Family & Psychological Services, Inc.

PO Box 3820, Cherry Hill, NJ 08034
Phone 856-424-4408 – Fax 856-596-9164
Locations: Marlton, Mantua, Hamilton, Mays Landing

Today's Date: _____

PATIENT INTAKE FORMS

Patient Information

Name: _____

Addr: _____

City, State, Zip: _____

Social Security Number: _____

Date of Birth: _____ Sex: [ ] M [ ] F

Marital Status [ ]Single [ ]Married [ ]Separated [ ]Divorced [ ]Widow(er)

Home Phone: _____

Cell Phone: _____

Email: _____

[ ] Spouse [ ] Parent Information

Name: _____

Addr: _____

City, State, Zip: _____

Social Security Number: _____

Date of Birth: _____ Sex: [ ] M [ ] F

Home Phone: _____

Cell Phone: _____

Email: _____

Insurance/Guarantor Information

Name: _____

Social Security Number: _____

Date of Birth: _____ Sex: [ ] M [ ] F

Home Phone: _____

Cell Phone: _____

Financially Responsible for Patient (If self, leave blank)

Name: _____

Social Security Number: _____

Date of Birth: _____ Sex: [ ] M [ ] F

Relationship to Patient: _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Addr: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Primary Care Physician: _____

Office Phone: _____

Office Fax: _____

Addr: _____

City, State, Zip: _____

Other Identifying Information

Ethnicity: _____

Religion: _____

Sexual Orientation: [ ] Heterosexual [ ] Homosexual
[ ] Bisexual [ ] Other _____

Education – what is the highest level of education obtained?

_____

Employment

Are you currently : [ ]Employed [ ]Unemployed [ ]Student [ ]Other

Current Employer: _____

Length of present position: _____

Title: _____

How did you hear about our practice?

[ ] Brochure [ ] Health Plan [ ] Internet [ ] Ongoing Care
[ ] Patient [ ] Phone Book [ ] Magazine [ ]PCP [ ] Relative
[ ] Word of Mouth [ ] Other [ ] Referral _____

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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 intensity of them, how they are affecting you (and/or your spouse/family). Please do **NOT** give one or two word responses, such as "Marriage Counseling". **Please answer this question completely!!**

Treatment Goals – What are your treatment goals?

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

Trauma – Please describe any traumatic events that you have experienced, when they occurred, and persons involved.

Family Psychiatric History – Please indicate below if there is any history of mental illness in your family, known diagnosis and any known treatment received and approximate date of treatment.

Current Medical Conditions and Medications – Please indicate below, any current medical conditions, treatments, allergies as well as current medications, dosage, purpose.

Substance Abuse History– To be completed for all patients age 12 or older.

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

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Social Support – Please indicate 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/Past Legal History

_____

_____

Strengths / Limitations

Physical_____

_____

Mental_____

_____

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

[ ] Difficulty falling asleep
[ ] Difficulty getting out of bed
[ ] Difficulty staying asleep
[ ] Not feeling rested in the morning
Avg. hours of sleep per night _____

[ ] Persistent loss of interest in previously enjoyed activities
[ ] Withdrawing from other people
[ ] Depressed Mood
[ ] Rapid mood changes
[ ] Anxiety
[ ] Frequent feelings of guilt
[ ] Difficulty leaving your home
[ ] Outbursts of anger
[ ] Spending increased time alone
[ ] Feeling Numb
[ ] Irritability
[ ] Panic Attacks
[ ] Avoiding people, places, activities or specific things
[ ] Fear of certain objects or situations (ie. flying, heights, bugs)
Describe _____
_____
[ ] Repetitive behaviors or mental acts (ie. counting, checking doors, washing hands) Describe _____
_____
[ ] Worthlessness
[ ] Sadness
[ ] Fear
[ ] Hopelessness
[ ] Helplessness
[ ] Feeling or acting like a different person

[ ] Changes in eating/appetite
[ ] Eating more
[ ] Voluntary vomiting
[ ] Excessive exercise to avoid weight gain
[ ] Eating less
[ ] Use of laxatives
[ ] Binge eating
[ ] Are you trying to lose weight?
[ ] Weight gain _____lbs.
[ ] Weight loss _____lbs.

