MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your psychiatric care to Heart, Mind, Body LLC. When you schedule an appointment with Heart, Mind, Body LLC we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible. To avoid cancellation fees, it must be greater than 48 hours before your scheduled appointment. If 48 hours or less, cancellations will be charged as noted below. This gives us time to schedule other patients who are be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 16, 2023 any patient who fails to cancel/reschedule an appointment 48 hours before their appointment will charged 50% of the full cost of a visit.
- An appointment cancelled less than 48 hours before their scheduled visits will be charged 100% of the full appointment fee.
- Cancelations 3 times in a 12 month period, the client will be discharged as a patient of Heart, Mind, Body LLC.
- No calls will be discharged as clients of Heart, Mind, Body LLC and charged 100% of their appointment cost.
- The fee is charged to the patient, not the insurance company. Below is the credit information provided by you, giving us permission in advance to charge these fees to.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Heart, Mind, Body LLC via text message or voice message 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours, you may leave a message or send a text message.

Heart, Mind, Body LLC
973-600-2463

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its' terms. I approve to charge my credit card in the event that I do not follow these guidelines.

Signature (Parent/Legal Guardian):

Relationship to Patient:

Printed Name:

Date:

Credit card number:

Expiration date:

Security Code:

Billing zip code:

Psychiatric Evaluation Intake Form

1. Patient Contact Information

Patient Name_____ Preferred Name _____
Last First MI

Address_____

Best contact phone number: _____Email address: _____

Primary Care Physician _____Tel _____Fax_____

Pharmacy _____ Phone #_____

2. Date of Birth | | | / | | / | | | | | **3. Age** | | **Years**
M M D D Y Y Y Y

4. Race/Ethnicity (Check one or more):

☐ American Indian/ Alaskan Native ☐Asian ☐ AfricanAmerican ☐ Hispanic ☐ Caucasian ☐ Other_____

5. Current marital status (Check one):

☐ Single,never married ☐ Married,living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner ☐ Divorced
☐ Married,not living together

6. If you are married or cohabitating with partner, how long has this been? | | | |
Years Months

7. Total number of marriages? | | **How many children do you have?** | |

8. Spouse's/Partner's Name_____

9. Who else lives with you? _____

10. How many years of formal education have you completed? | |
Years

11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other_____

12. What best describes your current employment status? (Check one from each category a, b, & c)

a. Employment Status
- ☐ Unemployed, not looking for employment
- ☐ Unemployed, looking for employment
- ☐ Full-time employed ☐ Part-time employed
- ☐ Retired ☐ Self-employed
- ☐ On welfare ☐ Social security disability

b. Student Status
- ☐ Part-time
- ☐ Full-time
- ☐ Not a student

c. Volunteer Status
- ☐ Volunteer Part-time
- ☐ Volunteer Full-time
- ☐ No Volunteer Work

14. What is your occupation? _____

15. Current Residence

☐ Own my house/ condo ☐ Retirement Complex/Senior Housing ☐ RENTING ☐ Apartment /Condominium

16. What is your spouse's occupation? _____

Are you currently seeing a therapist? (Name/contact #)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Have you ever been treated for any of the following (check all that apply):

____ Depression _____ADHD ____ Bipolar (Manic / Depressive) Disorder
____ Anxiety _____OCD ____ Schizophrenia
____ Panic Attacks _____PTSD ____ Alcohol Problems (including AA)
____Anorexia/ Bulimia _____Binge-eating ____ Drug Problems _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Please List *all* current medications below(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	**Generic Name**	**√ if yes**	**How long did you take it?**	**What Dosage did you take? Mg/d**	**Did it help? √ if yes**	**How often In a day?** Write **1, 2** or **3** times a day	**Any Side effects**
Selective Serotonin Reuptake Inhibitors(SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors(SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL / SR	Bupropion XL/ SR						
Remeron	Mirtazapine						
Viibryd	vilazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)							
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid	Viibryd	Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia	Saphris	Loxitane	Prolixin

Family History :Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post traumatic stress								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following (please check all that apply)? **Please write in your medical problem in each category**

	Mark √		Mark √		Mark √
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other medical issues		High Cholesterol		Sleep apnea	

Regarding alcohol, when was your last drink?_____
In the past 30 days, about how many of those days have you had at least one alcoholic drink?_____
What is the maximum number of drinks you have had in one day in the past month?_____drinks
DUI_____DWI_____Public Intoxication_____Seizures_____DT's_____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this approx date	Age peak use	Hx abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Diet Pills						
Hallucinogens (LSD,mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Pain Pills						
Inhalants						
Sleeping Pills						
Laxatives						
Cigarettes,cigars, Or tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						
Anabolic Steroids						
Caffeine(coffee, Tea,cola's,iced tea						
Benzodiazepines (xanax,valium,ativan Restoril, Librium)						
Other:						

List all prior surgeries and hospitalizations for medical illnesses

_____
_____
_____

Are you allergic to any medication or food? If so, please list below

_____
_____

Last menstrual period (if applicable) _____
Contraceptive method: _____

Emergency contact: _____**Phone #**_____

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		0 Not at all	1 Several Days	2 More than half the days	3 Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	0 Not at all	1 Several Days	2 Over than half the days	3 Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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 THIS INFORMATION CAREFULLY.

