportation concerns.

CONFIDENTIALITY

Information regarding any client and their treatment, as well as records compiled, obtained, and prepared by GenPsych will be maintained confidential. Information will be disclosed only upon written request by the client, legal guardian, and in those cases required by law. As a GenPsych client, you are asked to respect the privacy and confidentiality of your fellow clients by not sharing information regarding each other with any outside person or entity. However, there may be times when you are concerned about the safety or welfare of another client, in which case you are expected to bring that information to the attention of staff immediately so steps can be taken to keep the individual safe.

As required by law, there are some important limits to confidentiality 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 reason able attempts to notify the family of the client.

- **Abuse or Neglect of Children and Vulnerable Adults**

If a client states or suggest that he or she is abusing a child or vulnerable adult or has recently done so, 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 to the appropriate social service and/or legal authorities.

Please refer to the GenPsych Notice of Privacy Practices for further information regarding the uses and disclosures of protected health information.

NON-FRATERNIZING POLICY

It is the policy of GenPsych to prohibit fraternization between and among clients outside of the program; as such fraternization is deemed therapy interfering behavior.

II. PROCEDURE:

A. It is the expectation of GenPsych that all clients refrain from fraternizing with other clients outside the therapeutic program environment.
B. Each client receives a client handbook upon admission, orienting them to GenPsych and its policies and procedures. This handbook includes the policy regarding non-fraternization.
C. All clients and legal guardians where applicable, sign off indicating receipt, review and agreement of policies and procedures laid out in GenPsych's client handbook.
D. In the event that fraternizing outside program hours is discovered to have occurred between clients, the primary therapist will reiterate GenPsych's policy and the justifications thereof directly to the client and legal guardian where applicable.
E. Upon discovering fraternization outside of program hours, the primary therapist will implement appropriate clinical interventions which may include the signing of a behavior contract by the client and legal guardian where applicable, regarding fraternization.
F. Legal guardians of adolescent clients are requested to monitor for and report to GenPsych outside fraternization by any means including face to face, phone, computer, etc.

G. The primary therapist will follow up with the client and legal guardian where applicable, in order to ensure that further incidents of fraternizing do not occur.
H. In the event that fraternizing outside program hours persists after the above interventions have been implemented, the client may be referred to another level of care or another provider for services.

REPORTING OF SYMPTOMS

Your safety and welfare is our primary concern. Please report any thoughts, urges, or plans you may have to injure yourself in any way to staff immediately. If this occurs outside of program hours, please report it to a family member, doctor, hospital, or call 911. In the event such symptoms were to occur, we may ask you to engage in a no-harm contract in order to assist you with these issues and help keep you safe. Additionally, below is a list of psychiatric emergency screening services by county. You may find this information helpful if you should experience a crisis while you are not at program or after you are discharged, so please keep this information.

PSYCHIATRIC EMERGENCY SCREENING CENTERS

Atlantic County

Primary Screening Center for Atlantic County:
Psychiatric Intervention Program (PIP)
@ Atlanticare Regional Medical Center
1925 Pacific Avenue
Atlantic City, NJ 08401 **HOTLINE:** (609) 344-1118

Burlington County

Primary Screening Center for Burlington County:
Lester A. Drenk Behavioral Health Center SCIP
218 A Sunset Road
Willingboro, NJ 08046 **HOTLINE:** (609) 835-6180

Essex County

Primary Screening Centers for Essex County:
(1) East Orange General Hospital
300 Central Avenue
East Orange, NJ 07019 **HOTLINE:** (973) 266-4478

Newark Beth Israel Medical Center
201 Lyons Avenue
Newark, NJ 07112 **HOTLINE:** (973) 926-7444

(3) University Behavioral Health Care
150 Bergen Street
Newark, NJ 07101 **HOTLINE:** (973) 623-2323

Hunterdon County

Primary Screening Center for Hunterdon County:
Hunterdon Medical Center
Emergency Services Behavioral Health
2100 Wescott Drive
Flemington, NJ 08822 **HOTLINE:** (908) 788-6400

Mercer County

Primary Screening Center for Mercer County:
Capital Health Regional Medical Center
750 Brunswick Avenue
Trenton, NJ 08638 **HOTLINES:** (609) 396-4357 **or** (609) 989-7297

Middlesex County

Primary Screening Center for Middlesex County:
University Behavioral Health Care
671 Hoes Lane
Piscataway, NJ 08855 **HOTLINE:** (732) 235-5700

Raritan Bay Medical Center PES
530 New Brunswick Avenue
Perth Amboy, NJ 08861 **HOTLINE:** (732) 442-3794