[ ] Difficulty catching your breath
[ ] Unusual sweating
[ ] Increased energy
[ ] Tremor
[ ] Frequent worry
[ ] Increase muscle tension
[ ] Easily startled, feeling "jumpy"
[ ] Decreased energy
[ ] Dizziness
[ ] Physical sensations others don't have
[ ] Intrusive memories
[ ] Racing thoughts

[ ] Difficulty concentrating or thinking
[ ] Flashbacks
[ ] Thoughts about harming/killing yourself
[ ] Thoughts about harming/killing someone else
[ ] Large gaps in memory
[ ] Nightmares

[ ] Feeling as if you were outside yourself, detached, observing what you are doing
[ ] Feeling puzzled as to what is real and unreal
[ ] Persistent, repetitive, intrusive thoughts, impulses, or images
[ ] Unusual visual experiences such as flashes of light, shadows
[ ] Hear voices when no one else is present
[ ] Feeling that your thoughts are controlled or placed in your mind
[ ] Feeling that the television or the radio is communicating with you
[ ] Difficulty problem solving
[ ] Inappropriate expression of anger
[ ] Difficulty or inability to say "no" to others
[ ] Sense of lack of control
[ ] Abusive relationship
[ ] Concerns about your sexuality
[ ] Difficulty meeting role expectations
[ ] Manipulation of others to fulfill your own desires
[ ] Self-mutilation/cutting
[ ] Ineffective communication
[ ] Decreased ability to handle stress
[ ] Difficulty expressing emotions
[ ] People say they can't understand what you are saying
[ ] Loss of words when speaking
[ ] High dependency on others

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Patient and/or Responsible Party's Acknowledgement

By initialing the entries and signing below, you have acknowledged that you have received a copy of the described informational forms and that you agree to their terms in their entirety.

_____I have retained a copy of the Agency Requirements for Family & Psychological Services, Inc. I have read, understood and agree to all terms of this document.

_____I have retained a copy of Clients Rights and Responsibilities for Family & Psychological Services, Inc. I have read, understood and agree to all terms of this document.

_____I have retained a copy of the Security Camera Policy and Understanding for Family & Psychological Services, Inc. I have read, understood and agree to all terms of this document.

_____I have retained a copy of the Payment Policy for Family & Psychological Services, Inc. I have read, understood and agree to all terms of this document.

Print Name	Signature	Relation to Patient	Date

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 private insurance and any other health/medical plan, to issue payment check(s) directly to Family & Psychological Services, Inc. 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.

Print Name	Signature	Relation to Patient	Date

Authorization to Release Information

I hereby authorize Family & Psychological Services, Inc. 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, Inc. 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. A photocopy of this assignment is to be considered as valid as the original.

Print Name	Signature	Relation to Patient	Date

Informed Consent for Treatment

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.

Print Name	Signature	Relation to Patient	Date

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

My signature below 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 (HIPAA).

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

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____ Date of Birth: _____/____/_____

Release of Information

_____ I authorize the release of information including the diagnosis, records, services rendered to me and claims information.

This information may be released to: (Please print and use full legal names)
_____ Spouse_____
_____ Child(ren)_____
_____ Other_____

_____Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

Communication

Please call (1st) _____ my Home _____ my Work _____my Mobile Phone Number _____
Please call (2nd) _____ my Home _____ my Work _____my Mobile Phone Number _____

If unable to reach me:
_____ leave a detailed message
_____ please leave a message asking me to return your call
_____ please do NOT leave a message

The best time to reach me is on (day) _____
between (time) _____ and _____

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

Contact method for automated appointment reminders. Please select only ONE option.

_____ SMS Text Message ONLY Mobile Phone # _____
_____ SMS Text Message AND Email Mobile Phone # _____ Email _____
_____ Voice Message AND Email Phone # _____ Email _____
_____ Email Message ONLY Email _____

By signing below, I authorize Family & Psychological Services, Inc. or its affiliates to contact me with an automated message via the above indicated contact method.

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

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Payment Policy – You may ask for a copy of this policy to retain 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 ---**$100.00.**

9. **Fees for Documentation:** If reports or forms are needed to support a disability claim, attorney review or any other 3rd party, including court – related or court-ordered reports, they will be forwarded only after full payment is received for services provided. A consent for the release of confidential information must be signed by the authorizing person, pursuant to legal, ethical and HIPAA standards.

Insurance Information

Insurance Name _____ Plan Type (circle one) HMO, PPO, POS, Other _____

Claims Address _____ Benefits Phone _____

Member ID# _____ Group # _____

Insurance Guarantor Name _____ Phone _____ Date of Birth _____

Relationship to patient _____

***Please note, many HMO insurance plans require a referral from your Primary Care Physician**

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

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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 ---**$100.00.**

9. Fees for Documentation: If reports or forms are needed to support a disability claim, attorney review or any other 3rd party, including court – related or court-ordered reports, they will be forwarded only after full payment is received for services provided. A consent for the release of confidential information must be signed by the authorizing person, pursuant to legal, ethical and HIPAA standards.

