## tree lake wide

# NewsomePsychologicalServices, Inc.

[***www.newsomepsychologicalservices.com***](http://www.newsomepsychologicalservices.com)

# 101 Creek Crossing Blvd. 614 East Landis Avenue

# Hainesport, NJ 08036 Vineland, NJ 08360

# Phone: (609)702-5880 Phone: (609)702-5880

# Fax: (609)702-5882 Fax: (609)702-5882

## CLIENT INFORMATION AND CONSENT FORM (MINOR)

***To be completed by parent/guardian and/or client, if age 16 or older***

|  |
| --- |
| **A. ABOUT CLIENT** |
| **Legal Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Name Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date of Birth:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Gender:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **SS#:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name of parent/legal guardian:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **Name of other parent/legal guardian (if joint custody per divorce decree):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Street Address:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **City:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **State:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Zip Code:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Okay to send letter? Yes No | If no, please identify preferred method of communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Parent Cell phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Okay to leave message?Yes No | **Home phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Okay to leave message?Yes No | **Client Cell phone (if age 16 or older):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Okay to leave message?Yes No | **Best number to call:**Parent Cell Home Client Cell (if age 16 or older) |
| **Employment/School:**Employed Student | **Emergency contact: By providing this information, you are authorizing communication for emergency only.**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Responsible Financial Party:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client: \_\_\_\_\_\_\_\_\_ |
| **B. TREATMENT INFORMATION**  |
| **What brings you/client to therapy?****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **What would you/client like to accomplish in therapy?****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_*\_\_\_\_\_\_\_** | **Have you/client participated in therapy before?**Yes No |
| **Is treatment for any of these reasons?** | ***If any items to the left were answered Yes, please note that special billing and processes will apply. Also, please complete these additional items to the right.*** | Do you have an attorney in the matter? Yes NoName of Attorney:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Will you/client be using accident or disability insurance coverage?Yes No |
| Related to employment Related to auto accident Related to other accident Related to a legal matter  | Yes NoYes No Yes NoYes No |
| **C. CLIENT’S INSURANCE INFORMATION**  |
| **Primary Insurance Company/Plan:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Secondary Insurance Company/Plan:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Accident/Disability Insurance Company:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policy/Claim No. \_\_\_\_\_\_\_\_\_\_\_\_Name of Adjustor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to insured:Self Spouse Child Other | ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to insured:Self Spouse Child Other |
| Name of Insured (if not self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of Insured (if not self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | ***Office use only:*Dx****Start date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****End date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PAYMENT AND INSURANCE NETWORK INFORMATION**

* Payment is due at the time of visit. Sorry, but there are no exceptions. If your insurance company fails to pay for services, you will be responsible for payment to Newsome Psychological Services, Inc. (herein referred to as NPS, Inc.)
* We accept cash, check, Visa, Master Card, or Discover.
* If NPS, Inc. is filing in-network insurance claims on your behalf, you pay only the co-payment, co-insurance, and/or deductible, which are based on the information from your insurance company. Finalized claims represent your financial responsibility and may vary from the amount collected at the time of your visit.
* In-network: Please call your insurance company to familiarize yourself with your benefits for in-network services.
* Out-of-network: Please call your insurance company to familiarize yourself with your benefits for out-of-network services. Please note that you have complete financial responsibility for health care services provided by an out-of-network professional.
* Also, there are sometimes different benefits for mental health claims. You should ask for the benefit for “*Mental health office visit”* with procedure code “90837”.
* Some NPS, Inc. clinicians are participating providers in the Aetna network, the Blue Cross Blue Shield Traditional network, and the NJ Medicaid network.

**Responsible financial party, please initial that you have read and understand the Payments and Insurance Network Information section above and that you have been provided with the insurance network information that applies to your plan. \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT CONTRACT**

*To be completed by parent/guardian and client, if age 16 or older.*

**Services**

* Your clinician expects full and honest participation in treatment.
* Your clinician will discuss your treatment and answer any questions you may have. No therapies will be used without your understanding and consent.
* You are expected to keep and attend all scheduled appointments.
* Between session assignments are common aspects of the treatment experience.
* If you have a complaint about your treatment, therapist, or any of our policies, please discuss these with your clinician or elevate it to the Practice Manager or Clinical Director so we can resolve it. You may ask to see our formal complaint procedure policy.
* We do not offer telemedicine services.

**Parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_\_\_\_\_\_\_, if age 16 or older, please initial that you have read and understand the Services section.**

**Cancellation and Missed Appointments**

* The courtesy of advance notice is appreciated if you need to cancel and/or reschedule your appointment. Confidential voicemail is available 24 hours a day.
* Cancellations with fewer than 48 hours notice and missed appointments will be billed at $60.00 each, except in the case of a genuine emergency. NJ Law prohibits billing Medicaid clients for missed appointments or late cancellations.
* If you demonstrate a pattern of missed or cancelled appointments, services may be suspended.

**Parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_\_\_\_\_\_\_, if age 16 or older, please initial that you have read and understand the Cancellations and Missed Appointments section.**

**Emergency Procedures**

* For **urgent** psychiatric issues, please use the procedures discussed with your clinician. You can leave messages on the confidential voicemail for all after-hour emergencies.
* For **emergencies**, dial 9-1-1 or go to your nearest emergency room. At your earliest convenience, please notify your clinician of your status.
* Please leave a message on the confidential voicemail for all non-emergency issues that cannot wait until the next visit to be addressed.

**Parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_\_\_\_\_\_\_, if age 16 or older, please initial that you have read and understand the Emergency Procedures section.**

**Electronic Communication**

* NPS, Inc. will only use email or text message communication with clients via HIPAA compliant methods.
* When an appropriate release is obtained, information and records may be transmitted electronically via facsimile or by email. In those cases, the risks associated with the release of the information are explained in a separate release of information form.
* While our email server is encrypted and meets HIPAA standards for compliance, email communications are not completely secure and confidential. If you choose to communicate with us by email or cell phone text messaging, please be aware that records are retained in the logs of internet and cell service providers, and unintended third party access may occur. Any emails received from you and any responses are part of your legal record.
* Email and text message communication between an NPS, Inc. clinician and patient are not to be used for treatment, diagnosis, or emergencies.

**Parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_\_\_\_\_\_\_, if age 16 or older, please initial that you have read and understand the Electronic Communication section.**

**Confidentiality**

* All treatment notes and files are confidential, available to no one else, and kept under lock and key.
* NPS, Inc. administrative personnel and clinicians are bound by confidentiality laws and may not release to anyone any identifying information of your participation in services.
* If your clinician wants to discuss your case with another health practitioner, your written permission will be obtained first.
* When the client is more than 14 years of age but has not yet reached the age of majority, an authorization shall be signed by the client and by the client’s parent/guardian, pursuant to NJSA 45:14B-36(e). Clinicians are not required to release to a minor’s parent/guardian records or information relating to the minor’s sexually transmitted disease, termination of pregnancy, or substance use, or any other information that in the reasonable exercise of the clinician’s professional judgment may adversely affect the minor’s health or welfare.
* Issues discussed in therapy are private and generally legally protected as both confidential and “privileged”. Situations where your clinician may break this confidentiality, releasing only that information pertinent to the situation:
	+ Suspected abuse of a child, elderly, or disabled person.
	+ If you have communicated a threat of imminent, serious physical violence against a readily identifiable target or against yourself and the clinician reasonably believes you intend to carry out the threat, the law requires that the clinician notify the authorities. This included notifying the police in the municipality/township wherein you reside and may include one or more of the following:
		- Arranging for admission to a hospital for psychiatric care (voluntarily or involuntarily).
		- Advising law enforcement of the threat and providing the identity of the intended victim.
		- Warning the intended victim or the intended victim’s parent or guardian if the intended victim is under 18.
		- Warning the parent or guardian if the client is under 18 and threatens to commit suicide or threatens bodily harm or injury upon himself.
	+ If your clinician is ordered by a court to release information as part of legal involvement.
	+ When an insurance company is involved, e.g., filing a claim, insurance audits, case review, or appeals.
	+ In natural disasters protected records may become exposed.
	+ Otherwise required by law.

**Parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_\_\_\_\_\_\_, if age 16 or older, please initial that you have read and understand the Confidentiality section.**

**Cell Phone Use and Video and Audio Recording During Session**

NPS, Inc policy prohibits audio and video recording of therapy or evaluation sessions. This includes making and/or receiving phone calls, using your cell phone camera or audio function, or use of any other recording device .If you cannot or choose not to abide by this policy, please let us know. If you do not adhere to this policy, and are using your cell phone or other recording device in any unauthorized manner, we will terminate the session.

**Parent/guardian\_\_\_\_\_\_\_\_\_\_ and client \_\_\_\_\_\_\_\_ If 16 or older, please initial that you have read and understand the Cell phone use section**

**REFERRAL INFORMATION**

**Referral source:**

Friend Relative Doctor Attorney Insurance Company Other

If a doctor or attorney referred you, may we send them a letter? Yes No

If yes, please provide their name and mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT AND AUTHORIZATION**

* I have read and understand this form and have had any questions answered to my satisfaction.
* I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.
* I authorize release of medical or any other information necessary to process my claim.
* I request payment of insurance or government benefits to the party who accepts assignment of those benefits.
* I authorize payment to Newsome Psychological Services, Inc.

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature (if age 16 or older): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTICE OF PRIVACY PRACTICES- CLIENT ACKNOWLEDGEMENT**

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have received this practice’s Notice of Privacy Practices, written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at or controlled by this practice. I understand I can obtain this practice’s current Notice of Privacy Practices on request.

**Signature (if age 16 or older)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to client** (if signed by legal representative of client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_