Family Psychiatry and Therapy
17 Arcadian Way, Paramus, NJ 07652
Phone: 201-977-2889 Fax: 201-977-2890

PATIENT REGISTRATION FORM

(Last Name) (First Name) (Middle Initial)

Birth Date:_____/_____/_____ Age_____ Gender: ☐ Male ☐ Female ☐ Other

Mailing Address_____
(Number/Street/Apartment)

_____
(City) (State) (Zip)

Home Phone_____ May we leave you a message? ☐ Yes ☐ No

Cell Phone_____ May we leave you a message? ☐ Yes ☐ No or Text you? ☐ Yes ☐ No

Email_____ May we email you? Yes No
Please note that email is not considered to be a confidential medium of communication

Please list any children/ages:_____

Marital Status: ☐ Never Married ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Ethnic Group:_____ Race:_____ Language:_____

Emergency Contact:_____ Phone_____ Relationship_____

WHO MAY WE THANK FOR YOUR REFERRAL?

☐ Doctor/Therapist_____ ☐ Friend/Family Member_____

☐ Attorney/Other Professional_____

☐ School/Contact Name_____

☐ Google Search ☐ HealthGrades ☐ Psychology Today ☐ ZocDoc ☐ Yelp ☐ Don't Recall/Other_____

(Mandatory) Why are you here today?_____

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HEALTH AND SOCIAL INFORMATION

Do you currently have a primary care physician? ( )Yes ( )No When was your last physical?_____

If yes, Dr.'s Name_____Phone_____

Address_____

Are you currently seeing more than one medical Health Specialist? ( )Yes ( )No

If yes, why?_____

Please list any allergies / reactions_____

Please list any persistent physical symptoms, or health concerns (e.g. chronic pain, headaches, hypertension, diabetes)

_____

Are you currently on medications to manage a physical health concern? ( )Yes ( )No

If yes, list_____

Are you having any problems with your sleep habits? ( )Yes ( )No

If yes, ( )Sleeping too little ( )Sleeping too much ( )Poor quality sleep ( )Disturbing dreams ( )Other_____

How many times per week do you exercise? _____ What activities?_____

Are you having difficulty with appetite or eating habits? ( )Yes ( )No

If yes, ( )Eating less ( )Eating more ( )Binging ( )Restricting ( )Purging ( )Other_____

Have you experienced significant weight change in the last 6 months? ( )Yes ( )No

Do you drink alcohol? ( )Yes ( )No If yes, how many drinks per day?_____ a week?_____

Do you engage in recreational drug use? ( )Daily ( )Weekly ( )Monthly ( )occasionally ( )Never

If yes, list: 1._____ 2._____ 3._____ For how long?_____

Do you smoke cigarettes or use other tobacco products? ( )Yes ( )No If yes, Type/Frequency_____

Have you had suicidal thoughts recently? ( )Frequently ( )Sometimes ( )Rarely ( )Never

Have you ever attempted suicide? ( )Yes ( )No If yes, When?_____

Do you self-harm? (e.g. cutting) ( )Frequently ( )sometimes ( )Rarely ( )Never

In the past year have you experienced any significant life changes or stressors? If yes, explain:_____

_____

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HEALTH AND SOCIAL INFORMATION CONTINUED

Are you currently in a romantic relationship? ( )Yes ( )No If yes, how long?_____

What is the quality of your relationship?_____

_____

Extreme depressed mood	Yes / No If yes, When?
Dramatic mood swings	Yes / No If yes, When?
Rapid speech	Yes / No If yes, When?
Extreme anxiety	Yes / No If yes, When?
Panic attacks	Yes / No If yes, When?
Phobias	Yes / No If yes, When?
Sleep disturbances	Yes / No If yes, When?
Hallucinations	Yes / No If yes, When?
Unexplained losses of time	Yes / No If yes, When?
Unexplained memory lapses	Yes / No If yes, When?
Alcohol/substance abuse	Yes / No If yes, When?
Frequent body complaints	Yes / No If yes, When?
Eating disorder	Yes / No If yes, When?
Body image problems	Yes / No If yes, When?
Repetitive thoughts (e.g. obsessions)	Yes / No If yes, When?
Repetitive behaviors (e.g. frequent hand washing)	Yes / No If yes, When?
Homicidal thoughts	Yes / No If yes, When?
Suicidal attempts	Yes / No If yes, When?

