Relief & Solutions Counseling Center

Dear Client:

Welcome! We appreciate the opportunity of being your healthcare provider. We are a group of licensed clinicians, who are specially-trained in Behavioral Health Counseling, and able to help you with any questions related to your visit. Please take a moment to read and sign this introduction form. If you should have any questions, please ask your therapist or our staff, and we will be more than happy to help you.

Appointment: At your initial appointments, a therapist will ask you a series of questions and develop an individualized treatment plan. If, for any reason, you are unable to keep an appointment, please contact your therapist directly to make appointment changes. If you do not cancel your appointment at least 24-hours in advance of your appointment, a cancellation fee of $75.00 may apply. Also, a $25.00 late payment fee will be assessed for each visit a patient does not pay their co-pay in full at the time of the visit. Phone calls between sessions should be used for making appointments and emergencies. If direct or collateral contact is provided outside the time of face-to-face, in-office sessions, you may be billed for this service at the rate of $150.00 for a 45 min. session. Neither of these fees are billable to insurance.

Insurance: If you are paying without insurance, please make payment via cash or check payable to "Relief & Solutions". When you are covered by health insurance, your co-pay, co-insurance or deductible is expected to be paid at each visit. We have arranged to handle the insurance billing, on your behalf, for those insurance plans that allow it. Any fees not paid by the insurance carrier will be your responsibility to pay. We recommend that you review your insurance policy regarding outpatient and office-based healthcare. It may be necessary to contact your health insurance carrier to acquire their authorization to receive care. **When you change health insurance carrier, your phone number, address, or receive correspondence regarding your bill from your insurance carrier, please advise our office.**

Authorization to Treat Minors: If the patient is under the age of 18 years old, a parent or legal guardian's permission to treat the client is required. By signing this form, you attest to being the parent or legal guardian of the patient and give the therapist permission to provide counseling services.

Assignment of Benefits: Payments made by the authorized insurance company are usually made to our office directly for any services rendered. In the event that your insurance company sends payment directly to you, then you or the responsible party agree to forward the payment to our office immediately upon your receipt of payment.

Release of Information and Disclosure: Our office will process insurance claims for services rendered to you. You understand and accept full responsibility to authorize our office to release any information necessary to process an insurance claim(s). If the patient's Private Healthcare Information of a specific healthcare professional is sought, authorization for it must be made separately.

Litigation: I/We understand that information discussed in therapy is for therapeutic purposes only and is not intended for use in any legal proceedings involving any parties, particularly if goals are not reached in couple's therapy. I/We agree not to subpoena the therapist to testify for or against either party or to provide records in a court action.

Patient's Understanding and Agreement

I have reviewed the information within this Information and Registration Form. I understand, and agree to the information provided within this form. I also understand that by signing this form, I am consenting to treatment for myself or a designated minor whom I am the legal guardian of by a therapist at Relief & Solutions Counseling Center. Further, I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient/Guardian/Responsible Party

Date

Print Name

Relief & Solutions Counseling Center

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PATIENT INFORMATION

TODAY'S DATE: _____ **REFERRED BY:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **AGE:** ___ **GENDER:** _____

STREET ADDRESS: _____ **TOWN:** _____

STATE: _____ **ZIP CODE:** _____ **SOCIAL SECURITY #:** _____

PHONE NUMBERS: HOME: _____ **E-MAIL:** _____

MOBILE: _____ **MARITAL STATUS:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE NUMBER(S): _____

EMERGENCY CONTACT ADDRESS: _____

ILLNESS CURRENTLY BEING TREATED FOR: _____

BY WHOM: _____ **PHONE NUMBER:** _____

CURRENT MEDICATIONS: _____

PRIMARY INS. CARRIER: _____ **POL./I.D.#:** _____

POLICY HOLDER NAME: _____ **DATE OF BIRTH:** _____

RELATIONSHIP: _____ **SOCIAL SECURITY #:** _____ **EMPLOYER:** _____

SECONDARY INS. CARRIER: _____ **POL./I.D.#:** _____

POLICY HOLDER NAME: _____ **DATE OF BIRTH:** _____

RELATIONSHIP: _____ **SOCIAL SECURITY #:** _____ **EMPLOYER:** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any co-payments, co-insurance or payment of fees if, regardless of reason, the insurance company is unable or refused to provide reimbursement. I also authorize Relief & Solutions Counseling Center to release any information required to process claims for services rendered in accordance with HIPPA regulations.

