FPS

Family & Psychological Services Inc.
Greentree Commons
951 Route 73 North, Suite B
Marlton, NJ 08053

429 Woodbury-Glassboro Rd.
Mantua, NJ 08071

901 Route 168 Unit 406B
Turnersville, NJ 08012

717 East Elmer Street
Vineland, NJ 08360

2681 Quakerbridge Road, B2
Hamilton, NJ 08619

Date: _____

Patient Name: _____ DOB _____/_____/_____

Last First M.I.

Soc. Sec. # _____-_____-_____ Marital Status: Single Married Separated Divorced Widow(er)

Mailing Address: _____

Email Address: _____

Patient Phone #'s	Ok to Call?	**Spouse/Parent Phone #'s**	Ok to Call?
Home: ( ) _____	Yes or No	Home: ( ) _____	Yes or No
Cell: ( ) _____	Yes or No	Cell: ( ) _____	Yes or No
Work: ( ) _____	Yes or No	Work: ( ) _____	Yes or No

Spouse/Parent Name (If applicable):

_____ DOB ____/____/____ Soc. Sec. # _____-_____-_____

Last First M.I.

Insurance/Guarantor Name (Individual whose name the insurance is carried by):

_____ DOB ____/____/____ Soc. Sec. # _____-_____-_____

Last First M.I.

Children's Names	Date of Birth	Age	In Household
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No

Emergency Information:

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Employment/Education Information:

Current Employer: _____ Phone: _____

Employer Address: _____

Title: _____ Years Worked: _____

Level of Education:_____ High School:_____ College:_____

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Prior Treatment: Please indicate below prior counseling or psychiatric help you have received, including the names of the treating professionals, name of facility, type of treatment received and approximate date of treatment.

_____

_____

Medical History: _____

_____

Medical Problems (including allergies): _____

_____

Current Medications: Please include below, the medication, prescribed dosages, and date of initial prescription and refills, and doctor prescribing medication (if applicable).

(Please check) Is the prescribing doctor _____ a psychiatrist or _____ your primary physician?

Medication Dosage Date of Initial Prescription Prescribing Physician

Presenting Problem(s): What are the problems, concerns, issues, or challenges that have caused you to seek counseling today? Please include the beginning and history of the problems, the detail of the problems, the detail and intensity of them, how they are affecting you (and/or your spouse), and your counseling goals. Please do NOT give one or two word responses, such as "Marriage Counseling". **Please answer this question completely!!**

_____

_____

_____

_____

_____

Substance Abuse History

(to be completed for all patients age 12 or over)

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Others						

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Family History of Mental Health Problems or Chemical Dependency:

_____

_____

_____

Clinical or Adjustment-Related Symptoms: Please circle the following symptoms you are experiencing as a result of your presenting problems, issues, concerns, stressors, or challenges

anxiety depressed mood agitation insomnia mood swings
difficulty coping difficulty concentrating panic attacks
compulsions addictive behavior social withdrawal hurt/grief
ruminative thinking anger management problems

Social Support: Please identify your current support system (eg, family, friends, institutions, etc.) below that you reach out to for support, and help you with your needs, issues, concerns and problems.

_____

_____

_____

Current and Past Legal History:

_____

_____

Past or Present Issues of Childhood: Please explain if you or the child you are bringing here experienced or have been experiencing any traumas, disabilities, adjustments of family, social, or school challenges.

_____

_____

_____

Patient Signature: _____ Date: _____

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Clients Rights and Responsibilities

You have the right:

- To be treated with respect, consideration and dignity at all times.
- To receive information about your diagnosis, & treatment
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternatives and likely consequences of your decision.
- To express a concern to the Administrator, Office Manager or Staff.

You have the responsibility:

- To review and understand your health insurance coverage benefits and limitations.
- To learn and understand the proper use of your insurance plan's services and procedures for obtaining coverage. This includes knowing the referral policy for your plan and restrictions covered by your plan.
- To always provide your insurance plan identification card and be prepared to show it at each office visit.
- Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered, or if the information provided is inaccurate.
- To pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit, unless prior arrangements have been made.
- To notify the office of any change in insurance change.
- To keep scheduled appointments and notify the office promptly if you will be delayed or unable to keep an appointment (**minimum of 24 hour notice**).
- To follow the advice of your Therapists and consider the alternatives and/or likely consequences if you refuse to comply
- To ask questions and seek clarification until you fully understand the care you are receiving.

Insurance companies do not pay for all services, even those that might be helpful to a client. When a service is not covered by your insurance policy, you are responsible for paying the bill. Therapists dictate your diagnosis for each visit. We are unable to change this information just so the claim will be paid.

Client Signature:_____ Date:_____

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Agency Requirements

1. Clients or legal guardians are responsible for the full payment of co-pays and or deductibles, as well as any other applicable fees for professional services rendered, in accordance with all the agency requirements.

2. Payment must always be made in full before professional services are rendered, except when prior arrangements are made in writing between the Client or Legal Guardian and the billing department of the agency.

3. This agency must be given at least a 24-hour advanced notice of cancellation, or a $25 late fee will be charged. The same fee applies for failing to show for a scheduled session. For couples counseling, if one party cannot attend the session, it is the responsibility of the other party to keep the appointment to avoid a full charge. Please note that "late cancellation" and "No Show" charges are the full responsibility of the Client or Legal Guardian, Not the insurance company.

4. Please be aware that this agency charges a $30 processing fee for any check received as "non-sufficient funds." For a NSF check, the Client or Legal Guardian is required to pay this fee, in addition to the session fee, before further appointments can be made. This agency does not accept post-dated checks under any circumstances.

