Inner Balance Psychology Center

2 Tree Farm Road Suit A-220
Pennington, NJ 08534

1628 JFK Blvd Suite 1003
Philadelphia, PA 19103

34 East Main Street
Marlton, NJ 08053

Intake Forms

Today's Date: ____/____/_____

Patient Name: _____
(Last) (First) (MI)

Patient Birth Date: _____/_____/_____ Age: _____

Gender identity: □ Male □ Female □ Transgender Preferred Pronoun: _____

Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

In the treatment of a minor where parents are divorced it is Inner Balance policy that both parents provide consent for treatment. If necessary, please provide contact information for all legal guardians. (Name and contact information)

_____

_____

Are you employed? □ No □ Yes Are you in School? □ No □ Yes

If yes, where? _____

How did you learn about Inner Balance Psychology Center?

Are you currently on any Medications? (please list the medication and dosage)

_____

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Statement of Understanding

1. I understand that in case of an emergency, I may not be able to reach my therapist. In this situation, I agree not to harm myself in any way, and if necessary I will call or go the nearest Hospital Emergency Room. The Mercer County Crisis Center can be contacted at 609-396-HELP twenty-four hours per day. The Burlington County Crisis Center can be contacted at 609-835-6180 twenty-four hours per day. The Mercy Hospital of Philadelphia Crisis Center can be contacted at 215-748-9000. The Philadelphia Crisis Center for children can be contacted at (844) 376-0083.

2. I also understand that the information concerning my treatment will be held in confidence by my therapist unless I give specific written consent for the release of this information. In the event of an emergency, the therapist is authorized to request a release of information necessary for the emergency treatment.

3. I also understand that the following types of information may be contained in my patient files (a) identifying demographic information (b) the reason for the referral or requests for my treatment (c) initial diagnosis (d) treatment plans (e) services provided during my treatment (f) treatment progress (g) status at termination. I authorize the release of the above information to my insurance information should they request it.

4. I also understand that I have the right to release my records in the hands of attorney, physician or medical/mental health professional upon my written authorization.

5. I also understand that it is my right to request a change of therapist. In the event that I would like to transition from one therapist in the practice to another it is my responsibility to discuss my concerns with my current therapist and Inner Balance Psychology Center will do our best to accommodate your request.

6. I also understand that a minimum of 48 hours notice is required for all cancellations. I understand that if an appointment is cancelled with less than 48 hours notice, I will be charged a $100.00 fee. As an alternative to last minute cancellations, I have the option of a telephone session at the regularly scheduled time, thereby avoiding the missed appointment fee.

7. Co-pays are expected at the time of service. Inner Balance Psychology Center, LLC will file claims to your insurance company on your behalf, and you are responsible for any payments made directly to you for our services, in addition to any co-pays, co-insurances or deductibles. If your insurance is terminated or does not pay for our services, you are then financially responsible for charges incurred on your account. As a courtesy, a credit card may be placed on file and you agree that it will be charged for any outstanding balances on your account. Please notify us of any change in your name, address, phone or insurance coverage. _____

8. In the event that your account is past due and payment has not been received within 90 calendar days, your account may be sent to a collection service. You agree to reimburse us the fees of any collection agency, which will be added to the account at the time it is placed with a collection agency and may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

Client Name_____

Signature_____ Date_____

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Consent

I understand that I have made the decision to see treatment at Inner Balance Psychology Center

Federal law permits Inner Balance Psychology Center to disclose information in the following circumstances without your written permission: If you make a serious threat to harm yourself or another person, the law requires Inner Balance Psychology Center to protect you or that other person. In addition, the law requires Inner Balance Psychology Center to report any suspected child abuse or neglect to the appropriate authorities.

In the case of children. The same law applies. If your child makes a serious threat to harm themselves or another person Inner Balance Psychology Center will disclose information necessary to protect your child or that other person.

If you have any questions regarding your treatment or our policies, please feel free to ask your therapist.

I hereby acknowledge that I have read (or have had read to me) the information above and I understand and give my consent to participate in treatment with Inner Balance Psychology Center.

_____
Name (Printed)

_____
Signature Date

_____
Signature of Clinician Obtaining Consent Date

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Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"*PHI*" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless the covered entity can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified. Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization.

If you are self-pay, then you may restrict the information sent to insurance companies.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations. I am required to make such reports even if I do not see the child in my professional capacity. I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger. I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused, I am required by law to report this to the Pennsylvania Department of Public Welfare.

Adult and Domestic Abuse: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Worker's Compensation: If you file a worker's compensation claim, I will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist's Duties

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy or Electronic – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. You have the right to receive a copy of your PHI in an electronic formal or (through written authorization) designate a third party who may receive such information.

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. If I revise my policies and procedures, I will notify you by mail. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr. Dawn Raffa at (609) 613-0110. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect in 2019. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

ACKNOWLEDGE OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below I am acknowledging that I have been provided with a copy of the notice of privacy practices. I have therefore been advised of how health information about me may be used and disclosed by the staff of the Inner Balance Psychology Center and how I may obtain access to and control of this information.

_____
Name

_____ _____
Signature Date

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Insurance Disclaimer:

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We encourage all patients to know and understand their healthcare benefits prior to their first session at Inner Balance Psychology Center.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that my insurance plan may be considered out of network with Inner Balance Psychology Center and if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____

Patient's Name / Date

Non-Disclosure Form Regarding electronic communication and phone sessions

As a patient at Inner Balance Psychology Center, _____ understands that if I should choose to communicate with Inner Balance Psychology employee's via electronic communication (i.e. Google Hangouts, email or via phone) I will not be afforded the same level of confidentially as in person communication.

_____

Signature Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1 MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I D NUMBER (For Program in Item 1)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name First Name Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind A. B. C. D. E. F. G. H. I. J. K. L.		22 RESUBMISSION CODE ORIGINAL REF NO 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28 TOTAL CHARGE $	29 AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.