_____ _____

RESPONSIBLE PARTY NAME **PHONE NUMBER**

_____

ADDRESS

X _____ _____

RESPONSIBLE PARTY SIGNATURE **DATE**

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Notice of Patient Fee Responsibilities

Insurance Company Payments: This notice applies to patients at Relief & Solutions Counseling Center who are covered by a health insurance plan. The amount which the patient or responsible party has to pay for services rendered is determined **solely by** the insurance company, not Relief & Solutions. As an in-network provider, Relief & Solutions is contracted with numerous insurance companies; agreeing to the terms they set. As a contracted provider, Relief & Solutions cannot alter or re-negotiate the amount patients are responsible to pay. We've agreed with your insurance company to "… Make every reasonable effort to collect all monies due and payable that are the responsibility of the insured and/or his or her dependents for services rendered." This means that Relief & Solutions does not have the authority to reduce or waive a co-pay, coinsurance or deductible amount, even if we wanted to.

It is the patient's responsibility to be aware of the terms of his/her health insurance policy. We strongly encourage you to contact your insurance carrier directly and be familiar with the details of your policy; including what you are responsible to pay for mental health services provided at this office. This office agrees to accept that amount you are responsible to pay as determined by your insurance company. When a ***deductible*** applies, we *estimate* the amount patients are responsible to pay at $80.00/session and reconcile according to the EOB (Explanation of Benefits) after your insurance company processes a claim. We do our due diligence to gather benefit information from insurance companies and file timely claims with them. It is unfortunately sometimes the case that Relief & Solutions unknowingly receives and forwards to patients inaccurate information regarding benefits and patient responsibilities from insurance company representatives. When this, or any other occurrence of misinformation happens, it in no way alters the amount patients are responsible to pay according to the actual terms outlined in your insurance policy.

You are therefore responsible to pay 100% of fees as determined by your insurance company.

Patient Payments: Relief & Solutions normally accepts patient payments in the form of cash or check. In occurrences of a single occurrence of a bounced check, Relief & Solutions reserves the right to refuse to accept any future payments by the same method and the patient agrees to make alternate arrangements for payment, typically cash.

In cases where services rendered at this office are not covered by an insurance company, the private pay rate is $150.00 for a 45 min. session.

By signing below, you acknowledge and agree to the above terms.

_____ _____

patient/responsible party signature date

Relief & Solutions Counseling Center

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Notice of Privacy Practices (HIPPA)
Receipt and Acknowledgment of Notice

Patient Name: _____ DOB:_____

I hereby acknowledge having been advised of Relief & Solutions Counseling Center's Notice of Privacy Practices (NPP). I further acknowledge and consent to Relief & Solutions Counseling Center communicate with me regarding my appointments and treatment at Relief & Solutions via electronic means (i.e. mobile phone, e-mail, SMS, internet, etc.). I understand this means Relief & Solutions and my treating provider there may transmit my Protected Health Information (PHI) such as information about my appointments and other individually identifiable information about my treatment to me via electronic means.

I understand, acknowledge and accept the risks inherent in the electronic transmission of information such that communication may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that Relief & Solutions will take reasonable precautions to protect my PHI, but cannot guarantee that all PHI transmitted via electronic communications pursuant to this authorization will be encrypted. Therefore, I understand and accept that Relief & Solutions shall not bear any responsibility or liability with respect to any error, omission, claim or loss arising from, or in connection with electronic communication of information with me.

I understand that in the event I no longer wish to receive electronic communications from Relief & Solutions, I must revoke this authorization by providing written notice to Relief & Solutions. This authorization does not allow for electronic transmission of my PHI to third parties and I understand that I must execute a separate authorization for my PHI to be disclosed to third parties. I understand that if I have any questions regarding this notice of my privacy rights, I can contact Christopher Robinson, LCSW at 192 Third Avenue, Suite 4 Westwood, NJ 07675, phone: 201-666-2400.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

- ☐ *I request a copy of Relief & Solutions' NPP*
- ☐ *Patient Refuses to Acknowledge Receipt:*

_____ _____

Signature of Relief & Solutions Representative *Date*

Relief & Solutions Counseling Center

Relief & Solutions Counseling Center

192 Third Avenue
Suites 3 & 4
Westwood, NJ 07675
P-201-666-2400
F-201-666-2472

Credit Card Authorization

Please complete the following information. This form will be securely stored in your file and may be updated upon request at any time. All clients are required to have a valid credit/debit card authorization on file.

I, _____, authorize Relief & Solutions Counseling Center to charge my credit/debit card for professional services as follows:

Please initial:

- _____ Co-pays, coinsurance, deductibles and payments not covered by my insurance company.
- _____ Appointments not covered by my insurance company: $150.00.

- _____ Appointments I miss without notice **or** cancellations with less than 24 hours notice: $75.00.

_____ I will not dispute charges ("chargeback close quote") for sessions. I have received nonpayment by my insurance company or appointments I miss according to the above policy.

Charges will appear on your credit card statement as: Relief & Solutions

Card type (circle one): Visa MasterCard Discover American Express

Card #: _____

Expiration date: _____ Verification/Security code: _____
(MC/Visa/Discover: 3-digit code on back by signature line. AMEX: 4-digit code, above card number, upper right side)

E-mail address: _____

Billing address: _____

_____

_____ _____
Signature date