Center for Wellness
Partial Hospitalization(PHP) Program /
Intensive Outpatient Program (IOP) Intake Packet

Client Demographic Information: Please Print As Neatly As Possible to Avoid Any Billing Errors

Client First Name:	Middle:	Last Name:

Client Street Address:

City:	State/Zip:	Cell Phone: ( )

Home Phone: ( )	Work Phone: ( )
OK to leave a voicemail at home? Yes____No____ OK to leave a voicemail at work? Yes____No____ OK to leave a message on a cell phone? Yes____No____	OK to leave a message with a family member? Yes_____ No_____ Family Member's Name(s): _____ _____ _____ _____

Best Contact Email:

Client Date of Birth: _____/_____ /_____	Client Gender: Male_____ Female_____ Transgender_____ Non-binary _____	Client Pronouns: He/Him ____ She/Her _____ They/Them____ Other (specify)_____	Marital Status: (ex. Single, married, divorced, separated, etc)

Age:	Legal Guardian (if applicable):	Veteran Status: Yes/No

Insurance Policy Information:

Insurance Company/HMO:	Client ID Number/Member ID:
Group Number:	Policy Holder's Name:
Policy Holder's DOB:_____	Relationship to Policyholder (ex. Spouse, child, guardian, etc)

Policy Holder's S.S#: _____	

Claims Mailing Address:

City:	State/Zip:	Claims Phone Number:

Secondary Policy Information (if applicable)

Insurance Company/HMO:	Client ID Number/Member ID:

Group Number:	Policy Holder's Name:
Policy Holder's DOB_____ Policy Holder's S.S# _____	Relationship to Policyholder (ex. Spouse, child, guardian, etc)

Claims Mailing Address:

City:	State/Zip:	Claims Phone Number:

Pharmacy Information:

Pharmacy Name:
Phone Number: ( )

Notice of Client Financial Responsibility

Billing and Insurance:

As a courtesy to our clients, Center For Wellness (CFW) will try it's best to verify your behavioral health/mental health benefits with your insurance carrier with your permission. In order to do so, we must obtain a copy of your insurance card and obtain the name, address, and birthdate of the subscriber. **The information that we receive is not a guarantee of full or partial payment.** It is strongly recommended that you reference your mental health benefit policy or directly consult your insurance carrier with any questions regarding benefits and participation prior to starting program. CFW will bill your insurance carrier for services provided in a timely manner. **All co-payments are due at the time of service.** Co-insurance, deductible and any outstanding balances are due upon receipt of our billing invoice.

Payment Options:

CFW accepts cash, checks, major credit cards and money orders. Monthly payment plans may be arranged at your request. A fee of $35.00 will be added to your balance due for all returned checks.

Missed Individual Outpatient Appointments:

We understand that there are exceptions when a client cannot make a scheduled appointment. However, we value your session time and do not schedule anyone else for your appointment day/time. **Therefore, we require a 24 hour advance cancellation notice.** If you give us less than 24 hours notice or simply do not show for your scheduled appointment, a missed appointment fee of $100.00 will be applied to your balance. No additional appointments will be scheduled until your balance/late fees are paid in full.

Estimated Fees:

The fees associated with your care may include but are not limited to the following services:

- $350.00 Psychiatric Diagnostic Evaluation/Exam (non-MD)
- $300.00 Intensive Outpatient Program Per Day
- $500.00 Partial Hospitalization Program Per Day

*The above fees are effective 12/1/18.

Laboratory services are provided by outside third parties which may not be in network with the same insurance plans with which Center For Wellness is in network. Patients accept liability for charges arising from laboratory testing, which is necessary for some patients based on psychiatric and/or substance abuse history.

Past Due Balance/Collections:

If you have any questions concerning your financial obligations to CFW, please contact Dr. Gagandeep Singh at 732-655-4239 extension 302. In the event that the client does not pay our billing invoices or neglects to make acceptable payment arrangements, we reserve the right to transfer the outstanding balance to a collection agency.

My signature below indicates that I have read, understand, and agree to all of the above.

_____ _____ Client Signature

Date

_____ _____ Parent/Legal

Guardian Signature (If under 18) Date

Notice of Licensed Practitioners/Clinical Supervision

It is the policy of Center For Wellness to fully disclose the licensure status of doctors and therapists that clients may work with individually or within a group setting. New Jersey law mandates that provisional licensed therapists practice under the supervision of fully licensed therapists. Center for Wellness conducts an extensive qualification review of all staff and ensures that our staff practices in full compliance with New Jersey law.

- A "Psychiatrist": is a physician who specializes in the prevention, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. Psychiatrists can prescribe medication if deemed necessary and agreed upon by the patient.

