GENPSYCH
Mental Health of the Future

Demographic and Insurance Information

Please complete all questions on both pages 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: Voicemail at home? Yes___ No___ Voicemail at work? Yes___ No___ Voicemail on cell phone? Yes___ No___	OK to leave a message with a family member? Yes___ No____ Family member's name(s):_____

Email Address:		

Date of Birth _____/_____/_____	Gender: Male_____ Female____	Marital Status: (ex. Single, divorced, married, separated, etc)

Age	Legal Guardian (if applicable)

INSURANCE POLICY INFORMATION

Insurance Company/HMO	Patient ID #/Member ID

Group #	Policy Holder's Name

Policy Holder's DOB: _____ **Policy Holder's SS#: _____**	**Claims Mailing Address:**
Phone	**Relationship to Policy Holder:**

SECONDARY POLICY INFORMATION (if applicable)

Insurance Company/HMO	**Patient ID/Member ID**
Group Number	**Policy Holder's Name**
Policy Holder's DOB	**Relationship to Policy Holder**
Claims Mailing Address	**City**
State/ZIP	**Phone**

PHARMACY INFORMATION

Pharmacy Name
Address
Phone Number

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SIGNATURES

_____	_____
Client or Parent/Legal Guardian Signature	**Date**
_____	_____
Responsible Party Signature	**Date**
_____	
Print Name	

GENPSYCH
Mental Health of the Future

OFFICE COPY

AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

The paragraphs below contain several agreements. Please read carefully and sign **client copy** and **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.

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we 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 to that you call at least 24 hours in advance, and calling early in the day I 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 from or "no-shows."

Please note: For those clients who may be receiving GENPSYCH, PC transportation services, as consideration for our lengthy van waiting list, a fee of thirty-five dollars ($35) will be charged for every cancellation of transportation without proper notice.

I understand and agree to the above

Patient Name (Print) _____

Patient or Parent/Legal Guardian Signature: _____ Date: _____

GENPSYCH
Mental Health of the Future

CLIENT COPY

AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

The paragraphs below contain several agreements. Please read carefully and sign **client copy** and **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.

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I understand and agree to the above

Patient Name (Print) _____

Patient or Parent/Legal Guardian Signature: _____ Date: _____

GENPSYCH
Mental Health of the Future

CLIENT COPY

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-payments 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, 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- Medication 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- Medication Management
- $350.00- Psychiatric diagnostic evaluation exam
- $209.00- Intensive Outpatient Program
- $339.00- 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/Legal Guardian Signature: _____ Date: _____

GENPSYCH
Mental Health of the Future

OFFICE COPY

NOTICE OF CONSUMER FINANCIAL RESPONSIBILITY

Billing and Insurance
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I understand and agree to the above

Patient Name (Print) _____

Patient or Parent/Legal Guardian 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)

Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
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

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION EMERGENCY CONTACT

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

**** GenPsych, its employees, and patients are strictly prohibited from receiving any remuneration by GenPsych or its affiliates as a direct result of this release. However 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.

I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until _____.

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 a condition of obtaining insurance coverage or required by applicable laws or regulations 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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION EMERGENCY CONTACT

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION EMERGENCY CONTACT

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until _____.

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 a condition of obtaining insurance coverage or required by applicable laws or regulations 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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

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PRIMARY CARE PHYSICIAN

Please check the category below that specifies your current status regarding care by a Primary Care Physician.

- ○ I have a Primary Care Physician. I will provide GenPsych with his/her contact information so that he/she may collaborate with my GenPsych provider. *a release form must be filled out in order for GenPsych to contact them.

- ○ I have a Primary Care Physician but I do not want GenPsych to collaborate with him/her in my care.

- ○ I do not have a Primary Care Physician and I need assistance finding one. *PCP referral list provided to patient

_____

Patient Name (PRINT)

_____ _____

Patient Signature Date

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION PRIMARY CARE PHYSICIAN

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: Primary Care Physician

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until _____.

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 a condition of obtaining insurance coverage or required by applicable laws or regulations 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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION REFERRAL

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: ___Referral_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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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 a condition of obtaining insurance coverage or required by applicable laws or regulations 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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION Psychiatrist/APN

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION THERAPIST

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- Information May be Released To_____ (Please check if appropriate)
- Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: ___Therapist_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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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 on my signing this form.

Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

CONSENT TO RELEASE / RECEIVE HEALTHCARE INFORMATION

Client's Name _____ DOB: _____

I, _____, request and authorize GenPsych, PC to release/receive (circle one or both) healthcare information to/from the following for the purposes of _____

- ○ Information May be Released To_____ (Please check if appropriate)
- ○ Information May be Obtained From_____ (Please check as appropriate)

Name of individual: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Additional/release form required for more than one individual)

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

_____ All healthcare information _____ ** Toxicology Test Results

_____ ** Substance Abuse Evaluation History _____ ** HIV / AIDS Disclosure

Other: (please specifically define information to be released) _____

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Client Signature: _____ Dated: _____

Parent/Legal Guardian Name _____ Dated: _____

Parent/Guardian Signature: _____ Dated: _____

GenPsych PC Witness: _____ Dated: _____

GENPSYCH
Mental Health of the Future

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. NJ 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 2 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 Clinical Social Worker (LCSW).

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) practice 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 license 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

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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, 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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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
- Informed Consent Procedures for Medications

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 a assistance with completing it, a member of GenPsych staff will assist me.

Signature: _____

Parent/Legal Guardian Signature: _____

Date:_____