Monmouth County

Primary Screening Center for Monmouth County:
(1) Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740 **HOTLINE:** (732) 923-6999

Centra State Medical Center PES
901 West Main Street
Freehold, NJ 07728 **HOTLINE:** (732) 294-2595

Jersey Shore University Medical Center PES
1945 Corlies Avenue, Route 33
Neptune, NJ 07753 **HOTLINE:** (732) 776-4555

Riverview Medical Center PES
1 Riverview Plaza
Red Bank, NJ 07701 **HOTLINE:** (732) 219-5325

Morris County

Primary Screening Center for Morris County:
St. Clare's Hospital, Inc.
25 Pocono Road
Denville, NJ 07834 **HOTLINE:** (973) 625-0280

Morristown Memorial Hospital PES
100 Madison Avenue
Morristown, NJ 07960 **HOTLINE:** (973) 540-0100

Chilton Memorial Hospital PES
97 West Parkway
Pompton Plains, NJ 07444 **HOTLINE:** (973) 831-5078

Ocean County

Primary Screening Center for Ocean County:
Kimball Medical Center (PESS)
600 River Avenue
Lakewood, NJ 08701 **HOTLINE:** (866) 904-4474 **or** (732) 886-4474

Somerset County

Primary Screening Center for Somerset County:
Somerset County PESS
110 Rehill Avenue
Somerville, NJ 08876 **HOTLINE:** (908) 526-4100

Union County

Primary Screening Center for Union County:
(1) Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07201 **HOTLINE:** (908) 994-7131

Overlook Hospital (CIP)
99 Beavior at Sylvan Road
Summit, NJ 07901 **HOTLINE:** (908) 522-2232

Rahway Hospital (PESS)
865 Stone Street
Rahway, NJ 07065 **HOTLINE:** (732) 381-4949 **or** (732) 499-6165

Warren County

Primary Screening Center for Warren County:
Family Guidance Center of Warren County
370 Memorial Parkway
Phillipsburg, NJ 08865 **HOTLINE:** (908) 454-5141

Instructions and Information

(1) This document is called an advance directive for mental health care and allows you to make decisions in advance about your mental health treatment, including medications and voluntary admission to inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM. IF YOU DO NOT SIGN AND DATE THIS FORM, OR IF IT IS NOT APPROPRIATELY WITNESSED, IT WILL NOT TAKE EFFECT. IF YOU DO SIGN IT, DATE IT, AND HAVE IT WITNESSED, IT WILL TAKE EFFECT IF A DOCTOR OR ADVANCE PRACTICE NURSE DOCUMENTS THAT YOU ARE INCAPABLE OF MAKING TREATMENT DECISIONS.

If you choose to complete and sign this document, you may still decide to leave some items blank.

A witness cannot be your designated mental health care representative or your current treating professional. If there is only one witness, that person also can be anyone except someone to whom you are related or your cohabitant or domestic partner, anybody who is currently entitled to any part of your estate, or the operator of your congregate residence if you live in one (group home or boarding home, for example).

(2) You have the right to appoint a person as your mental health care representative to make treatment decisions for you. You should notify your representative that you have appointed him or her, and should give him or her a copy of this document and any revisions you make to it. If you revoke or replace it, you should also tell the representative. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your representative has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your representative to act will only become effective if you become incapable of making a decision about your care. Your treatment providers must still seek your informed consent at all times that it is required and you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

YOU MAY REVOKE OR CHANGE THIS DIRECTIVE WHEN YOU ARE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU DO NOT WANT TO BE ABLE TO REVOKE OR CHANGE IT WHEN YOU ARE INCAPACITATED. IF YOU REVOKE IT WHEN YOU ARE INCAPACITATED, THE PROFESSIONALS IN CHARGE OF YOUR TREATMENT WILL PROVIDE WHAT IS IN THEIR JUDGMENT THE BEST MEDICAL

TREATMENT AND YOUR WISHES, EXPRESSED HERE, WILL HAVE NO LEGALLY BINDING EFFECT ON THEM. THEY WILL NOT HAVE THE AUTHORITY TO CONTACT YOUR MENTAL HEALTH CARE REPRESENTATIVE, AND YOUR REPRESENTATIVE WILL NOT HAVE THE AUTHORITY TO MAKE DECISIONS ON YOUR BEHALF.

