Massler Center for Psychological Wellness, P.C.

127 East Mount Pleasant Avenue
Livingston, NJ 07039
Office: (973)535-8555 Fax: (973)535-8777

PATIENT INFORMATION:

NAME: _____ ___Mr. ___Mrs. ___Ms. ___Dr.

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #:_____

E-MAIL ADDRESS(ES): _____

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

EMPLOYMENT INFORMATION:

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____

WORK PHONE #: _____ EXT: _____

SPOUSE'S OR SIGNIFICANT OTHER'S INFORMATION:

MARITAL STATUS: M S W D OTHER: _____

NAME: _____

ADDRESS: _____

HOME PHONE #: _____ WORK PHONE#: _____

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

****RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR OR NOT FINANCIALLY RESPONSIBLE):**

PERSON RESPONSIBLE: _____ RELATIONSHIP: _____

ADDRESS(if different from patient): _____

PHONE #: _____

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

OCCUPATION: _____ EMPLOYER: _____

WORK PHONE #: _____ EXT: _____

EMAIL ADDRESS: _____

PAYMENT INFORMATION:

Payment is due at the time of service.

PREFERRED METHOD OF PAYMENT: (CIRCLE ONE) CASH CHECK (Provide DL# below)

BANK NAME: _____ DRIVER'S LICENSE #: _____

CC#: _____ EXP: _____ CID#: _____

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

INDIVIDUAL WE MAY 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 VISIT. IF NOT SO PAID, A MONTHLY CHARGE OF 1% OF THE OUTSATNDING BALANCE WILL BE ADDED TO MY ACCOUNT.

PATIENT'S SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____

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Automatic Credit Card Authorization

The Massler Center will securely store your credit, debit, HSA card on file as a convenient method of payment for the portion of services you are financially responsible for. These charges include an agreed session fee, no show/late cancellation fee, or any portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure. Please keep in mind you may not be billed on the same day of service, but rather a short time after. If you would like a receipt emailed to you, please indicate your email information below.

I authorize The Massler Center to charge the portion of my bill that is my financial responsibility to the following card:

_____Visa _____AMEX _____Mastercard _____Discover _____HSA/FLEX

Session fee: $_____

Credit Card#: _____

Expiration date: _____ Security Code: _____

Patient name: _____

Cardholder Name: _____

Email Address: _____

Signature: _____

This authorization will remain in effect until I (we) cancel this authorization.

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT
NAME_____ADDRESS_____

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_____ 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 of Child/Youth (required for youth age 14 and over) Date

_____ _____
Signature and Relationship of Legal Guardian (required for youth under 18) Date

_____ _____
Signature of Client (18 and over) 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 you 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

☐ TEXT

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 of Child/Youth (required for youth age 14 and over) Date

_____ _____
Signature and Relationship of Legal Guardian (required for youth under 18) Date

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Cancellation Policy

All sessions are 45 minutes in length except in cases of emergency (or prearranged appointments) that cause the session to be lengthened. 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 24 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.

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 youth age 14 and over) Date

_____ _____
Signature and Relationship of Legal Guardian (required for youth under 18) Date