TREATMENT HISTORY

Are you currently receiving psychiatric services, counseling, or psychotherapy? ( )Yes ( )No

If yes, current practitioner's name_____

No, but past practitioner's name_____

Are you currently or previously taking prescribed psychiatric medications (antidepressants or other)? ( )Yes ( )No

If yes, please list medications_____

Prescribed by_____ Dates taken_____

OCCUPATIONAL INFORMATION

Are you currently employed? ( )Yes ( )Full-time ( )Part-time ( )No

If yes, who is your current employer/position? _____

Please list any work-related stressors, if any_____

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RELGIOUS / SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( )Yes ( )No

If yes, what is your faith?_____If no, do you consider yourself to be spiritual? ( )Yes ( )No

FAMILY MENTAL HEALTH HISTORY (Immediate Family Members Only – Do not include yourself or spouse)

DIFFICULTY	YES / NO	FAMILY MEMBER
Depression		
Bipolar disorder		
Anxiety disorder		
Panic disorder		
Schizophrenia		
Alcohol / Substance abuse		
Eating disorder		
Learning disability / Special education		
Trauma history		
Suicide attempts		
Chronic illness		
ADHD / ADD		
Anger management		
Sudden cardiac death before age 50		
Birth defects		

MISSED APPOINTMENTS: In fairness to other patient and our providers, we require at least 24 hours' notice to cancel or reschedule an appointment. Monday appointment cancelations must be received by the previous Friday. A cancelation fee will apply if an appointment is cancelled or rescheduled without proper notice. This is a corporate policy and applies to all patients, please ask staff for further details and fee amounts.

Patient Signature: _____ Date: _____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION / HIPPA NOTICE

Patient Name_____ Date of Birth:____/ ____/ _____

_____(Initials) Information is **not** be released to anyone.

OR

_____(Initials) I authorize the release of information including the diagnosis, records, examination rendered to me and claims (financial) information.

Information May Be Released To:

☐ Spouse Name of Spouse_____

☐ Children Name(s) of Children_____

☐ Other Name(s) _____

Authorization to Release Information to Your Insurance Company

We need your authorization to release your medical information to your insurance companies so that we can determine your benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.

I, _____, authorize Helene Miller, MD and Family Psychiatry and Therapy to release my medical information (or information for my child, _____) to Medicare and/or my insurance company to determine my benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.

Coordination of Care

In addition, we may need your authorization to release information to certain professionals (e.g., physician, therapist, attorney, etc) involved in your treatment so that we can collaborate and provide more comprehensive care. You may revoke this authorization at any time in writing, except if we have already taken action based on the authorization.

Please list the names and phone numbers of the other Providers from whom you are receiving care.

Name:_____ Phone Number: _____

Name:_____ Phone Number: _____

Name:_____ Phone Number: _____

HIPPA

I have received notice of Family Psychiatry and Therapy Privacy Practices and understand the document completely.

Printed Patient Name:_____ Signature of Patient:_____

Printed Name of Responsible Party (if not patient)_____Signature:_____

Date: _____/ _____/ _____

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HIPPA - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include referral to/from another physician, health care agency, dentist, school.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be providing you with a bill for your visit that you will send to your insurance company for reimbursement.
- Health care operations include the business aspects of running our practice, conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal assessment review, sharing your health information with staff members to assess our performance, assess quality of care and learn how to improve services.
- To avert a serious threat to health or safety of you, the public or any other person
- Law enforcement/national security/protective services. We may release medical information in response to a court order, a subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if under certain circumstances we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; in emergency circumstances to report a crime.
- As required by law. We will disclose medical information about you when required to do so by federal, state or local law. An example of this is to report information related to victims of abuse, neglect or domestic violence.
- Appointment reminders/Treatment Alternatives/Health-Related Benefits and Services, or payment of your care.
- Individuals involved in your care or payment of your care. If you do not wish such information be shared, please follow the procedures described in the Right to Request Restrictions.
- Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.
- Worker's Compensation. We may release information for workers' comp or similar programs.
- Public Health Risks for example to prevent or control disease, injury, disability; reactions to medication, food, other products; to report births, deaths, abuse, neglect, or domestic violence.
- Coroners, Medical Examiners and Funeral Directors so they can carry out their duties.