IF YOU ARE AN INPATIENT IN A PSYCHIATRIC FACILITY WHEN YOU EXPRESS A DESIRE TO REVOKE OR CHANGE YOUR DIRECTIVE, THE PHYSICIAN WILL DETERMINE WHETHER YOU ARE CAPABLE OF MAKING THAT DECISION AT THAT TIME, AND THE REVOCATION WILL NOT BE EFFECTIVE IF YOU ARE NOT CAPABLE OF REVOKING OR MODIFYING THE DIRECTIVE.

(5) You have the choice of whether to specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again.

(6) You cannot use an advance directive to consent to civil commitment. The procedures that apply to your advance directive are different from those provided for in the New Jersey Screening and Commitment Law (N.J.S.A. 30:4-27.1 et seq.). However, you can designate a representative to consent to your voluntary commitment under particular conditions.

(7) If there is anything in this directive that you do not understand, you should ask someone you trust to explain it to you. Advocates at New Jersey Protection and Advocacy will also be happy to direct or assist you. You can reach them at by phone at (609) 292-9742, (800) 922-7233 (if calling within New Jersey), (609) 633-7106 (TTY), or by email at advocate@njpanda.org.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive. If the provider cannot provide the treatment you designate, or if it would not be legal, ethical, or good medical practice to provide a treatment you designate, she or he will be able to deny you that treatment and substitute his or her best medical judgment, but only by seeking the approval of the hospital or agency ethics board. If a provider does not follow your directive, you and your mental health representative will be given notice and an opportunity to contest that decision.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) you may register your directive with the state by completing the last page of the attached form and sending the original of that page and a copy of the advance directive to: DMHS Registry, P.O. Box 727, 50 E. State Street, Trenton, NJ 08625-0727. If you register your directive, DMHS will send you a password that will allow you or anyone with your name and that password to view the directive on the internet. Your directive will also be available to mental health professionals who have applied to the registry for access and to whom you give your name and social security number.

THIS IS ONLY ONE POSSIBLE FORM. ANY FORM OF DIRECTIVE THAT IS SIGNED, DATED AND APPROPRIATELY WITNESSED (SEE INSTRUCTIONS) IS ACCEPTABLE AND WILL BE HONORED BY NEW JERSEY MENTAL HEALTH PROFESSIONALS AND HOSPITALS.

Declaration of Mental Health Care Representative

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment. I want this declaration to be followed if I am incapable, as defined in New Jersey Statutes 26:2H-108. I designate _____ as my agent for all matters relating to my mental health care including, without limitation, full power to give or refuse consent to all medical care related to my mental health condition. If my agent is unable or unwilling to serve or continue to serve, I appoint _____, as my agent. If both are unable or unwilling to serve or continue to serve, I appoint _____, as my agent. I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

If my wishes are unknown to my agent, I want my agent to make decisions regarding my mental health care that are consistent with what my agent in good faith believes to be in my best interests. My agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

I specifically authorize my representative to receive information about my treatment for HIV/AIDS and alcohol and substance abuse diagnosis and treatment if applicable and relevant._____(initial)

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatment and outpatient services.

(initial one of the following)

_____ This designation of a mental health care representative is irrevocable if I have been found under the standards in New Jersey Statutes Annotated 26:2H-108 to lack capacity to directly consent to my care.

_____ I can revoke this designation of a mental health care representative at all times.

If you wish to complete an instruction directive, continue on page 2. Otherwise, go to the signature section on page 5.

Mental Health Instruction Directive

The following are my wishes regarding my mental health care treatment if I become incapable.

Preferences and Instructions About Physician(s) or other professionals to be Involved in My Treatment

I would like the professional(s) named below to be involved in my treatment decisions:

_____ Contact information: _____

_____ Contact information: _____

I do not wish to be treated by_____ (facility or professional)

Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____ Contact information _____

Name _____ Contact information _____

Preferences and Instructions About Medications for Psychiatric Treatment

____I consent, and authorize my mental health care representative, if appointed on page 1, to consent, to the administration of the following medications:

_____

____I do not consent to, and I do not authorize my mental health care representative to consent to, the administration of any of the following medications:

_____

_____I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:_____
and these side effects can be eliminated by dosage adjustment or other means.

_____I am willing to try any other medication the hospital doctor recommends
_____I am willing to try any other medications my outpatient doctor recommends
_____I am not willing to try any other medications.

