Privacy Practices Notice
And Client Acknowledgement

Client Name:____

Date of Birth:____

I have received and read this provider's Privacy Practice Notice written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the provider's legal duties with respect to my protected client information.

I understand that this practice reserves the right to change the terms of its Privacy Practices Notices, and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain the current Privacy Practice Notice on request.

Signature:____

Date:____

Relationship to client if signed by a personal representative of client:

____

Consent to Treatment

I, ____, am agreeing to participate in psychotherapy with Hope Honeyman, LCSW. Sessions will be scheduled in advance and I understand that I am making a commitment to attend regularly.

I understand the my therapist does not provide 24-hour crisis intervention services and that in the event of an emergency, I am to contact the emergency services available to me. My therapist will provide, upon request, a list of available emergency service providers. I will discuss with my therapist any concerns I may have about when I should use such services.

I understand that my privacy is protected and that what I say in therapy is confidential. Exceptions can be made if I give permission or if there is a risk that I may endanger myself or others.

I have been informed that I will be expected to pay a fee for the services I receive. If I have insurance (other than those plans administered by Magellan Behavioral Health Services, Blue Cross/Blue Shield, Amerihealth, and Aetna) I understand that I will be paying for services "out-of-pocket", and that I will be responsible for submitting the invoice provided to me for any insurance reimbursement due to me and that there is no guarantee my insurance will cover this therapist's services. If I have a Magellan Behavioral Health, Blue Cross/Blue Shield, Amerihealth, or Aetna plan, I understand that I am responsible for my co-pay and any deductibles that may apply.

I understand that cancellation of sessions requires 24 hours notice. Failure to give 24 hours notice will require a cancellation fee of the full session fee (the co-pay plus the remainder of what your insurance would usually pay for a session).

I have read this consent and have raised any questions the I have about its contents.

Signature of Client____

Date_________________

Signature of Therapist:____

Date:_________________

Client Information Form

Date_____________________

Client name______________________________Parent/Guardian name_____________________

Client Date of Birth____________________ _________ Male _________Female

Client Social Security Number____

Address____City__________________

State_____________________ Zip___________________

Home Phone___________________Work Phone_____________________

Cell Phone______________________________Email address____________________________

Emergency contact name________________________________Relationship________________

Emergency Contact Phone Number____

Referred by____

Please complete for all household members, starting the primary person to be seen by therapist:

Name	Relat. To Client	Sex	DOB	Age	Marital Status	Occup/ School	Educ. Level	Race	Relig.

Client Symptom Form

Client name____Date___________________

Do you tire easily?		Yes	No
Do you get anxious easily?		Yes	No
Do you get easily depressed or sad?		Yes	No
Do you cry easily or often?		Yes	No
Do you have difficulty remembering things?	Often	Yes	No
Do you tend to oversleep?	Often	Yes	No
Do you have difficulty sleeping?	Often	Yes	No
Do you awaken during the night?	Often	Yes	No
Do you have nightmares?	Often	Yes	No
Do you tend to overeat?	Often	Yes	No
Do you tend to under eat?	Often	Yes	No

Do you get frequent headaches? Yes No
If yes, state frequency and type____

Do you drink more than 2 cups of caffeinated drinks a day? Yes No
If yes how many and what beverage?____

Have you gained/lost a significant amount of weight recently? Yes No
If yes, did you gain_______ or lose_______ How much weight?____________________________

When was your last physical/medical check up?____

Have you ever used illegal drugs? Yes No
If yes, when?____
Which drugs?____

Do you drink alcohol? Yes No
If yes, how often/how much?____

Is there a family history of drug or alcohol use? Yes No
If yes, by whom?____

Are you presently taking any medications? Yes No

If yes, list____

____

Have you ever been hospitalized in a psychiatric setting? Yes No
If yes, dates and name of hospital(s)____

Reason for hospitalization____

Have you ever been in counseling before? Yes No

If yes, when?____

For what concerns?____

Client and Insurance Information

Client name____Soc.Sec.#_____________________

Address____

City___________________________________State___________________Zip________________

Client DOB___________________ Gender_______________________ Marital Status__________

Circle one: Employed Student/full-time Student/part-time

Is patient's condition related to: (circle one if applicable)

Employment Auto Accident (City/State)___________________ Other accident

Parent/Guardian _____________________________Parent/Guardian Soc.Sec.#_____________

Address (if different from client)____

Home #_____________________ Cell #____________________ Work #_____________________

Email address____________________________

Insured's name_______________________________Insured's Date of Birth________________

Address (if different from client's)____

Insured's phone #______________________Insured's employer___________________________

Insurance Company_______________________800# for behavioral health__________________

ID #____ Policy/Group#_________________________

Co-pay_____________Deductible___________ Insured's email address ____________________

Client relationship to insured (circle one): Self Spouse Child Other

Is there another health insurance plan in force: Yes__________ No_____________

Fee Paying: Intake fee $_____________ Ongoing fee $_______________ Other fees__________

Medicare ID #____

Patient's or Authorized Person's Signature - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment to Hope Honeyman, LCSW.

Signed____ Date__________________________

Therapist____ Date___________________________

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name		First Name		Middle Initial
Subscriber Number From ID Card	Insurance Company Name		Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility)	Phone Number (if known)
Hope Honeyman, LCSW 1930 E. Marlton Pike Ste J-49 Cherry Hill, NJ 08003	(856) 424-6887

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)		Phone Number (if known)
Street Address (if known)	City, State and Zip Code (if known)	

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature____________________________ Date (required) ________________________

Section 9. Signature of Personal Representative (if applicable)

Signature____________________________ Date (required) ________________________

Relationship to the individual (required): ________________________________

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Last Updated: 01/10/06

MAGELLAN BEHAVIORAL HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Members have the right to easily access timely care in a timely fashion.
- Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their condition and treatment options.
- Members have the right to information about Magellan, its practitioners, services and role in the treatment process.
- Members have the right to information about clinical guidelines used in providing and managing their care.
- Members have the right to ask their provider about their work history and training.
- Members have the right to give input on the Members' Rights and Responsibilities policy.
- Members have a right to know about advocacy and community groups and prevention services.
- Members have a right to freely file a complaint or appeal and to learn how to do so.
- Members have the right to know of their rights and responsibilities in the treatment process.
- Members have the right to receive services that will not jeopardize their employment.
- Members have the right to list certain preferences in a provider.

Statement of Members' Responsibilities

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care. This is to help them understand their care.
- Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their providers as soon they know they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan isn't working for them.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to report abuse and fraud.
- Members have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

____

Provider Signature Date