CENTRAL JERSEY BEHAVIORAL HEALTH

PATIENT REGISTRATION FORM (5 pages)

TODAY'S DATE:	
PATIENT INFORMATION	
(Please Print)	
NAME:	HOME PHONE:
ADDRESS:	CELL PHONE:
	SOCIAL SECURITY NO.:
	MARITAL STATUS: [ ]SINGLE [ ]MARRIED
EMPLOYER/SCHOOL:	[ ]DIVORCED [ ]MINOR
EMPLOYER ADDRESS:	OCCUPATION:
WHO REFFERED YOU:	DATE OF BIRTH:
EMERGENCY CONTACT PERSON:	PHONE:

LIST OF PEOPLE AUTHORIZED TO MAKE/CANCEL/FOLLOW UP APPOINTMENTS ON YOUR (Patient) BEHALF

Name	Relation	Comment

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent/s have insurance coverage with _____ (name of insurance company) and understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signatures on all insurance submissions. The above named physician /practice may use my health care information and may disclose such information in the above named insurance company/s and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____

Signature of Patient/Parent/Guardian or Representative Date

_____ _____

Print Name of Patient/Parent/Guardian or Representative Relationship to Patient

Statement of Patient/Client Rights

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may the records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about Magellan, its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patient/Client Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Member should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

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

_____

Patient Signature Date

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

_____

Provider Signature Date

CENTRAL JERSEY BEHAVIORAL HEALTH

NAME:_____ DOB:_____

MEDICATION CONSENT FORM

_____ (Provider prescribing medication) has educated me regarding the medication that has been prescribed by _____ (Provider prescribing medication) to (please check the following) _____me, my child, or _____ a person for whom I am the legal guardian and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication, and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

Patient Name:_____
Patient/Legal Guardian Signature:_____
Provider's Signature:_____
Date:_____

It is recommended that women who are or may become pregnant, or are breast feeding, discuss this with their doctor BEFORE taking ANY medication.

It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report IMMEDIATELY to a health care provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include (but not limited to):

1. what medications, including prescribed and over-the-counter medications, the patient is or has been taking,
2. what food and drug allergies the patient has,
3. what medical conditions the patient has.

INFORMED CONSENT FOR TREATMENT

I_____(patient's name), agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider), a behavioral care provider. 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, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient 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 and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____ Date_____

Relationship to Patient (if applicable):_____

CENTRAL JERSEY BEHAVIORAL HEALTH

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. Patient

Last Name	First Name	Middle Initial	
Subscriber # from ID Card	Insurance Company Name	Date of Birth	Phone No.

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 Sec. 9 below)

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

The following behavioral health provider may disclose the information:

Name (person or organization if you are naming a practice)	Phone No.
Street Address (if known)	City and Zip Code

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

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

Name (person or organization if you are naming a practice)	Phone No.
Street Address (if known)	City and Zip Code

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.
- 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, you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of Individual

Signature_____ Date_____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date_____

Relationship to Individual (required)_____

FINANCIAL AND TREATMENT POLICY

1. The following service fees and charges are different from the medical procedure charges during consultation, therapy, nursing home and hospital care.
2. Co-payments and deductibles:
   Co-pays / self pay fees **are due upon arrival for each visit**
3. Appointments:
   Missed / Uncancelled appointments will be billed accordingly **($50.00). NO EXCEPTIONS.**
   Appointment changes and cancellations should be done **48 hours** before the said visit.
4. Insurance denials RELATED TO PATIENT'S contract termination, unauthorized visits & ineligible coverage, etc.
   The patients will be billed for the charges; it will be his / her responsibility to submit the claim to the insurance.
5. Balance between approved charges and insurance payments (Primary and Secondary):
   The patient shall be responsible for this balance. A patient invoice will be mailed and shall be due upon receipt.
6. Telephone Consultations and Medication Refills:
   Telephone Consultations and Medication Refills are billable.
   Fees / charges shall be the doctor's / Provider's discretion as arranged with the patient.

SCHEDULE OF FEES

PROVIDER LETTER/CERTIFICATION	$35
MISSED APPOINTMENT (if no 48hr notice)	$50
Disability Forms	$35pp or flat fee
Medical Records	$1pp

Self Pay Patients/Uninsured (see staff)

Specialist copays are payable at each visit (amt. indicated in your ins. Card)

_____

PATIENT'S SIGNATURE