We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Helene Miller, MD, 17 Arcadian Way Paramus, NJ 07652:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to any person identified by you. You must request a restriction in writing. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information, however we have the right to deny request for psychotherapy notes and provide treatment summary in lieu of psychotherapy notes. If you request copies there is a charge of $1.00 per page, with a minimum charge of $10.00 for records of 10 or fewer pages and a maximum charge of $100.00. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Physician's fees are based upon their hourly rate.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of 1/1/17, and we are required to abide by the terms of the Notice of Private Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or the Dept. of Health & Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.
For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775 Effective Date April 25, 2006

Family Psychiatry and Therapy

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Financial Policy

Patient Name: _____ Date of Birth: _____

Please understand that payment of your bill is considered part of your treatment. The following is a statement if our financial policy which we require you to read and sign prior to any treatment.

PATIENTS WITH NO MEDICAL INSURANCE:

BASIC POLICY: Payment for services is due in full at the time service is provided in our office. We accept cash and credit cards. Patient is ultimately responsible for all professional fees.

SIGNAUTRE: _____ **DATE:** _____

PATIENTS WITH MEDICAL INSURANCE:

We do not participate on any panels with any Medical Insurance Carrier. If your Medical Insurance carrier covers out of network benefits, we will submit claims for you. Please be advised that we will balance bill you what is usual and customary. If you receive a check from your insurance, you must forward check to Family Psychiatry & Therapy.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment in full is due at the time of each appointment and will be collected prior to appointment, the patient is ultimately responsible for all professional fees.

SIGNAUTRE: _____ **DATE:** _____

PATIENTS WITH AUTO INS. (MOTOR VEHICLE ACCIDENTS):

Charges for services incurred as a result of an automobile accident will be treated as a Personal Injury claim. You must provider necessary information to bill the carrier. We will bill the Auto Insurance carrier as a courtesy. If the Auto Insurance carrier determines that your condition is not as a result to your automobile-related injury, or your claim is denied for other reasons, you will be required to PAY ALL AMOUNTS DUE WITHIN 30 DAYS.

LETTER OF PROTECTION: I understand that I will not be seen unless my attorney has provided this office with a letter of protection to ensure that payment will be made for services rendered in the event the auto insurance does not pay or the policy coverage is terminated or exhausted. Patient is ultimately responsible for all professional fees.

NON-COMPLIANCE & FAILURE TO SHOW FOR TREATMENT: Insurance carriers and attorneys will require continues updates on your case, which cannot be provided if the patient is non-compliant to treatment. More than two missed appointments can result in dismissal from the practice.

SIGNAUTRE: _____ **DATE:** _____

PATIENTS WITH WORKERS COMPENSATION INS. (WORK RELATED ACCIDNET/INJURY):

Charges for services incurred as a result of a verified work-related injury will be treated as a Workers' Compensation claim and we will bill the Workers Compensation carrier as a courtesy. If the Workers' Compensation carrier determines that your condition is not as a result of your work-related injury, or your claim is denied for other reasons, you will be required to PAY ALL AMOUNTS DUE WITHIN 30 DAYS.

LETTER OF PROTECTION: I understand that I will not be seen unless my attorney has provided this office with a letter of protection to ensure that payment will be made for services rendered in the event the auto insurance does not pay or the policy coverage is terminated or exhausted. Patient is ultimately responsible for all professional fees.

NON-COMPLIANCE & FAILURE TO SHOW FOR TREATMENT: Insurance carriers will require continues updates on your case, which cannot be provided if the patient is non-compliant to treatment. More than two missed appointments can result in dismissal from the practice.