- A "Qualified Supervisor" is an individual who holds a full clinical license (LPC or LCSW) to provide mental health counseling services for a minimum of 2 years (obtaining at least 3,000 hours work experience subsequent to holding the license in a minimum of 2 years but no more than 6 years) in the state where the services are being provided, and who has a Clinical Supervisor's Certificate, or is designated as an Approved Clinical Supervisor (ACS) by the respective healthcare licensing board, or has completed a minimum of three graduate credits in clinical supervision from a regionally accredited institution of higher education.

- A "Licensed Associate Counselor" (LAC) is a Master's level practitioner who practices under the supervision of a Licensed Professional Counselor (LPC) and/or a Qualified Supervisor.

- A "Licensed Social Worker" (LSW) is a Master's level practitioner who practices under the supervision of a Licensed Clinical Social Worker (LCSW) and/or a Qualified Supervisor.

- A "Certified Alcohol and Drug Counselor" (CADC) practice under the supervision of a Licensed Certified Alcohol and Drug Counselor (LCADC)..

- A "Intern" is a student currently enrolled in an accredited Master's Program for Counseling or Social Work who practices under the supervision of a fully licensed practitioner, either a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW).

I, (Client Print Name) _____, acknowledge that I have received and understand Center For Wellness' Clinical Supervision Policy. I understand that I may address any questions or concerns with regard to a therapist's license status to my assigned therapist and their immediate supervisor if necessary.

Client Signature: _____
Date: _____

Parent/Guardian Signature (If Under 18): _____
Date: _____

Informed Consent For Treatment

I, _____(Client printed name), agree and consent to participate in mental/behavioral healthcare and/or substance abuse services offered and provided by Center for Wellness.

These services are offered: **Monday-Friday from 10:00 am - 3:30 pm (Adult PHP) Monday-Friday from 10:00 am - 1:00 pm (Adult IOP) and**

Monday, Wednesday, Thursday 3:30 pm - 6:30 pm (Teen IOP) or Summer Schedule Hours: (July 1st-August 31st) Monday, Wednesday, Thursday 9:30 am - 12:30 pm

Outpatient Individual Therapy sessions will be made by appointment only with your Therapist.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within:

(1) The scope of the provider's license, certification or training or (2) The scope of license, certification and training of the care providers directly supervising the services received by the client.

I understand that these services may include individual, group, and/or family therapy, medication management, and urine or other tests for illicit substances.

I understand that all of these services are voluntary and may be stopped at any time for any reason. If I decide to terminate services I can ask for assistance with alternative referrals. My treatment team may ask me at the time of my discharge the names and contact information of any follow up providers I will be seeing. This will be added to my medical record to complete my discharge summary.

I understand that my treatment team has the right to discharge me with referrals to a higher level of care/alternative level of care if deemed clinically necessary and with my overall best interest in mind.

I understand that I may also be discharged administratively if I do not regularly attend program at my recommended frequency and intensity.

If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this individual.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (If Under 18) Date

_____ _____
Treatment Team Member Signature Date

Email Communication Informed Consent

In order to communicate with you by email it is best if you are aware of the confidentiality issues that arise when staff from CFW communicate in this way to you and to document that you are aware of these and agree to them.

I _____ (Printed name) understand the following:

- I understand that all email messages that are sent over the internet by CFW are not encrypted, and therefore not secure and could be read by others. I understand that my email communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information I send to him/her or that he/she sends to me via email.
- I understand that for this reason my therapist has advised me not to send sensitive information via email. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers.
- I hereby give permission for my therapist to reply to my messages via email, including any information that he/she deems appropriate, that would otherwise be considered confidential.
- I understand that my therapist will try to limit email messages to brief inquiries or responses regarding scheduling or absences. I understand that my therapist may at times email me information about resources that I can use as part of my treatment. I hereby consent to receive such information via email.
- I understand that if I use email to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. ● If I believe I need a response within 48 hours, I will not use email but will call my therapist. If I do not receive an answer to a routine e-mail within two working days, I understand that I should call my therapist.
- I understand that any urgent and/or psychiatric emergencies or other emergency requests should not be sent via email and that client's should contact 911 or visit their nearest emergency room or hospital for immediate treatment.
- I understand that all email communications may be made part of my permanent medical record and would be accessible anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via email or SMS by notifying my therapist in writing.
- I agree that Center for Wellness (CFW) and its staff shall not be liable for any breach of confidentiality that may result from this use of e-mail via the internet or any liability for not responding to emergency requests.

_____
Client Printed Name:

_____ _____
Client Signature Date:

_____
Client Parent Guardian (If Under 18) Printed Name:

_____ _____
Client Parent Guardian (If Under 18) Signature Date:

Emergency Contact Release Form

Please note: Failure to provide at least one emergency contact will result in the client being unable to start treatment at CFW. Client's under 18 must have at least one parent/guardian as their emergency contact.

I understand that Center for Wellness (CFW) may contact the following person(s) in the event of an emergency.

Please note that emergency contacts will also be called to conduct wellness checks on client if client does not attend program as scheduled/agreed upon with their treatment team without proper notification or contact of their absence.

