NJ Psychcare Patient Registration Form

Date:_____

Name: _____ Sex: M F Jr. Sr.
Last First Middle

Email: _____ Title: Mr. Dr. Mrs.
Ms. Miss

Marital Status: Married / Single / Divorced / Widowed / Separated / Domestic Partner

Address: _____
Street # Street Name Apt #

_____
City State Zip

Social Security Number: _____ Date of Birth: _____ / _____/ _____
Month Date Year

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell #: ( ) _____

Employer: _____
Name Address Phone Position

If Student: Full Time Part Time Name of School: _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____
Member ID# _____
Name of Subscriber _____
Sex: M____ F____ / S.S. # _____
D.O.B. _____
Employer Name _____
Relationship of the patient to the Subscriber _____

Secondary Insurance Name _____
Member ID# _____
Name of Subscriber _____
Sex: M____ F____ / S.S. # _____
D.O.B. _____
Employer Name _____
Relationship of the patient to the Insured _____

Other family members that are patients_____

In case of Emergency, who should be notified? _____ Phone ( ) _____

Referred by_____ Phone ( ) _____

Primary Care Physician _____ Phone ( ) _____

I understand that I am financially responsible for all charges for services rendered and that a finance charge of 1% will accrue on any unpaid balance on my account older than 30 days. I authorize the release of medical information to my primary care or referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to NJ Psychcare LLC.

Patient or Responsible Party Signature _____ Date _____ / _____ / _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Address _____
City State Zip

NJ PSYCHCARE LLC.

Patient Name: _____

Date of Birth: _____

General Consent/Agreement to Outpatient Services

This form applies to NJ Psychcare LLC. The policies may change at anytime.

1. **CONSENT TO TREATMENT:** I consent to receive mental health care services provided by NJ Psychcare LLC. I acknowledge that no warranty or guarantee has been made to me as to result or cure. This includes Telepsych Treatment if and when needed.
   For Minors: I/We consent to the treatment of our Minor Child by NJPC (NJ Psychcare LLC). acknowledge that no warranty or guarantee has been made to me as to result or cure.
   Both legal guardians must consent to treatment. If Someone other than the parent is the legal guardian, legal documents must be presented

2. **PAYMENT FOR SERVICES**: I understand that NJ Psychcare LLC may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to NJ Psychcare LLC . If I should receive the payments, I understand that I will be responsible for paying NJ Psychcare LLC. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the office or the doctor, I will have to do so. I understand that NJ Psychcare LLC will hold me responsible in any one of the following situations.
   a.When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
   When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
   When my health plan does not participate with NJ Psychcare LLC for the services I want or need and I agree to pay for my care myself.
   When I receive services that are not covered under my health plan.

I understand if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of $35.00. If I cancel my appointment in advance or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

With no shows, late cancellations, or non payment of services, the office reserves the right to terminate services/close case.

3. **CONSENT TO PHOTOGRAPH:** I understand photographs, may be used for identification and charting purposes.

4. **ELECTRONIC PRESCRIBING**: I authorize electronic prescribing network, to release my medication refill history to NJ Psychcare LLC for the purpose of continued treatment.

5. **MY PERSONAL BELONGINGS:** I understand that I am responsible for my personal belongings and valuables.

6. **RELEASE OF INFORMATION:** I authorize NJ Psychcare LLC to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, psychotherapy notes, nurse's notes, and consultations.

7. I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payer for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. This may include business associates of Insurance companies for any audit and/or risk management assessment purposes. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

8. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT:** I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for NJ Psychcare LLC, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of NJ Psychcare LLC. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

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9. TELEHEALT/TELEPSYCHIATRY

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform. I understand that there are potential risks involving technology, including but not limited to: Internet interruptions, and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected. I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.
I understand that my health care provider or I can discontinue the telehealth/teleth

10. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received/reviewed NJ Psychcare Notice of Privacy Practices/Hippa Practices. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.
A copy of Hippa Practice is posted in the Office.

A photocopy is good as the original.

I agree to the items as outlined in the Agreement.

Name: (Print) ----------Signature:----------Date:----------

Relationship to Patient(Self/Parent/Personal Representative/Legal Guardian):----------

Name: _____ Date: _____

Psychiatric Intake Form

All Information on this form is strictly confidential

Name _____Date_____

Date of Birth _____Primary Care Physician _____Referred By_____

What are the problem(s) you are seeking help for?