Insurance Information

Insurance Name _____ Plan Type (circle one) HMO, PPO, POS, Other _____

Claims Address _____ Benefits Phone _____

Member ID# _____ Group # _____

Insurance Guarantor Name _____ Phone _____ Date of Birth _____

Relationship to patient _____

***Please note, many HMO insurance plans require a referral from your Primary Care Physician**

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

PLEASE RETAIN THIS COPY FOR YOUR RECORDS AND REFERENCE.

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PATIENT PAYMENT AGREEMENT

_____ Initials **1.** All professional services rendered by Family & Psychological Services are charged to the patient and are due at the time of Services, unless insurance coverage is verified, and Family & Psychological Services is a participating provider.

_____ Initials **2.** I have requested mental health 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 as agreed between myself and my mental healthcare professional and FPS.

_____ Initials **3.** I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, co-insurance, and/or deductible) incurred in full immediately upon presentation of the appropriate billing statement.

_____ Initials **4.** The cost for a missed appointment is **$100.00**.

_____ Initials **5.** The cost for a last-minute cancellation is **$100.00**. ("last-minute" cancellation shall be less than 24 hours notice)

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 agreement is to be considered as valid as the original.

Credit Card Type (circle one) [ ] Visa [ ] Mastercard [ ] Amex [ ] Discover

Card Number _____

Expiration Date (MM/YY) _____

CV Code (Code from the back of card) _____ Billing Zip Code _____

Cardholder Name (Please Print) _____

Signature _____

_____ _____

Patient/Responsible Party 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 will all 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 24 hour advanced notice of cancellation, or a $100.00 late fee will be charged. The same fee applies for failing to show for a scheduled session. Please note that "late cancellation" and "no show" charges are the full responsibility of the client or legal guardian, not the insurance company.

4. If test results and/or reports are rendered by the therapist, 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.

5. 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.

6. 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 impede 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.

7. 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**, as our staff cannot be responsible for them.

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

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

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

Security Camera Policy and Understanding (Marlton Location Only)

I, _____, understand that security cameras are in use in the Marlton office of Family & Psychological Services, Inc. for live and recorded surveillance. The cameras are in place for the security of patients, clinicians and staff.

They are intended for security purposes only.

The camera set up is limited to the front and back doors of the office suite only. They are not present in any treatment or group room.

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.

_____	_____	_____	_____
Print Name	Signature	Relation to Patient	Date

For Staff Use Only

_____ I have reviewed the entire intake packet and witness that all fields were completed at/by the time of the initial visit by the patient or parent/guardian

Witnessed by: _____ Position _____ Date_____

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CONSENT FOR RELEASE OF INFORMATION

Use of this form requires a signed "Notice of Privacy Practices" in clients file

Client Name:_____ **ACCT. #.:**_____

Spouse/Partner:_____ **(Only applicable to Marriage Counseling)**

I/We authorize *Family & Psychological Services, Inc.* and my/our therapist _____ to release & correspond with _____ in order to obtain & release:

__ **Billing Records** __ **Insurance Authorization Records** __ **Claim Records**

__**Testing Records** __ **EAP Authorization Information** __ **Testing Records**

__**Clinical Evaluation** __ **Treatment Plan & Recommendations** __ **Assessment Report(s)**

__**I/We authorize release of ANY and ALL of the ABOVE RECORDS to the recipient(s) specified above.**

Purpose for the Release of Information:_____
Name & Address (include fax &/or email address, if applicable) to send this *Release of Information:*

_____

_____

_____

_____

I/We understand that under The Health Insurance Portability Act of 1996 (HIPPA), section – ***Right to Release An Authorization For Other Uses And Disclosures***, I/We do not have to release this information; however, I/We choose to do so voluntarily for the purpose(s) as specified above. I/We further understand that I/We may cancel this authorization at any time by written notice, unless the information has already been sent. Also, I/We understand that a reasonable fee, based on our costs for copying, postage, and for an explanation may be made for the requested information. Notification of this fee is made in advance of record release, and the full fee payment is due prior to the release of the records.

Client Signature:_____ **Date:**_____

Spouse Signature: _____ **Date:**_____
Two signatures required if applicable to Marriage Counseling

Parent/ Guardian Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____