INITIAL EVALUATION

Demographic Information: (Please complete all questions on this form)

Date: _____

Name: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____ Social Security #: _____

Guardianship (for children and adults when applicable): _____

Marital Status:

☐ Never Married ☐ Divorced
☐ Married ☐ Separated
☐ Widowed ☐ Cohabitating

Race (optional):

☐ White ☐ Native American
☐ African-American ☐ Asian
☐ Hispanic ☐ Other _____

Gender: ☐ Male ☐ Female

Age: _____

Family Members:

Name	Age	Sex	Relationship

Employer: _____ Occupation: _____

School (for children, and adults when applicable): _____

Referral Source: _____

Insurance Information:

Insurance Company/HMO: _____ Phone: _____

Member ID#: _____ Managed Care Company: _____

Claims Address: _____ Phone: _____

Emergency Information:

Primary Care Physician: _____ Phone: _____

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Inner Balance Psychology Center, LLC

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.

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 $60.00 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 _____

Parent or Guardian Signature_____

Date_____

Inner Balance Psychology Center, LLC

READ ONLY COPIES
(These forms to be completed in the office at time of visit)

34 East Main Street
Marlton, NJ 08053
Phone: 609-613-0110

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

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

Inner Balance Psychology Center

Phone: 856 988-1451

Informed Consent to Treatment

I_____ agree and consent to participate in behavioral health services offered by Inner Balance Psychology center, a behavioral health provider. I understand that I am consenting and agreeing only to those services that my clinician is qualified to provide given the scope of their license, certifications and training.

No promises can be made as to the results of treatment or any of the procedures provided by the clinician.

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/elder abuse or neglect to the appropriate authorities.

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 the Inner Balance Psychology Center.

_____ _____

Signature of Patient *Date*

_____ _____

Signature of Clinician Obtaining Consent *Date*

Inner Balance Psychology Center

Consent to Treatment of a Child

You have made the decision to seek and to take part in treatment with Inner Balance Psychology Center. As part of treatment, the development of a treatment plan with the clinician and regular review of your child's work toward meeting the treatment goals is within your best interest. It is essential for your child's treatment that you agree to actively participate in this process.

No promises can be made as to the results of treatment or any of the procedures provided by the clinician.

It is your responsibility to pay for the services that you receive. If you fail to meet your financial obligation for therapy, the clinician has the right to terminate treatment or suspend it until payment is made in full. You may stop your child's services at any time, but are still financially responsible for sessions that you have completed.

Federal law permits Inner Balance Psychology Center to disclose information in the following circumstances without your written permission: If your child makes a serious threat to harm himself/herself or another person, the law requires Inner Balance Psychology Center to protect your child 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.

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 for my child to participate in treatment with Inner Balance Psychology Center.

_____

Printed name of Client (Child) Age of client

_____

Signature of Parent/Guardian Date

_____

Signature of Clinician Obtaining Consent Date

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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)

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? ☐ YES ☐ NO PLACE (State)

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NOTICE OF PRIVACY PRACTICES

Inner Balance Psychology Center

Dawn Raffa Ph.D

Effective Date: September 2015

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

How This Practice May Use or Disclose Your Health Information

This practice collects health information about you and stores it in a chart and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this practice, but the information in the record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We will use and disclose your protected health information to provide; coordination or manage your health care related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities

and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will

no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Payment. We use and disclose information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Appointment Reminders. We may use and disclose information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When This Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that

information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of

research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

Complaints

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Dawn Raffa (609) 613-0110 for further information about the complaint process.

Inner Balance Psychology Center
2 Tree Farm Road Suit A-220
Pennington, NJ 08534
34 East Main Street
Marlton, NJ 08053
609-613-0110
Fax 866-309-4180
www.innerbalancepsychology.com

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

Inner Balance Psychology Center, LLC

Non-Disclosure Form Regarding E-mail, Video Conferencing, and Cell Phone Communication:

As a patient at Inner Balance Psychology Center, _____ understands that if she or he should choose to communicate with their therapist via electronic communication, (i.e. Skype/Face Time/Google Hangouts, over the phone or through e-mail) it is not fully confidential. This patient also agrees to exchange public health information electronically.

Signed: _____
Patient Date

Signed: _____
Therapist Date