SIGNAUTRE: _____ **DATE:** _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

I, _____ (Print patient's name), **("Assignor") hereby assign to** Helene A. Miller MD, LLC, **("Assignee")** **all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), **not withstanding any other agreement to the contrary.**

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor. If an insurer denies a claim for health service benefits because the assignor failed to appear for a medical examination or examination under oath at the insurer's request, then this assignment, unless it is made to a hospital as defined in 11 NYCRR § 52.2(m), shall be voidable by an insurer and shall not be enforceable against an insurer, and an insurer shall not be obligated to pay benefits directly to any provider of health services other than a hospital as defined in 11 NYCRR § 52.2(m).

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ **(Print name of Patient)**

_____ **(Signature of Patient)**

_____

_____ (Date of signature)

_____ (Address of Patient)

Helene A. Miller M D LLC **(Print name of Provider)**

(Signature of Provider)

Family Psychiatry and Therapy

_____ (Date of signature)

17 Arcadian Way Suite 108 Paramus NJ 07652 (Address of Provider)

NYS FORM NF-AOB (Rev 2/2018)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

HELENE A. MILLER MD LLC
FAMILY PSYCHIATRY AND THERAPY
17 ARCADIAN WAY, SUITE 108
PARAMUS, NJ 07652

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☑ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☑ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☑

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☑
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)
FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
_____
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES [ ] NO [ ] IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
SEE ATTACHED	SEE ATTACHED	SEE ATTACHED	SEE ATTACHED	SEE ATTACHED
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
HELENE MILLER	MD	MA07400600			

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

HELENE A. MILLER MD.,LLC LIC # MA07400600 FAMILY PSYCHIATRY AND THERAPY

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [✓] NO [ ]

19. ESTIMATED DURATION OF FUTURE TREATMENT

NOT DETERMINED AT THIS TIME

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. X (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR. IF AN INSURER DENIES A CLAIM FOR HEALTH SERVICE BENEFITS BECAUSE THE ASSIGNOR FAILED TO APPEAR FOR A MEDICAL EXAMINATION OR EXAMINATION UNDER OATH AT THE INSURER'S REQUEST, THEN THIS ASSIGNMENT, UNLESS IT IS MADE TO A HOSPITAL AS DEFINED IN 11 NYCRR § 52.2(m), SHALL BE VOIDABLE BY AN INSURER AND SHALL NOT BE ENFORCEABLE AGAINST AN INSURER, AND AN INSURER SHALL NOT BE OBLIGATED TO PAY BENEFITS DIRECTLY TO ANY PROVIDER OF HEALTH SERVICES OTHER THAN A HOSPITAL AS DEFINED IN 11 NYCRR § 52.2(m).

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME Helene A. Miller, M.D. SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☑ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☑ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		271115748	Psychiatry

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

Family Psychiatry and Therapy
17 Arcadian Way, Paramus, NJ 07652
Phone: 201-977-2889 Fax: 201-977-2890

Medication Refill Policy

Patient Name _____

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone / Fax _____

Allergies _____

PLEASE READ CAREFULLY:

- An Initial Prescriptions may take up to 3 hours to process. Please verify with your pharmacy that it is filled, and do not call our office.
- Please contact your pharmacy to request a refill, and do not call our office for refills.
- Please allow up to 48 hours for your refill to be processed.
- Refills are only processed during weekday office hours (10:00am thru 5:00pm Monday thru Friday).
- Refills sent over the weekend will not be received or reviewed until the next business day.
- Refills will not be renewed unless patient is seen on a regular basis.
- If you are due for an appointment and in need of a refill, you will only be given enough medication until your next scheduled appointment.
- Any adverse reactions to medication are to be reported to the office.
- If you are being prescribed a controlled substance and not compliant with your appointments or urine drug screening, you will not receive a refill until your next scheduled appointment.
- For medical emergencies, call 911, or go to your nearest Hospital Emergency Room.

Initial

x_____ **I have Read and Understand the Prescription Policy and agree to abide by the policy.**

x_____ **I have received a copy of this signed agreement.**

_____ _____

Patient's Signature (Parent/Guardian if under 18) **Relationship**

_____ _____

Print Patient's Name **Date**

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Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely via encryption on file with Family Psychiatry and Therapy. In providing us with your credit card information, you are giving Family Psychiatry and Therapy permission to automatically charge your credit card on file for your session fee, co-pay, or deductible at time of service. This agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

The card may automatically be charged in the event of a late cancellation (less than 24 hours' notice), a no-show/missed appointment.

