P & P Psychiatric & Recovery Center
Child, Adolescent & Adult Psychiatry

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth:____/____/____

Gender: □ Male □ Female Marital Status: □ Divorced □ Married □ Separated □ Single □ Widowed

Street Address:_____ City:_____State:_____ Zip:_____

Email*:_____ Home#: (_____)_____-_____

Mobile#:(_____)_____-_____ Work#:(_____)_____-_____ Other#:(_____)_____-_____

REFERRAL INFORMATION

Source of referral: □ Internet □ Insurance Plan □ Friend □ Psychotherapist □ M.D.

Other (specify) _____

If MD, specify: _____ Referred Phone#: _____

PATIENT STUDENT/EMPLOYMENT DETAILS

Primary Care Physician: _____ PCP phone#: _____

Student Status: □ Full-time □ Part-time □ Not a student School/College Name: _____
Occupation: _____

Employment Status: □ Full-time □ Part-time □ Not Employed □ Self Employed
□ On active military duty □ Unknown
Employer Name: _____ Employer Work#: (_____)_____-_____

Employer Address:_____ City:_____State:_____ Zip:_____

EMERGENCY CONTACT

Contact Name: _____ Phone#: (_____)_____-_____
Relationship:_____ Mobile#:(_____)_____-_____

P&P Psychiatric and Recovery Center LLC.
11 Dundar Road Suite 207, Springfield, NJ 07081 Phone: 908-499-5375/Fax: 908-368-8520
E-mail: PandPPsychiatricandRecovery@gmail.com

INSURANCE/FINANCIAL RESPONSIBILITY

Primary Payer: □ Self pay □ Aetna □ BCBS □ Cigna □ Magellan
□ United Healthcare/UBH □ Other: _____

Insurance ID#:_____ Group#_____ COPAY (if known):_____

Subscriber's Full Name:_____
Subscriber's Birthdate:_____ Subscriber's SS#:_____

Secondary Payer (if any): □ Self pay □ Aetna □ Cigna □ Magellan
□ United Healthcare/UBH □ Other:_____

Insurance ID#:_____ Group#_____ COPAY (if known):_____

INSURANCE & MEDICARE ASSIGNMENT AND SELF PAY AGREEMENT AUTHORIZATION TO RELEASE

I certify that I have insurance coverage with the primary insurance company, if applicable; and the secondary insurance payer, if applicable, listed above. I assign directly to P&P Psychiatric & Recovery Center, LLC. all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual agreement between P&P Psychiatric & Recovery Center, LLC. and my insurance or other third-party payer. If Self Pay, I understand it is my responsibility to pay for services rendered at time of visit. I understand and agree that P&P Psychiatric & Recovery Center, LLC. may use my health care information to the above-named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization and provide this P&P Psychiatric & Recovery Center, LLC.

Signature of Patient, Parent or Personal Representative:_____
Print name of Patient, Parent or Personal Representative:_____
Relationship of Patient: □ Self □ Parent □ POA/Caregiver Date:_____

Signature _____ Date _____

Name: _____

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PATIENT CONSENT FOR RELEASE OF INFORMATION

_____ _____

Patient Name Date of Birth

I allow **P & P Psychiatric and Recovery Center, LLC.** to release the following information to the name/names I have provided:

Appointment information: _____

Medical information: _____

Billing Information: _____

_____ I DO NOT allow **P & P Psychiatric & Recovery Center, LLC.** to release any information to anyone at this time.

_____ _____

Patient Signature Date

I authorize **P & P Psychiatric and Recovery Center, LLC.** to make the disclosure of the following information: dates of service, diagnosis, medications prescribed to my primary care physician:

Physician name: _____Phone No: _____

_____ _____

Patient Signature Date

Should it be necessary for the practitioners at **P & P Psychiatric & Recovery Center, LLC**. to consult with one another regarding my care, I give permission for such.