Note: If you have questions about this notice, please contact privacy/complaint officer: D. Leigh Geffken, 16 Main Street, Unit D5, Sparta, NJ, 07871, 973-362-5652.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices of Heart, Mind, Body LLC (HMB) All of our staff may have access to information in your chart for treatment, payment and health care operations, which are described below, and may use and disclose information as described in this Notice. This Notice also applies to any volunteer or trainee we allow bhelp you while seeking services from us.

OUR PLEDGE REGARDING THE PRIVACY OF YOUR MEDICAL INFORMATION:

Your medical information includes information about your physical and mental health. We understand that information about your physical and mental health is personal. H M B a r e committed to protecting medical information about you. We create a record of the care and services you receive from us. We need his record to provide you with quality care and services and to comply with certain legal requirements. This notice appliesbany and all of the records of your care generated by us.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. We will post a copy of our current notice in our offices in a prominent place and will post the notice on our website.

OUR OBLIGATIONS TO YOU:

We are required by law to:

- make sure that medical information that identifies you is kept private except otherwise provided by state or federal law;
- give you this notice of our legal duties and privacy practices with respectbmedical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will explain what we mean adtry to give some examples. Not every use or disclosure in a category will be listed. This notice covers treatment, payment, and what are called health care operations, as discussed below. It also covers other uses and disclosures for which a consent or authorization are not necessary. Where New Jersey law is more protective of your medical information, we will follow state law, as explained below.

For Treatment: We may use medical information about you to provide you with medical treatment or services without consent or authorization unless otherwise required by applicable state law. We may disclose medical information about you to doctors, pharmacists, laboratories, or other health care providers or case managers or case coordinators or other service providers who are involved in taking care of you whether or not they are affiliated with us. For example, we may disclose medical information concerning you to the local hospital, or physicians or counselors who care for you as wlas to any other entity that has provided or will provide care to you.

We will disclose any mental health information, including psychotherapy notes, AIDS or HIV-related information, or drug treatment information, that we may have about you only with written authorization as required by New Jersey law, HIPAA and other federal regulations.

During the course of your treatment, we may refer you to other health care providers with which you may not have direct contact. These providers are called "indirect treatment providers." "Indirect treatment providers" are required to comply with the privacy requirements of state and federal law and keep your medical information confidential. These providers will be bound by the HIPAA privacy rule.

For Payment: We may use and disclose medical information about you without consent or authorization so that the treatment and services you receive from us may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan or insurance company about a treatment you are going to receive to obtain prior approval or to determine whether it will cover the treatment. We may also provide your information to case coordinators or case managers for payment purposes as well.

For Health Care Operations: We may use and disclose medical information about you without consent or authorization for "health care operations." These uses and disclosures are necessary to operate Heart, Mind, Body LLC and make sure that all individuals receive quality care. For example, we may use medical information or mental health treatment information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose your protected health information to doctors or staff or consultants for review and learning purposes. We may also use your protected health information in preparing for litigation.

Appointment Reminders: We may use and disclose medical information to contact you by mail or phone to remind you that you have an appointment for treatment, unless you tell us otherwise in **writing**.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
However, we will not use or disclose medical information to market other products and services, either ours or those of third parties, without your authorization.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization. We may also give medical information, including prescription information or information concerning your appointments to other individuals who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If New Jersey law requires specific authorization for such disclosures, we will obtain an authorization from you prior to such disclosures.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law without your consent or authorization.

To Avert a Serious Threat to Health or Safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Business Associates: Heart, Mind, Body LLC from time to time will hire consultants called "business associates," who render services to us. We may disclose your medical information to such business associates without your consent or authorization. Business associates are required to maintain and comply with the privacy requirements of state and federal law and keep your medical information confidential.
Examples of "business associates" are accounting firms that we hire to perform audits or billing and payment information, and computer software vendors who assist us in maintaining and processing medical information.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illnesses. For example, if you are injured on the job, we may release information regarding that specific injury.

Public Health Risks: We may disclose medical information about you for public health activities without your consent or authorization. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Administrative Proceedings: If you are involved in a lawsuit or dispute as a party, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in responseba subpoena, discovery request, or other lawful process by someone else involved in the dispute. Similarly we may disclose medical information about you in proceedings where you are not a party, but only if efforts have been made to tell you or your attorney about the request or to obtain an order protecting the information requested. In addition, we may disclose medical information, including mental health treatment information, to the opposing party in any lawsuit or administrative proceeding where you have put your physical or mental condition at issue if you have signed a valid release.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, 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 limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at Heart, Mind, Body LLC; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information including mental health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You or your personal representative have the following rights regarding medical information we maintain about you (when we say "you" this also means your personal representative, which may be your parent or legal guardian or other individual who sauthorized to care for you):

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. If you wish to be provided a copy of medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at {Enter name of company}. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing and or other supplies associated with your request.

