The Massler Center for Psychological Wellness, P.C.
127 East Mount Pleasant Avenue
Livingston, NJ 07039
&
49 Brant Ave., Suite 3
Clark, NJ 07066
Office: (973)535-8555 Fax: (973)535-8777

PATIENT DEMOGRAPHICS AND INTAKE FORM (Adult)

Patient Information:

Name: ____ DOB: ___________ Sex: _____

Street Address/Apt#: ____

City, State & Zip Code: _____________________________

Social Security Number: _______ - _____ - _______

Phone Number: ___________________________ Mobile Home

E-mail Address: ___________________________

Occupation: ______________________________ Full-time Part-time

Employer: ______________________________

Work Address: ____

Work Phone Number: _____________________ Ext: _________ Fax #: _________________

Emergency Contact Name: ___________________________ Relationship: _______________

Phone Number: _________________________

Spouse or Significant Other Information:

Marital Status: single married divorced separated widowed

Name: ____ DOB: ___________ Sex: _____

Street Address/Apt#: ____

City, State & Zip Code: _____________________________

Social Security Number: _______ - _____ - _______

Phone Number: ___________________________ Mobile Home

Responsible Party Information:

If you are not the responsible party, please provide us with the following information:

Person Responsible: ___________________________ Relationship: _______________

Street Address/Apt#: ____

City, State & Zip Code: _________________________________

Social Security Number: ________ - ______ - ________

Phone Number: _______________________________ Mobile Home

Occupation: __________________________________ Full-time Part-time

Employer: __________________________________

Work Address: ____

Work Phone Number: _________________________ Ext: __________ Fax #: ___________________

Payment Information:

Payment is due at the time of service.

Preferred Method of Payment: Cash Credit Card Check (Provide DL# below)

Bank Name: __________________________________ Driver's License #: ____________________________

CC#: ____ Exp: ___________ CID#: ___________

A credit card is required as back-up payment. If the account is past-due more than 60 days, the credit card provided will be charged.

Referral Information:

How did you hear of The Massler Center? hospital doctor friend relative other

Who may we thank?: __________________________________

Insurance Information:

Primary Insurance Company: _________________________________

Mailing Address: ____

ID#: _________________________________ Group #: _____________________ Effective Date: ___________

Subscriber's Name: ______________________________ Date of Birth: _____________

Patient's relationship to subscriber: self spouse child

Secondary Insurance Company: _________________________________

Mailing Address: ____

ID#: _________________________________ Group #: _____________________ Effective Date: ___________

Subscriber's Name: ______________________________ Date of Birth: _____________

I/We assume responsibility for all charges incurred. I/We understand payment is due at the time of the visit. If not so paid, a monthly charge of 1% of the outstanding balance will be added to my account.

Patient's Signature (unless patient is a minor): _______________________________ Date: ______________

Responsible Party's Signature: __________________________________ Date: ______________

Medical History:

Diagnoses: ____

____

Females only: Are your menstrual cycles regular? yes no

Past Surgeries: ____

Allergies: ____

Current Medications: ____

____

Primary Physician's Name: ___________________________ Phone number: ____________________

Other provider: ________________________________ Specialty: _______________________

Other provider: ________________________________ Specialty: _______________________

Other provider: ________________________________ Specialty: _______________________

Other provider: ________________________________ Specialty: _______________________

Psychiatric History:

Current Psychiatrist: _____________________________ Phone number: ____________________

Reason for leaving: _________________________

Current Therapist: _______________________________ Phone Number: ___________________

Family Psychiatric History:

Not Applicable

Diagnosis: ____________________________________ Relation: _________________________

Diagnosis: ____________________________________ Relation: _________________________

Diagnosis: ____________________________________ Relation: _________________________

Diagnosis: ____________________________________ Relation: _________________________

Diagnosis: ____________________________________ Relation: _________________________

Educational History:

Highest grade completed: ___________________ regular special education

Substance Use:

Check all that apply: tobacco alcohol

illegal drugs (Please specify: ____)

Have you ever been admitted to a detox or rehab facility: yes (how many times? ________) no

Social History:

People living in the home with you:

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

_______________________________________ Relation: _________________ Age: ________

Are there firearms in the home: yes no

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OFFICE INFORMATION, PSYCHIATRIC/TREATMENT FEE AGREEMENT, AND CONSENT

WELCOME: Thank you for choosing this office. We appreciate the opportunity to provide you with professional service and are confident that your visits will be productive. The information that follows contains important office and procedural information regarding our policies and methods of practice. Please read this document carefully and discuss any areas of question or concern.