5. Charge for testing and reports are billed as a separate fee from therapy sessions and, thus, not covered as part of the Client's authorization for treatment. Therefore, testing and reports must be paid separately from the co-pay, and should be discussed with the therapist performing such services. As such, payment is the responsibility of the Client or Legal Guardian, not the insurance company.

6. If test results and /or reports are rendered by the therapists, agencies, or third parties, they will be forwarded only after full payment is received for services provided. A Consent for release of Confidential Information form must also be signed by the authorizing person, pursuant to legal, ethical, and HIPAA standards. Appropriate authorization will be dept on file at the agency.

7. It is the agency policy that all reports prepared or written by a therapist, on behalf of a client of this agency, must be paid in full before they are released, including court-related or court-ordered reports, and the like.

8. Upon completion of a report, the Client or Legal Guardian will be sent an in voice. The report will be released immediately upon receipt of payment in full. However, in some cases, a retainer or full payment will be required before the report is written. After full payment is made, the completed report can be mailed or picked up by the appropriated party at the main office in Cherry Hill (pursuant to legal, ethical, and HIPAA standards.)

9. It is the responsibility of the Client or Legal Guardian to provide the agency with updated information at all times regarding changes in insurance coverage, Change of address, etc. Failure to do so impedes the billing process, which can result in denial of payment for services rendered. It this occurs, the Client or Legal Guardian should and will be made responsible for the payment of said invoice.

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10. If you bring children to the agency, please be fully responsible in meeting their needs. Also, please do not permit them to run around the office. In addition, **children are not permitted to be unattended at any time**. This would include leaving them in reception area, as our staff cannot be responsible for them. Moreover, it creates a distraction for everyone in the agency. We realize that children can be challenging and therefore appreciate your understanding and efforts regarding these requests.

11. Client complaints are handled in accordance wit regulatory procedures provided in the HIPAA Notice of Privacy Practices and also in accordance with Family & Psychological Services, Inc. complaint guidelines.

12. Clients and/or Guardians must review, understand, consent to, and sign the HIPAA Notice of Privacy Practices Agreement provided by the assigned therapist, or staff member of this agency. Assistance will be provided upon request.

13. I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

I have read and fully understand these statements and, by signing, agree to the requirements, policies, and procedures set forth herein:

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date:_____
(If Applicable)

Witnessed By: _____ Position: _____

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Client Acknowledgement of Receipt of HIPAA Privacy Practices at Family & Psychological Services, Inc.

My signature acknowledges that Family & Psychological Services, Inc. provides the information about its' "Notice of Privacy Practices," as stated in The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I was given the opportunity to read and ask questions about The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I was given the opportunity to receive a copy of The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name: _____ Relationship to Patient: _____
Please Print

Patient Signature: _____ Date: _____
(or Legal Guardian)

Witnessed By:_____ Position: _____

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Informed Consent for Treatment

I, _____ agree and consent to participate in behavioral health care services at *Family & Psychological Services, Inc.* by my assigned or chosen behavioral health counselor,_____.

I hereby consent to enter into a counseling agreement with *Family & Psychological Services, Inc.* I fully understand that I have the right to refuse behavioral health care services by my assigned or chosen counselor, and the right to terminate it. Moreover, I understand that the counseling modality and services used by the above-named provider is within the scope of the provider's license, certification, and training; or the scope of license, certification, and training of the behavioral health care providers directly supervising the services received.

I understand that the various consequences of counseling may include: personal growth discomfort, decision-making challenges, reactions by others in one's life to those changes, challenges to existing beliefs or thought processes, boundary changes, anger and other difficult feelings, uncomfortable insights, and awareness of unforeseen possibilities and choices.

I understand that all counseling sessions are confidential, but there are limits to confidentiality, as prescribed by law and the ethical standards of the counseling profession. Specifically, if a client states that he/she is going to harm him/herself or someone else, the counselor must take prescribed action. Additionally, if you communicate an incidence of current child abuse, or the counselor has cause to suspect that any juvenile is currently being abused or neglected, it must be reported to the *N.J. Division of Child Protection and Permanency* (formerly DYFS).

I understand that a separate *Consent for Release of Information* must be signed in order for a counselor to communicate with anyone about your care. I can revoke this Release at any time in writing. I also understand that the counselor may receive supervision at any time for my case, and confidentiality binds my counselor's clinical supervisor as well.

Children under the age of 18 or unable to consent to treatment will only receive counseling upon written consent of their parents/guardian. If applicable, I attest that I have legal custody of this individual and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I have read and understand this Informed Consent Form. It is without pressure or coercion that I (and my spouse/mate/partner) am signing this consent form.

Name: _____ Signature: _____ Date _____

Name: _____ Signature: _____ Date _____

Relationship to Patient (if applicable): _____

Witnessed By: _____Position: _____

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To ensure billing accuracy, patient (or guardian) must sign and date below prior to each visit. The red highlighted line indicates when an authorization (if applicable) expires. Therapists are responsible to complete the reauthorization prior to the highlighted visit (if allowable). All signatures must be obtained from the client in the therapy room. Therapists are responsible to indicate No Show and Late Cancellations on this form.

Patient Name: _____ Therapist's Initials _____

Date	Signature	Date	Signature
1		15	
2		16	
3		17	
4		18	
5		19	
6		20	
7		21	
8		22	
9		23	
10		24	
11		25	
12		26	
13		27	
14		28	