Preferences about voluntary hospitalization and alternatives:

By initialing here, I consent to giving my representative the power to admit me to an inpatient or partial psychiatric hospitalization program for up to ___ days:

____ (initial if you consent)

I would like the interventions below to be tried before voluntary hospitalization is considered:

___ Calling someone or having someone call me when needed. (Name:_____, telephone number:_____)

___ Staying overnight at a crisis respite (temporary) bed.

___Having a mental health care provider come to see me.

___Staying overnight with a friend:_____

___Seeing a mental health care provider for assistance with medications
___Other: _____

If hospitalization is required, I prefer the following hospital(s):

_____

Preferences about emergency interventions

I would like the interventions below to be tried before use of seclusion or restraint is considered (check all that apply)
___"Talk me down" one-on-one
___More medication
___Time out/privacy
___Show of authority/force
___Shift my attention to something else
___Set firm limits on my behavior
___Help me to discuss/vent feelings

___Decrease stimulation
___Other:_____

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on)

___ Seclusion ____ Seclusion and physical restraint (combined)

____ Medication by injection ___Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

___I wish my mental health care representative to be able to consent to electroconvulsive therapy in his or her complete discretion.

___I wish my mental health care representative to be able to consent to electroconvulsive therapy if I display the following symptoms:

_____

___I do not authorize my representative to consent to electroconvulsive therapy.

Expiration

This advance directive for mental health care is made pursuant to P.L 2005, ch 233 of the New Jersey laws and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to NJSA 26:2H-106 d. (1). If I do not revoke the directive, it will expire on _____, 20__. (leave blank if you do not want it to expire)

Signatures

I have voluntarily completed this advance directive for mental health care.

_____ (signature of declarant)

Address of mental health care representative: _____

Telephone number of mental health care representative _____

Address(es) of alternate mental health care representative(s) _____

_____

Telephone number(s) of alternate mental health care representative(s)

Affirmation of first witness (required):

I affirm that the person signing this mental health care advance directive:
1. Is personally known to me.
2. Signed or acknowledged by his or her signature on this declaration in my presence.
3. Appears to be of sound mind and not under duress, fraud or undue influence.
4. Is not related to me by blood, marriage or adoption.
5. Is not a person for whom I directly provide care as a professional.
6. Has not appointed me as an agent to make medical decisions on his or her behalf.

Witnessed by:

_____ _____, 20___
(signature and date)\

Affirmation of second witness: (two witnesses are required if the first witness is related to the declarant, entitled to any part of the declarant's estate, or the operator, administrator or employee of a rooming or boarding house or a residential health care facility in which the declarant resides)

I affirm that the person signing this mental health care advance directive:
1. Is personally known to me.
2. Signed or acknowledged by his or her signature on this declaration in my presence.
3. Appears to be of sound mind and not under duress, fraud or undue influence.
4. Is not related to me by blood, marriage or adoption.
5. Is not a person for whom I directly provide care as a professional.
6. Has not appointed me as an agent to make medical decisions on his or her behalf.

Witnessed by:

_____ _____, 20__
(signature and date)

Acceptance of appointment as agent: (optional)
I accept this appointment and agree to serve as agent to make mental health treatment decisions for the principal. I understand that I must act consistently with the wishes of the person I represent, as expressed in this mental health care power of attorney, or if not expressed, as otherwise known by me. If I do not know the principal's wishes, I have a duty to act in what I in good faith believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapable as that term is defined in NJSA 26:2H-109.

_____
signature of primary mental health care representative

_____
printed name of primary mental health care representative

_____
signature of first alternate mental health care representative

_____
printed name of first alternate mental health care representative

_____
signature of second alternate mental health care representative

_____
printed name of second alternate mental health care representative

Revocation

Complete this section if you wish to revoke this directive completely. You may also revoke or modify the directive by executing a new document. If you do so, you should tell your mental health care representative and replace the old documents in anyone's possession with your new directive. If you revoke this directive, it will no longer have any legal effect on your treatment.

_____I revoke the mental health advance directive I executed on or about_____, 20__ in its entirety.

_____ _____
(signature) (date)

Registration

I hereby submit my mental health advance directive to the Division of Mental Health Services in the New Jersey Department of Human Services to be registered. I choose the following password that will permit access for me and anyone with whom I share it. _____ (if left blank one will be assigned and provided to you.

I further understand that a licensed health care provider who is providing me with mental health care may be able to access my directive if needed. No other person will be permitted to see the directive (except as required for administration of the registry) without my permission.

_____
Signature

Print name:_____,

Please provide contact information for confirmation:

_____
(email, street address or telephone number)

Witness:

_____ (sign) _____(print name)

Dated: _____

Send original to: NJDMHS Registry, 50 E. State St, PO Box 727, Trenton, NJ 08625-0727 and attach a copy of your entire mental health care advance directive. You may also submit other documents to be registered that affect your legal ability to consent, such as a health care advance directive, durable power of attorney, temporary or limited guardianship orders, etc., which the registry will accept in its discretion.