Garden State Behavioral Health Services, South
2 Eves Drive, Suite 104
Executive Court
Marlton, New Jersey 08053
(856) 797-8777

Welcome to Our Practice

Please take some time to read this introductory letter to acquaint you with our practice and its policies. Garden State Behavioral Health Serviced South, L.L.C. is an independent practice located in Marlton, NJ. We provide outpatient behavioral health and substance abuse services. We intend to provide the highest quality care possible. Your familiarity with us will assist us in doing so.

Please let us know what we can do to provide you with quality care. Your input and participation in your care is essential. We view the providing of care as a partnership between you and us.

We accept fee for service (out of pocket) clientele as well as many insurance plans. Feel free to ask us about your plan. Should your insurance fail to pay your bill, you agree to make payment based on the rates billed to your insurance.

It is essential that you keep all scheduled appointments. Please call at least 24 hours in advance of any cancellations or changes. You will be responsible for payment/fees if proper notice is not provided. If we are able to book the appointment with another person you will not be charged. We will charge the full value of the appointment as billed to your insurance provider or out of pocket fee. We will charge a missed appointment fee if appropriate notice of cancellation is not given.

Psychotherapy and psychiatry are not practiced via the telephone under normal circumstances. It is not the normal course of treatment to provide phone sessions or to talk to your clinician in between sessions. It is not good practice to prescribe medications over the telephone. If you experience an emergency and need to talk to your clinician, you may be billed a fee.

Your signature below indicates your understanding and agreement with the terms above. If you are representing a minor child, you agree that you have the legal right to act on this child's behalf. Signing below also serves as a Consent for Treatment and agreement to receive services from Garden State Behavioral Health Services South, L.L.C.

_____ _____

Client or Parent Signature Date

_____ _____

Client Printed Name Witness

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Members Rights and Responsibilities Statement of Member Rights

Members have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission
- Easily access timely care
- Know about their treatment choice, this is regardless of cost or coverage by the member's benefit plan
- Share in developing their plan of care
- Information in a language they can understand
- A clear explanation of their condition and treatment options
- Information about clinical guidelines used in providing and managing their care
- Ask their provider about their work history and training
- Give input on the Member' Rights and Responsibilities policy
- Know about advocacy and community groups and prevention services
- Freely file a complaint or appeal and learn how to do so
- Know of their rights and responsibilities in the treatment process
- Receive services that will not jeopardize their employment
- Request certain preferences in a provider
- Have provider decisions about their care made to them without regard to financial incentives

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Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect
- Give providers information they need; this is so providers can deliver the best care
- Ask questions about their care; this is to help them understand their care
- Follow the treatment plan, which will b agreed upon by the member and provider
- Follow the agreed upon medication plan
- Tell their provider and primary care physician about medication changes, including medications given to them by others
- Keep their appointments; members should call their provider(s) as soon as they know they need to cancel visits
- Let their provider know when the treatment plan isn't working for them
- Let their provider know about problems with paying fees
- Report abuse and fraud
- Openly report concerns about quality of care they receive

_____ _____

Member Signature Date

My signature above shows that I have been informed of my rights and responsibilities and that I understand their information.

_____ _____

Provider Signature Date

The signature above shows that I have explained this statement to the patient. I have offered the member a copy of this form.

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Authorization to Disclose Information to Primary Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 12 months from the date signed.

I, _____, herby authorize _____

(please print patient's name) *(please print Treating clinician's name)*

Please check one:

_____ To release any applicable information to my Primary Care Physician

_____ To release medication information only to my Primary Care Physician

_____ _____

(Patient or patient's guardian, please sign) *Date*

_____

(Printed name above)

Primary Care Physician's Name, Address, & Phone Number

_____

_____

_____

_____

_____

Note to Behavioral Health Care Provider: Please maintain original copy in patients file

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Informed Consent for Treatment

I, _____ (name of patient) agree and consent to participate in behavioral health care services offered and provided by _____, (name of the provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and contest to treatment on behalf of this individual.

_____ _____ _____

Printed Name *Signature* *Date*

_____

Relationship to Patient (if applicable)

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Notice of Privacy Practices Receipt and Acknowledgment Notice

Patient/Client Name: _____

DOB: _____

I herby acknowledge that I have received and have given an opportunity to read a copy of Garden State Behavioral Health Services, South's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Michael Adornetto, LCSW, at Garden State Behavioral Health Services, South, at 2 Eves Drive, Suite 104 Marlton, NJ 08053, or by calling (856)-797-8777.

_____ _____

Signature of Patient/Client *Date*

_____ _____

Signature of Parent, Guardian, or Person Representative *Date*

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual above (power of attorney, healthcare surrogate, etc.)

Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of Staff Member *Date*

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Patient Information

Name: _____

DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell/Work Phone: _____

Marital Status (please circle): Married Single Divorced Widowed Other

Employer's Company Name: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relation to Patient: _____

Primary Physician: _____ Phone #: _____

****Required**** ***If you are paying out of pocket, skip this section***

Primary Insurance Company: _____ ID#: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Address: _____

Holder's DOB: _____ Telephone: _____ Copay: _____

Authorization to Release Information and Assignment of Benefit

I authorize the release of any medical information necessary to my Insurance carrier to process this claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered. I request that payments be made directly to Garden State Behavioral Health Services South, LLC, or its designee. I certify that the information I have reported regarding my insurance coverage is correct and accurate. I understand that I am financially responsible for the charges uncured for services received at the date the service is rendered. I authorize the physician(s) to treat me and/ or my child.

Signature (Parent or Guardian): _____Date: _____