Outstanding Balance: If there is an outstanding balance owed, Family Psychiatry and Therapy will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize Family Psychiatry and Therapy, *to charge session fees, co-pays, deductibles and outstanding balances on my account to the following credit card:*

Credit Card Type: Debit / Credit // ☐ Visa ☐ Mastercard ☐ Amex ☐ Other

Credit Card Holder's Name: _____

Credit Card #: _____

Expiration Date: ____/ ____/ _____

Patient Signature: _____ Date: _____

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General Practice Policies - PLEASE READ CAREFULLY

Appointment Policy

An appointment is considered a mutual commitment between you and your clinician and is subject to personal accountability and responsibility in keeping and managing the appointment. A 24 (twenty-four) hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Monday appointment cancellations must be received by the previous Friday. Appointments for which you arrive late will still end at the appointed time. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling (if applicable) of the appointment.

Agree and Initial Here_____

Drug Screening Policy

Drug screens are performed on patients when necessary. All new patients and patients who are prescribed controlled substance medications will have an initial drug screen and may be subjected to ongoing and/or random drug screening after. All patients who are prescribed controlled substances either by medical staff or any other third-party providers will be subject to regular drug screening. Any charges that may result from the drug screens will be the responsibility of the patient if not covered by the insurance company.

Agree and Initial Here_____

Payment for Services

If we are not billing an insurance company for your service, the full payment is due at the time of service. Your co-payment and any deductibles and balances, which may apply, will be collected when you check-in. Family Psychiatry accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. Credit cards on file may be charged for outstanding balances.

Agree and Initial Here_____

Confidentiality

The practice operates in a "multi-disciplinary" way, meaning that the clinician's function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicidal or homicidal risk factors or child/elder abuse or neglect. You will complete a Release of Information that you can use to list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your account. Children (under the age of 17) have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians or child protective services.

Agree and Initial Here_____

Contact and Treatment

Our office staff will take messages during regular business hours. Please allow 48-72 (business) hours for a response as clinicians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We can address routine concerns much more effectively than crisis concerns. You may be asked to schedule a sooner appointment with your provider if our staff cannot address your concerns. Please note that most concerns are best addressed in sessions, and providers cannot be interrupted from treating others to take your calls. If your concern involves a safety issue, please notify our office immediately. If you have an after-hours concern, you may leave a message on our voicemail. If your need is emergent due to safety issues at any time, please call 911 or go to the nearest Emergency Department.

Agree and Initial Here_____

Dismissal

If you are "dismissed" from the practice you can no longer schedule appointments, get medication refills, or consider us to be your physician/therapist. You must find a provider(s) in another practice. Common reasons for dismissal include failure to keep appointments, frequent no-shows, noncompliance with treatment plan or medical advice, verbally abusive or threatening behaviors to any of our staff or failure to pay your outstanding balance. We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we may assist you with care options.

Agree and Initial Here_____

Printed Patient Name:_____ Signature of Patient:_____ Date:_____

Office Use Only:

Office Staff Name:_____ Signature of Office Staff:_____ Date:_____

Comments:_____ Reviewed with Provider? Yes ( ) No( )_____

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CONSENT FOR CHILD MENTAL HEALTH EVALULATION AND/OR TREATMENT

Child's (Last Name) (First Name) (Middle Initial)

Birth Date _____/_____/_____ Age_____

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Family Psychiatry and Therapy. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of New Jersey Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential record at Family Psychiatry and Therapy, and I consent to disclosure for use Family Psychiatry and Therapy staff for the purpose of continuity of my child's care. Per New Jersey mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

3. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature of Parent	Printed Name	Date	Relationship to Child

Signature of Parent	Printed Name	Date	Relationship to Child

For parents who are not married with full legal custody:

I have sole legal custody of my child: _____ Initial x

Legal Guardian	Printed Name	Date	Relationship to Child