We may deny your request to inspect and/or obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at Heart, Mind, Body LLC. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include areason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make that amendment;
- Is not part of the medical information kept by us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of some of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at Heart, Mind, Body LLC. Your request must state a time period which may not be longer than six years starting with your first visit. Your request will be provided to you on paper. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care like a family member or friend. However, you will need to make alternative arrangements for payment if you restrict access of individuals responsible for the payment of your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer at {Enter name of company}. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer at Heart, Mind, Body LLC. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint in writing to the Privacy Officer at Heart, Mind, Body LLC. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission as set out in an authorization signed by you. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By signing below: I confirm receipt of this information.

_____. _____.

(Full name). (Date)

_____

(Signature)

Heart, Mind, Body LLC
16 Main Street, Unit D5
Sparta, NJ 07871
www.Heartmindbody.org
Scheduling: (973) 362-5652
Fax: (973) 957-3222

INFORMED CONSENT FOR TREATMENT

I hereby request that I, _____,
(Name)
born _____, be accepted and consent for mental health care.
(Date of birth).

By my signature below, I agree to the

following statements.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Impact Behavioral Health.
2. I have been given information regarding my rights and responsibilities as a patient.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services. I understand that I may be responsible to pay a co pay and that it is payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my prescriber/therapist at any time. I understand that I may also contact the licensing board, which regulates my provider/therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

Signature of Patient or Parent/Guardian Date

Parent or Guardian:

I, _____, do hereby state that I am the natural parent or legal guardian of the patient; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Signature Date

Heart, Mind, Body LLC
16 Main Street, Unit D5,
Sparta, NJ 07871
973-362- 5652
Fax: 973-957-3222

Client Email / Texting Informed Consent Form

You may give permission to Heart, Mind, Body LLC staff to communicate with you by email and text message. This form provides information about the risks of these forms of communications, guidelines for email/text communication, and how to use email and text communications. It also will be used to document your consent for communication with you by email and text message.

How we will use email and text messaging: We use these methods to communicate least amount of information, non-sensitive and or non-urgent issues. All communications to or from you may be made a part of your human services record. You have the same right of access to such communications as you do to the remainder of your record. Your email and text messages may be forwarded to another Heart, Mind, Body LLC member as necessary for appropriate handling. We will not disclose your emails or text messages to third parties or others unless allowed by state or federal law. Please refer to your Notice of Privacy Practices for information as to permit uses of your information and your rights regarding privacy matters.

Risk of using email and text messages: The use of email and text message has several risks that you should consider. These risks include, but are not limited to, t h e following:

a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Emails and texts can be used as evidence in court.

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Conditions for the use of email and text messages: Heart, Mind, Body LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent

and received. You as the Client/s/Parents/Legal Guardians must acknowledge and consent to the following conditions:

a. **IN AN EMERGENCY, DO NOT SEND an EMAIL or TEXT** to Heart Mind Body LLC; **PLEASE CALL or TEXT 911.** Do not email or text for urgent problems. If you have an urgent problem during regular business hours, please call our agency at (973) 362-5652. Urgent messages or needs should be relayed to us by using regular telephone communication ONLY.

b. Emails and text should not be time-sensitive. While we try to respond to email and text messages daily, we cannot guarantee that any particular email or text will be read and responded to within any particular period of time. If you have not heard back from us within three working days, call our office to follow up if we have received your email or text.

c. You should speak with our agency to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.

d. Email and text messages may be filed electronically into your medical-record.

e. Heart, Mind, Body LLC staff will not forward to unidentifiable email/texts to outside parties without your written consent, except as authorized by law.

f. You should use your best judgment when considering the use of email or text messages for communication of sensitive information.

g. ~~Heart, Mind~~, Body LLC staff are not responsible for the content of messages or any costs associated with messages.

h. Heart, Mind, Body LLC is not liable for breaches of confidentiality caused by you or any third party.

i. It is your responsibility to follow up with your staff person if warranted.

j. It is your responsibility for charges your phone plan may have for texts.

Withdrawal of Consent: I understand that I may revoke this consent at any time by so advising Heart, Mind, BODY LLC in writing. My revocation of consent will not affect my ability to obtain future services nor will it cause the loss of any benefits to which I am

otherwise entitled.

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I consent to receiving appointment reminders and other communications/information, email and/ or text from Heart, Mind, Body LLC.

(Client initials) I consent to receive text messages at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general reminders/information is:

Area Code/Number: ( ) -

Carrier: (Verizon, Sprint, T-Mobile, etc.)

(Client initials) I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general reminders/ feedback/information is

(Email Address)

(PLEASE COMPLETE AND RETURN THIS PAGE)

I understand that this request to receive emails and/or text messages will apply to all future

Client, Parent and/or Legal Guardian Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Heart, Mind, Body LLC staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that may impose to communicate with me by email or text message.

Client Name (*Type or Print*):	
Client Signature:	Date:
Staff Name (*Type or Print*): D. Leigh Geffken	
Staff Signature: *D. Leigh Geffken*	Date:
Parent/Legal Guardian Name (*Type or print*):	
Parent/Legal Guardian Signature:	Date:

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