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 telepsychiatry 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/telepsychiatry.

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):----------