POLICIES AND PROCEDURES

Client Contract

Please take the time to carefully read this contract in its entirety. This contract sets forth the office policies of The Massler Center for Psychological Wellness, P.C./Dr. Jessica Halpern and contains many elements important to your care. Please ask us if you have any questions. We take your care very seriously and we want to make sure you agree to all of our policies before you become a client.

Consent for Treatment

I, the undersigned patient or legal guardian, consent to evaluation and medically necessary treatment by Jessica Halpern, M.D. I understand that I have the right to be informed of and participate in the selection of treatment modalities. I understand I can terminate consent for treatment at any time and that Jessica Halpern, M.D. may terminate consent for treatment at any time. Potential reasons include but are not limited to misusing psychiatric medications or misusing psychiatric services. If this should occur, Jessica Halpern, M.D. will discuss the reasons with me and will provide me with one or more referrals for another treatment provider.

Notice of Privacy

As required by law and professional ethics, we keep all client personal information in strict confidence, except as defined within this contract. I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Release of Information

Upon your request and completion of our authorization form, The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. will release your personal information to third parties as directed by you. This can be useful to involve other parties in your care, such as family members, schools, and/or professionals.

In the event of an emergency, The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. may use her professional judgment to release your personal information as she feels is appropriate to respond to the emergency. In addition to your emergency contact, the authorities may be notified if Dr. Jessica Halpern becomes concerned about your personal safety or the safety of someone else.

Availability

Our services are provided by appointment only and walk-ins are not accepted; however, there might be instances in which you might call and an appointment will be available on the same day. You may call our office at (973) 535-8555 for any questions or concerns.

Non-urgent and Emergency Contact

I agree to call Dr. Jessica Halpern for any non-urgent medical or psychiatric issues, including side effects to medications. Dr. Jessica Halpern might not always be available to answer the phone when you call, but will make every effort to return your call within 1 business day. In the event of an urgent situation in which you cannot wait for a return call or in an emergency, I agree to immediately call 911 or go to the nearest emergency room. Please do contact her after you have received proper emergency assistance so that she can be aware of the situation.

Fee Schedule
In the table below, child or adolescent refers to any patient that is under the age of 18. Adult refers to any patient that is 18 years or older.

Price	Appointment Type	Duration
	*Initial Consultation (Child/Adolescent)	
$500	Part 1- Parent Interview	45 minutes
$400	Part 2-Child/Adolescent Interview	45 minutes
$250	Part 3- Recommendations for treatment	25 minutes
	Initial Consultation (Adult)	
$500	Part 1- Evaluation	45 minutes
$250	Part 2 (if necessary)- Recommendations for treatment	25 minutes
$250	Follow-up Medication Management	25 minutes

*In some cases, parts 1 and 2 of the child/adolescent consultation can be completed on the same day in one 90-minute session ($900), although part 3 will need to be completed at a later time in order to allow more time to obtain necessary collateral information. This can be discussed further with The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. during the appointment scheduling process.

Payment
I understand that I am responsible for payment in full at the time services are provided. Fees for service will be discussed in advance between myself and The Massler Center for Psychological wellness, P.C./Jessica Halpern, M.D and any changes to the fee schedule will be made known to me. I agree to complete the Credit Card Payment Authorization Form prior to my first consultation. I understand that my credit card will not be charged until the time of service unless I cancel my appointment within 48 hours of the scheduled appointment time. My credit card will also be charged if I fail to show up for my appointment. Failure to pay the agreed amount at the expected time may result in transfer of care. I understand there are additional services that may require billing as well. These include but are not limited to: reading and writing of reports, obtaining collateral information from other providers, phone calls lasting longer than 15 minutes, and frequent phone calls. The Massler Center for Psychological wellness, P.C./Jessica Halpern, M.D. reserves the right to charge for these services at a prorated fee of $400/hour, or to require me to schedule an office appointment to address these services. The Massler Center for Psychological wellness, P.C./Jessica Halpern, M.D. will not split the bill between two parents nor try to collect from a parent who does not come to the sessions. The responsibility for payment or to recover what is owed is on the parent who brings the child to the appointment. If payment for services is not paid within 30 days from when the service was provided, there may be a 1% per month late fee added to the amount due and every month thereafter that the payment continues to be late.

