



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

100 Horizon Center Blvd.
Hamilton, NJ 08691

Welcome to Family & Psychological Services, Inc.

Founded in 1974, Family & Psychological Services, Inc. is a well-established private, non-profit organization that provides a variety of counselling services throughout the South Jersey area by a dedicated and caring team of mental health professionals. The name, *Family and Psychological Services* was adopted to reflect the primary services offered.

Family & Psychological Services, Inc. respects the diversity of all individuals and groups, and attempts to promote the well-being, stability, happiness, growth and highest quality of life to all who seek its professional services and support.

Billing Inquiries:	856-424-4408	ext. 1017
General Information:	856-424-4408	ext. 1019 or ext. 1020
Office Manager:	856-424-4408	ext. 1023
Executive Director:	856-424-4408	ext. 1036

For Additional Information:

www.fps-nj.com



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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?

<u>Medication</u>	<u>Dosage</u>	<u>Date of Initial Prescription</u>	<u>Prescribing Physician</u>
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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 kept 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 invoice. 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. If 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 with 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 _____



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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. 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.

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	

FAMILY & PSYCHOLOGICAL SERVICES

Payment Policy

Please retain this document for your reference

- 1. Insurance:** We participate with most major insurance plans. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions. **IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER**, all services provided in our office (unless otherwise indicated) will be submitted to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility, and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse, and will determine the patient liability for a claim.
IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER OR IF YOU DO NOT HAVE HEALTH INSURANCE, payment in full is expected from you at the time of your visit.
- 2. Proof of Insurance:** All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.
- 3. Referrals:** In accordance with your insurance carrier, it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.
- 4. Claims Submission:** Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance coverage is a contract between you and your insurance carrier. We are not party to that contract.
- 5. Non-covered Services:** Certain office procedures or services may not be covered, or may be considered “not medically necessary”, “experimental”, “cosmetic” or simply “non-covered” by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.
- 6. Non-payment of patient balances:** Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due. This includes, but is not limited to, attorney, collection, and contingent fees.
- 7. Non-sufficient funds (NSF)/ Returned Checks:** A fee of \$35.00 will be charged for all returned checks.
- 8. Missed Appointments:** Failure to cancel your appointment without 24 hours from your scheduled visit may result in a fee of \$25.00.



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May 26, 2017

New Policy and Procedure Forms

Dear FPS Clients,

Please find the following new forms pertaining to updated/new policy and procedures for Family & Psychological Services. These forms will replace and overturn any contradicting information in the Intake Packet until such a time when the Intake Packet will be fully updated.

1. Payment Policy
2. Assignment of Benefits
3. Security Camera Policy and Understanding

Please initial each item below

_____ I hereby acknowledge that I have read, understand and retained a copy of the new Payment Policy for FPS.

_____ I hereby acknowledge that the information set forth in the attached documents shall overturn any contradicting polices in the original intake packet.

Client Name (Please Print)

Client Signature

Date

FAMILY & PSYCHOLOGICAL SERVICES

ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Family & Psychological Services is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including any private insurance and any other health/medical plan, to issue payment directly to Family & Psychological Services for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Family & Psychological Services to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Family & Psychological Services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. I hereby authorize Family & Psychological Services to maintain the payment information listed below in the event that my financial obligation is not met at the time of service or upon receipt of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

CREDIT CARD* TYPE (CIRCLE ONE): VISA, MASTERCARD, AMEX, DISCOVER, OTHER

CARD NUMBER: _____

EXP. DATE: _____

CV (CODE FROM BACK OF CARD): _____ BILLING ZIP CODE _____

SIGNATURE: _____ PRINT NAME: _____

PRF-052017

Patient/Responsible Party Signature

Date

Family & Psychological Services, Inc.

Security Camera Policy and Understanding

I, _____, understand that security cameras are in use within the Marlton offices of Family & Psychological Services. The cameras are in place for the security of patients, clinicians and staff.

Any footage recorded will be held in a Cloud environment. If deemed necessary, it may be used for purposes of maintaining, monitoring and reviewing the safety activities and policies of the office.

It is not intended to be used outside of any security-related needs, such as, but not limited to marketing, advertising, social media marketing.

The current security set up is limited to the front and back doors of the office suite to monitor those coming and going out of both doors, where necessary.

By signing below you understand that this security measure is in place and acknowledge release of the agency for any liability when used for the purposes of security.

Signature: _____ Date: _____

Print name: _____