1._____

2._____

3._____

Current Symptoms Checklist:

- ☐ Depressed Mood
- ☐ Sleep Pattern Disturbance
- ☐ Unable to enjoy activities
- ☐ Loss of interest
- ☐ Excessive Guilt
- ☐ Fatigue
- ☐ Concentration/Forgetfulness
- ☐ Change of appetite
- ☐ Decreased sexual interest
- ☐ Elevated Mood
- ☐ Decreased Need for Sleep
- ☐ Distractibility
- ☐ Impulsivity
- ☐ Increased Risky Behavior
- ☐ Irritability
- ☐ Increased sexual interest
- ☐ Excessive Energy/Activity
- ☐ Talkativeness
- ☐ Excessive Worry
- ☐ Anxiety Attacks
- ☐ Avoidance
- ☐ Nightmares
- ☐ Voices/Visions
- ☐ Suspiciousness
- ☐ _____
- ☐ _____
- ☐ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you did not want to live? ☐ Yes ☐ No

If you are currently having thoughts about harming yourself and feel that you may act on these thoughts, CALL 911 OR VISIT THE EMERGENCY ROOM AT YOUR NEAREST HOSPITAL

Medical History

Allergies_____

Current Height_____Current Weight_____

Medical problems (high blood pressure, diabetes, etc.)_____

_____

_____

_____

Surgeries_____

_____

List All current prescription medications and how often you take them: (If none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For **Women Only:** Are you currently pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No

Name: _____ MRN _____

Past Psychiatric History

Outpatient Treatment ☐ Yes ☐ No

If yes, please describe when, by whom, reason for treatment and nature of treatment (medications, therapy).

_____

_____

_____

Psychiatric Hospitalization ☐ Yes ☐ No

If yes, please describe for what reason, when, where, and the dates of hospitalization.

_____

_____

_____

Suicide Attempts ☐ yes ☐ no

If yes, please indicate number of attempts, method used, and when?

_____

Family Psychiatric History

Please check and indicate the family member who has been diagnosed or treated for:

	Yes	No
Bipolar Disorder	☐	☐_____
Depression	☐	☐_____
Anxiety	☐	☐ _____
Anger	☐	☐_____
Suicide	☐	☐ _____
Schizophrenia	☐	☐ _____
Post-Traumatic Stress	☐	☐ _____
Alcohol Abuse	☐	☐_____
Other Substance Abuse	☐	☐_____

Has any family member been treated with psychiatric medication? ☐ Yes ☐ No

If yes, who was treated, with what medications and how effective was the treatment?

_____

_____

Substance Use

Alcohol use? ☐ Yes ☐ No Type (liquor, beer,wine)_____

How many drinks?_____How often?_____

Started_____Quit_____

Tobacco use? ☐ Yes ☐ No Type (cigarettes, cigars, pipe, vaporizer, chewing tobacco)_____

How much?_____How often?_____

Started_____Quit_____

Drug use? ☐ Yes ☐ No Type (marijuana, stimulants, hallucinogens, opioids, benzodiazepines, etc.)_____

_____

How much?_____How often?_____

Started_____Quit_____

Social History

Race_____Religion/Spirituality_____

Do you identify as: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Transgender ☐ Other_____

Are you currently: ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed

How long? _____

Have you had any prior marriages? ☐ Yes ☐ No

If so, how many? _____ How long? _____

Name: _____ MRN _____

Do you have children? ☐ Yes ☐ No

If yes, list ages and genders _____

Educational History

What is your highest level of education or degree obtained? _____

Occupational History

Are you currently: ☐ Employed ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long in the present position? _____

What is/was your occupation? _____

Hobbies _____

Legal History

Have you ever been arrested? ☐ Yes ☐ No

Do you currently have any pending legal problems? ☐ Yes ☐ No

Please describe_____

Religion/Spirituality_____

Childhood History

Where did you grow up?_____Parents together/separated/divorced?_____

Siblings? _____Physical/sexual/emotional abuse? _____

Review of Symptoms: Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Snoring
- ☐ Difficulty Breathing
- ☐ Coughing Up
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Shortness of Breath
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping
- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction
- ☐ Thyroid Problem

Is there anything else you would like your provider to know? _____

_____

_____