Cancellation Policy
Appointment times are reserved just for you. The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. is happy to change or cancel your appointment, but that will require at least 48 hours (2 business days) in advance. If a cancellation is not made within that time, or if the appointment is missed without notification, The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. reserves the right to charge me the full fee for this appointment. Emergencies will be taken into consideration. If I paid for the appointment in advance and cancel the appointment before the required 48 hours (2 business days), then I will be offered a full refund. I understand that in the event of a missed or cancelled appointment, medications may or may not be refilled depending on the level of clinical supervision required for the medication.

Late Arrival
If I am late to my appointment, I understand that Dr. Jessica Halpern may only be able to see me for the remainder of my appointment time in consideration of other patients.

Electronic Communication
I understand that voicemail, text, and e-mail are not confidential means of communication with The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. I will reserve their use for managing appointments or for requesting direct (in-person, phone, or videochat) communication. For my convenience, I can choose to e-mail The Massler center for Psychological Wellness, P.C./Jessica Halpern, M.D. reports for review; however, I understand that she will not reply with clinically sensitive information. I will allow The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. to leave messages on my voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality.

Health Insurance Coverage
I understand that The Massler Center for Psychological Wellness P.C./Jessica Halpern, M.D. does not participate in any health insurance plans. I may be able to submit insurance claims for reimbursement as out-of-network benefits; however, it is solely my responsibility to seek reimbursement and verify coverage. The Massler Center for Psychological Wellness P.C., will submit claims on your behalf if you would like. The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. accepts no responsibility for lack of payment from insurance companies.

Discharge
Discharge is the formal release of a professional from their obligation and care to a client. Discharge can occur for many different reasons, some which are as simple as a client moving out of the area or getting so much better that regular care is no longer required. Discharge also occurs if our office is unable to communicate or schedule an appointment with me for a 6 month period of time.

Termination of Care
The Massler Center for Psychological Wellness, P.C./Jessica Halpern, M.D. will not begin care, or will not continue care, if in her professional opinion she can no longer be of benefit to me and she will discuss this with me. I will be provided with one or more referrals for continuation of treatment, and I will be discharged if appropriate. I have the right to terminate treatment at any time.

By signing, you certify that you have read, understand, and agree to all the policies in this contract.

Patient Name: ____ Date of Birth: ____________________
Patient signature (unless patient is a minor): _____________________________ Date: ___________________________
Name of Legal Guardian (if applicable): _______________________________ Relation: ________________________
Signature of Legal Guardian (if applicable):_____________________________ Date: ___________________________

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Credit Card Authorization Form

Name of Client: ____

Name as it Appears on Credit Card: ____

Credit Card Number: ____

Credit Card Expiration Date: ____

Credit Card CVC Code: _________________ Zip Code____________________

I authorize the Massler Center for Psychological Wellness, P.C., to charge my credit card the agreed amount as reflected on the fee schedule signed during intake.

____ ________________________
Signature of Authorized Card Holder Date

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME____________________________ ADDRESS____

S.S. #_____________________ DOB_________________ TELEPHONE #________________________________

I hereby authorize the Massler Center for Psychological Wellness, P.C. to (please check) ___ RELEASE and/or ___ OBTAIN information from my record to:

NAME______________________________ TITLE:______________ TELEPHONE#________________________
ADDRESS____

For the purpose of: (Please check one)

___ Continued Treatment/Coordination of Care ___ Other (please specify)______________________________

Description of information to be released: (Please check specific items)

___ Treatment Plan/Records ___Written/Verbal Communication ___ Medical Records ___ Student Records

___ Other (please specify) ____

If the requested portion of the record contains information pertaining the treatment or abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, I specifically authorize the release of such information by initialing one or both of the following:

________ I understand that if my record contains **information concerning the treatment for abuse, physical and/or mental illness or drug/alcohol treatment**, such information will be released pursuant to this consent.
________ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicated that a person has been potentially exposed to HIV.

Specifications of the date, or condition upon which this consent expires:____

I have the right to revoke this authorization in writing by sending a request to The Massler Center for Psychological Wellness, P.C, I understand that this authorization is voluntary and that I may refuse to sign this authorization. A copy of this authorization will be provided if requested.