If client or client's emergency contacts can not be reached successfully the treatment team reserves the right to call the local police to conduct a wellness check to client's home address after one business day of no contact from either client or client's emergency contact(s).

Emergency Contact(s): Please Print Clearly

_____ _____ Name:
Relationship: Phone Number:

_____ _____ Name:
Relationship: Phone Number:

_____ _____ Name:
Relationship: Phone Number:

I understand the emergency contact policy and that this release form will remain in effect until I am discharged from CFW. If I wish to revoke consent to contact the individual(s) listed above I may do so by providing a written request to my Primary Therapist. This will be put in my clinical record.

_____
Client Printed Name:

_____ _____
Client Signature Date:

_____
Client Parent Guardian (If Under 18) Printed Name:

_____ _____
Client Parent Guardian (If Under 18) Signature Date:

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Please Note: We strongly encourage you to identify at least one family member/close friend to be involved in your treatment here at CFW in some capacity)

I request and authorize Center For Wellness to release to and/or receive healthcare information of the patient named above to:

Name:_____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____

This request and authorization applies to:

O All healthcare information

O Healthcare information relating to the following (family sessions, absences, billing, collateral phone calls etc):
_____

O Urine drug screen results

O Other: _____

O Yes O No I authorize the release of my medical records regarding mental health and or substance abuse treatment to the person(s) listed above.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (If Under 18) Date

_____ _____
Treatment Team Member Signature Date

***This authorization expires 30 days after discharge from a CFW program

Client Acknowledgement of Documents

Psychiatric Advance Directives:

I have a psychiatric advance directive: Yes _____/No _____

If yes, I will provide Center for Wellness with a copy: Yes _____/No _____

If no, but I would like more information about how to create a psychiatric advance directive: Yes _____/No_____
(If Yes, information can be discussed with you during your individual sessions).

I do affirm that I have read, understood, and received copies of the following documents:

- Informed Consent for Treatment/Informed Consent for Email Contact
- Client Handbook which also includes:
    - Client's Rights
    - Complaint and Grievance Procedure
    - Notice of Privacy Practices
    - Medications and the Heat Advisory

_____
Client Printed Name:

_____ _____
Client Signature Date:

_____
Client Parent Guardian (If Under 18) Printed Name:

_____ _____
Client Parent Guardian (If Under 18) Signature Date:

Center for Wellness

312 Applegarth Road, Suite 200, Monroe Township, NJ 08831
Phone (732) 655-4239 Fax (732) 444-3120
www.centerforwellnessnj.com

Telehealth Consent Form

Prior to starting video-conferencing services, I am aware and agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to confidentiality) that may differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the other person(s).
- We agree to only use the video-conferencing platform(s) selected for our virtual sessions. ● You need to use a webcam and enable audio during the session at all times. ● It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. (see Session Guidelines below)
- It is important to use a secure internet connection rather than public/free Wi-Fi. ● It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance (ideally with at least 24 hours notice).
- You will be available for the duration of the day for all groups to receive a full day PHP/IOP. ● We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes your current location, at least one emergency contact, and the closest ER to your location, in the event of a crisis situation. This is especially important in a PHP or IOP setting, and you agree to follow our recommendations pertaining to your safety.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- As your mental health provider, we may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.
- Telehealth is a temporary service that is being offered to clients due to extreme circumstances as a precautionary measure. Once these circumstances abate, therapy sessions may return to in-person services as previously scheduled.
- Applicable payment (if any) will need to be charged on credit card, mailed, or dropped off at the office and received at least weekly.

Telehealth Consent Form Agreement/Acknowledgement

_____

Electronic Client Signature (if 18 or older):

_____

Date:

_____

Electronic Parent/Guardian Signature (for minors):

_____

Date:

Center for Wellness

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Credit Card Authorization Form

Credit Card Holder Information:

NAME ON CREDIT CARD:

TYPE OF CREDIT CARD: VISA / MASTERCARD / AMEX / DISCOVER TYPE OF

ACCOUNT: PERSONAL / BUSINESS

COMPANY NAME:

Credit Card Information:

ACCOUNT NUMBER:

EXPIRATION DATE:

SECURITY CODE:

CITY: STATE, ZIP CODE:

Authorized User Of Credit Card:

NAME:

ADDRESS:

PHONE NUMBER:

EMAIL ADDRESS:

IDENTIFICATION (DL copy attached):

RELATION TO OWNER:

TYPE OF CHARGES (ie, co-pays):

AUTHORIZED AMOUNT (may state max amount if exact unknown):

DATE OF CHARGES (may put a range):

Authorization of Card Use:

I certify that I am the authorized holder and signer of the credit card referenced

above. I certify that all information above is complete and accurate.

I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the “AUTHORIZED AMOUNT” field. I understand this is only for up to this amount during the time period of “DATES OF CHARGES” referenced above. If additional charges are going to be authorized a new form will have to be completed.

CARDHOLDER NAME:

SIGNATURE/DATE: