BEHAVIOR HEALTH SOLUTIONS LLC

Robin T. Farber, LCSW
1358 Hooper Avenue, PMB 116, Toms River, NJ 08753

NEW CLIENT APPLICATION

Client Name ____ Street Address ____

City ____ State ___________ Zip ___________________

Home Phone _____________________Work Phone ________________________Cell Phone ______________________________

SS# ____________________________Date of Birth _______________E-Mail Address ____________________________________

May we contact you at all above phone numbers ? Yes [ ] No [ ] Specify: ____

Marital Status: Married[ ] Single [ ] Other [ ] Sex: M[ ] or F [ ]
Occupation: Student [ ] Employed [ ] Other [ ] School/Employer ______________________________________

Referred By ____ May we send a brief note to them? Yes [ ] No [ ]

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Person Responsible for Bill _______________________________Relationship to Patient ___________________________________

Medical Insurance _______________________________________Insurance ID #____

Name of Insured Party___________________________________

Insur. Co. Address _______________________________________ Insur. Co. Phone _______________________________________

Primary Care Doctor ______________________________________Address/Phone #____

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Presenting Problem: ____

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Previous Mental Health Evaluation/Treatment:

When? ___________ Where? ____________________Medication? _______________________ Hospitalization? _______________

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AUTHORIZATION FOR RELEASE OF INFORMATION

I agree that the information given above is accurate to the best of my knowledge.
I authorize the release of any medical information necessary to process my insurance claims.
I authorize payment of mental health benefits to Behavioral Health Solutions/Peak Performance Solutions for services provided.

____ ___________________________________
Signature of Client (or parent if client is a minor) Date

BEHAVIOR HEALTH SOLUTIONS LLC
Robin T. Farber, LCSW
OFFICE POLICY

CANCELLATIONS:

Any missed appointment or cancellation without at least 24 hour notice will be charged the full session fee. Each session time is reserved for a particular patient and cannot be filled at the last minute. As a courtesy, phone sessions are available if you are unable to come to the office.

PAYMENT POLICY:

Payment is expected when services are rendered. Cash or checks are accepted. This includes co-payments for insurance plans with which we are a participating provider. We will not bill you for co-payments. Due to increasing office costs, a $25.00 monthly billing fee will be added to your account if your co-payment is not paid by the end of the monthly billing cycle.

The patient is responsible for submitting his/her own insurance claims. If you request that this office submit your claims, a $25.00 per month administrative fee will be added to your account. As part of our contractual agreement, we will submit insurance claims for insurance companies with which we are a participating network provider. There is no additional cost for in-network claim submission.

It is the responsibility of the patient to know and understand his/her insurance policy. You are responsible for notifying our office of any changes to your coverage or plan. We will consider the effective date of your plan change to be
THE DATE YOU NOTIFY OUR OFFICE OF THE CHANGE and provide proof of new coverage.
Any services that are denied by insurance for any reason will be the direct responsibility of the patient.

EMERGENCIES:

This office is not available on an emergency basis. In the event of an emergency, you should go to the nearest hospital emergency room or call 911 immediately.

CHANGING APPOINTMENTS:

If you wish to change an appointment and you are leaving a message on the office answering machine, please state the date and time of the appointment that must be canceled and two possible dates and times preferred. Please also leave a phone number with an ideal time frame for a return call.

PRIVACY PRACTICES:

Our office adheres to strict privacy practices. A written copy of our "Notice of Privacy Practices for Protected Health Information" has been provided to you. Please notify the Office Manger if you would like a copy of this form.

- I understand the above-stated 24-hour cancellation policy.
- I agree to the payment policy outlined above.
- If I should receive any insurance payment directly for services that are unpaid to the provider, I agree to immediately forward all such payments to the provider.
- I understand that this office is not available on an emergency basis.
- I have read and understand the "Notice of Privacy Practices for Protected Health Information".
- I have read and understand this office policy and agree to its terms and conditions.

______________________________________ ________________________

Signature of patient   Date

Behavior Health Solutions, LLC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, evaluation, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines that she will need to consult with another specialist in the area. She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purposes:

- We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.
- We verify insurance coverage prior to your first appointment and obtain prior authorization and precertification when required to do so by your policy coverage.

An example of use of your health information for health care operations:

The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your records.

Your health information rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, buy we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. The accounting will not include internal uses of information for treatment, payment or operations, disclosures made to you or make at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Revoke any authorizations that you made previously to use of disclose information expect to the extent information or action has already been taken by delivering a written request to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please notify our office in writing. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities as a provider:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of the Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable request regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provision in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice in writing.

To request information of File a Complaint:
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office in writing.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office.
You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services.
We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from our office.

We cannot and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Uses and Disclosures

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object. We may also disclose information in an emergency.
- We may use and disclose your protected information to assist in disaster relief efforts.
- We may contact you to provide you with appointment reminders or follow up letters.
- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
- As required by law, we may disclose you protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- We may disclose you protected health information to public authorities as allowed by law to report aubse or neglect.
- We may disclose your protected health information to law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.
- Federal law allows us to release your protected health information to appropriate health oversight agencies for health oversight activities
- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
- To avoid a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or the public assistance program personnel
- Other uses and disclosures in additional to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices

______________________________	______________________
Signature of Patient	Date
______________________________	______________________
Signature of Parent/Guardian (if patient is a minor)	Date

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Telehealth Informed Consent

I, ____________________________________, hereby consent to participate in telemental health with,

Robin T. Farber, LCSW , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, we will reschedule the session and the interrupted session will be billed at a prorated amount.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is:

____

and my emergency contact person's phone: ____________________________

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

____   _______________________

Signature of Client (or parent/guardian if client is a minor)   Date