I understand that after the Massler Center for Psychological Wellness, P.C. disclosed my health information, it may be subject to re-disclosure and, at that point, the information may no longer be protected by privacy laws or under the terms of this agreement.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below:

____ ________________________
Signature Date

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ELECTRONINC METHODS OF COMMUNICATION AGREEMENT

ELECTRONIC MEANS OF COMMUNICATION: New technologies enable multimodal vehicles of communication. Please discuss your preferred method of contact with your treatment provider/psychologist, as communications like email and text messaging are less confidential means of communication and can be accessed in the future.

I, ________________________________of____
(Name of Patient/Client) (Address, City, State, Zip)

acknowledge that I have been adequately informed about the growing impact of technology on the manner in which confidential material and other discussions between client and provider transpire. Additionally, I acknowledge that consent for communications via

☐ EMAIL

are appropriate and acceptable methods of communication for scheduling appointments and discussing other matters relevant to my treatment.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below:

This authorization will automatically expire within 2 years from the date of signature. I have the right to revoke this authorization in writing by sending a request to the Massler Center for Psychological Wellness, P.C.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

____ ____________________
Signature Date

&
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Cancellation Policy

Our goal is to start and end sessions on time so as to not interfere with the next appointments. Please arrive early or on time so that we can get started when your session is scheduled to begin. If you arrive late, please understand that your session is unlikely to be extended.

Please keep in mind that when you schedule an appointment and do not show up or cancel at the last minute that the time scheduled for your session will remain open. While we would like to be as flexible as possible in accommodating our clients, it is virtually impossible for us to schedule someone else at such short notice. As a result, your will be held financially responsible for your scheduled time. **Unless there is a severe unforeseen situation, our office requires a 48 hour notice to change or cancel an appointment or you will be charged the contracted rate determined during intake. We reserve the right to charge for missed sessions if we feel the policy is not being respected. Insurance companies do not cover missed appointment fees.** When you schedule an appointment please remember the date and time of your appointment. If you miss an appointment, it is your responsibility to either reschedule or arrange for the next session.

I have read the cancellation policy and agree to adhere to the policy as stated.

____ _________________________
Signature of Client/Legal Guardian Date

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LIMITS OF CONFIDENTIALITY

Confidentiality is an ethical obligation of a professional not to reveal information obtained through professional contact with a client without specific consent. It protects the client from any unauthorized disclosures of information given in confidence to a professional. However, there are instances when state law specifies confidentiality be suspended, specifically when there is a clear and imminent danger to another individual, to society, or to the child directly, confidentiality must be breached. The following situations require a breach of confidentiality when working with children:

1. When there is a reasonable suspicion of child maltreatment (i.e., child physical, sexual, or emotional abuse or neglect), we are legally obliged to breach confidentiality and to report our suspicion to the appropriate authorities.

2. When a child poses a physical threat to another person, we must use reasonable are to protect the intended victim against such danger.

3. When a minor child poses a threat to himself or herself (e.g., in any situation in which the minor is in danger of death), when the delay of medical treatment would pose a health risk to the minor, or when treatment is needed to decrease physical pain, we are required to notify those responsible for the minor child.

4. When information requested is based on a court order.

5. Adolescent Confidentiality: Adolescents possess some unique rights as it pertains to confidentiality, specifically regarding pregnancy status, status of some sexually transmitted diseases, substance use, and use of oral contraceptives.

Additionally, it is important to note that strict confidentiality cannot be maintained within certain agencies (e.g., schools, clinics, hospitals) because agency personnel involved in a child's case usually have access to the child's records.

I, ________________________________of____
(Name of Patient/Client) (Address, City, State, Zip)

acknowledge that I have been adequately informed about confidentiality and the limits to confidentiality, including situations in which confidentiality may be breached. Additionally, I acknowledge that I have been provided the opportunity to ask questions regarding confidentiality and that all questions posed have been sufficiently addressed.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below:

This authorization will automatically expire within 2 years from the date of signature. I have the right to revoke this authorization in writing by sending a request to the Massler Center for Psychological Wellness, P.C.

____ ______________________
Signature of child/youth required for age 14 and over Date

____ ______________________
Signature and relationship of legal guardian required for youth under 18 Date