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulation promulgated there under, as amended from time to time (collectively referred to as HIPAA"). This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing. I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. P & P Psychiatric & Recovery Center, LLC. will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You have the right to revoke this authorization, in writing, at any time, except to the extent that P & P Psychiatric & Recovery Center, LLC. has taken action in reliance on it. By signing this authorization, I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and no longer protected under HIPAA. This authorization will expire on _____ (date).
If I fail to specify expiration date this authorization will expire one year from the date on which it was signed.
This information has been disclosed to you from record protected by 42 CR Part 2. The Federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFT Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

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PATIENT CONSENT FOR EVALUATION OR TREATMENT
CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
CONSENT FOR OFFICE POLICIES AND PROCEDURES

Medical / Psychiatric care and treatment at P & P Psychiatric & Recovery Center, LLC may be provided by Physicians, Advanced Registered Nurse Practitioners (ARNP), Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), or other State of New Jersey recognized behavioral health practitioners. I hereby authorize P & P Psychiatric & Recovery Center, LLC. to evaluate, diagnose, and render appropriate treatment to the patient designated below.

I hereby give my consent for P & P Psychiatric & Recovery Center, LLC. and their Business Associate's (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). You can ask for a copy of the Notice of Privacy Practices provided by P & P Psychiatric & Recovery Center, LLC. which describes such uses and disclosure in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. P & P Psychiatric & Recovery Center, LLC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at 11 Dundar Road Suite 105, Springfield, NJ. You can also pick up a copy in our office. With this consent, P & P Psychiatric & Recovery Center, LLC. communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; SMS/Text message, Email, and/or postal delivery.

It is further understood that all information given by the patient or family member to a treating clinician is confidential and will not be released, except under special circumstances, without patient consent or consent of legal guardian as described in details in the Notice of Privacy Practices. You can authorize us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by our office.

By signing this form, I am consenting to allow P & P Psychiatric & Recovery Center, LLC. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, P & P Psychiatric & Recovery Center, LLC may decline to provide treatment to me.

I understand and agree with all the preceding information unless otherwise indicated in writing. I agree and accept the terms of all these documents.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Print name of Patient, Parent, Guardian or Personal Representative

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HIPAA COMPLIANCE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Coordination of Care

Date: _____

Dr._____

Address:_____

In an effort to coordinate care of our shared patient:
_____

DOB: _____ We are informing you that I am seeing your patient at

P & P Psychiatric & Recovery Center for treatment.

Current Problems/Diagnoses:

_____

_____

Medication(s):_____

_____

Level of Care: Outpatient

If you need any further information, I can be reached at any of the addresses listed below:

Sincerely,

Olubunmi Adetule PMHNP-BC, APN.

Please note: Information on substance abuse or HIV/AIDS status has only been included if the client specifically authorized the release of this information.

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MEDICATION INFORMED CONSENT FORM

Patient Full Name _____ Date of Birth (MM/DD/YYYY) _____

Medication & Dosage Range:

_____

Diagnoses:

_____

_____

- ☐ I have discussed possible **other treatments** with the patient
- ☐ I have discussed possible **other treatments** with the patient and parent/guardian (if applicable) providing informed consent.
- ☐ I have discussed the **reason for treatment(s)**, the **expected outcome(s)**, the approximate **length of treatment**, and how the treatment will be **monitored** with the parent/guardian providing consent. I have also discussed the benefits and risks of this psychotherapeutic medication(s) including the possible **side effects**, the potential **medication interactions**, **contraindications** and the potential **effects of stopping** the medication with the parent/guardian providing consent. It is my clinical opinion that the person understands the information provided.

  Provider Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian (If applicable) Print :_____

Signature of Parent/Legal Guardian: _____ Date: _____

☐ I consent to the use of the psychotherapeutic medication(s) listed above.

☐ I do not consent to the psychotherapeutic medication(s) listed above.

Comments:

_____

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Late cancellation and no-show cost

I _____, hereby authorize P & P Psychiatric and Recovery Center LLC to bill me for no-show or late cancellation according to their policy.

No-show or late cancellation policy:

We understand that sometimes things don't go as planned, but we hope you'll do your best to stick to your appointment scheduled. Because last-minute changes can affect other patient's ability to receive our services.

If you are unable to attend the scheduled appointment, you must cancel within 24 hours from the time the appointment was made (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday.

Cancellations that occur out of 24-hour window or failure to show to an appointment will be considered as No-show.

Fee for no show will be charged $100.

_____ _____

Client Signature Date

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