BRICK PSYCHIATRIC SERVICES, INC.

1541 Route 88 West, Suite J
Bricktown, NJ, 08724
P: 732-202-0622
F: 732-202-0620

3445 Route 9 North
Howell, NJ 07731
P: 732-994-5700
F: 732-994-5701

REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____/_____/_____ SEX: M / F
Last name First Name Initial MM DD YYYY

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ ALTERNATIVE PHONE: _____

EMAIL: _____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment reminders, insurance updates, health bulletins) ☐ Yes ☐ No

May we:

Leave a general message on your primary phone's answering machine ☐ Yes ☐ No

Leave a detailed message on your primary phone's answering machine ☐ Yes ☐ No

Leave a detailed message with a family member ☐ Yes ☐ No

EMERGENCY CONTACT: _____

PHONE: _____ RELATIONSHIP: _____

PRIMARY CARE PROVIDER: _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

INSURANCE ID: _____

SECONDARY INSURANCE COMPANY: _____

INSURANCE ID: _____

Insurance Holder: _____ Date of Birth: _____/_____/_____
Last name First Name MM DD YYYY

Address: _____
Street City State Zip Code

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PAYMENT/RELEASE OF INFORMATION CONSENT

I hereby agree that Brick Psychiatric Services is authorized to bill and receive payment from my insurance company and for services rendered to me or my family. Brick Psychiatric Services may release only the appropriate information required by said companies for the payment of claims submitted. Please note patient privacy policies located in the waiting room. This consent is valid continually until revoked in writing.

Filing insurance is NOT a guarantee of payment. Brick Psychiatric Services will bill my insurance company (if participating). If my insurance company denies payment for any reason, I understand that I will be responsible for the assigned fee.

A 24 HOUR NOTICE IS REQUIRED FOR ALL APPOINTMENT CENCELLATIONS. FAILURE TO DO SO WILL RESULT IN A $50 FEE, WHICH IS THE SOLE RESPONSIBILITY OF THE PATIENT.

_____ _____

Signature of Patient, Parent, or Guardian | Date

PHARMACY POLICY

Please note that **you are responsible for calling your pharmacy regarding prescription refill requests**. Brick Psychiatric Services is not responsible for calling your pharmacy.

To ensure that you receive your medication in a timely manner, *please ask your pharmacy to call or fax us so that we may provide them with a prompt response*.

If you are having difficulty in contacting your pharmacy and/or have question regarding your prescriptions, please call us during the work week and within our office hours. Calls regarding prescription refills made after hours and on weekends will not be returned. For more information about our pharmacy policies, feel free to ask our staff.

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MEDICAL RELEASE

NAME: _____

DATE OF BIRTH: _____/_____/_____ SS#: _____

I hereby authorize Brick Psychiatric Services to release to as well as obtain information from relevant parties (examples: physicians, hospitals, clinics.)

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE: _____

The following information from the medical records of the patient listed above:

- ☐ Admission Assessment
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Laboratory Tests and Results
- ☐ Medications
- ☐ Treatment Plan
- ☐ Other _____

I understand that these medical records contain information pertaining to psychiatric counseling and/or testing, alcohol/drug abuse counseling and/or testing, along with HIV/AIDS diagnosis or testing. I do expressly and voluntarily authorize the disclosure of said medical records to the person(s) and/or entity as stated above. This authorization of consent will remain in effect indefinitely unless revoked (in writing), by the above patient (or by the patient's parent, legal guardian, or legally authorized agent) to our Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State laws and United States Federal laws.

AUTHORIZATION

I hereby allow the following person(s) to be given information regarding my treatment. This information may be given solely to the people listed below through verbal communication or in person.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ I do not wish for anyone to be able to obtain information regarding my treatment

I CERTIFY that I have read (or have had read to me) the above statement and fully understand the content.

Signature: _____ Date: _____
Witness: _____ Parent/Guardian: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information may be used and disclosed, along with how you can access this information. Please review this statement carefully. The privacy of your health information is important to us.

Our legal duty: We are required by applicable state and federal law to maintain the privacy of your health information. We are required to give you this notice regarding our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices described in this notice while it is in effect. This notice will take effect with your agreement to it and will remain in effect until another statement replaces it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable laws. We reserve the right to make changes and institute new terms to our privacy practices effective for all health information that we maintain, including health information we related or reviewed before the new notice was instituted. Before we make any significant changes to our privacy practices we will inform you and make the new notice available to you.

You may request of copy of our notice of privacy practices at any time. For more information about our privacy practices or for additional copies of this notice, please contact Brick Psychiatric Services using the information at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for your treatment, payment, and health operations.

Treatment: We may use and disclose your health information to obtain payment for services we have provided you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for you healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with the opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victims of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

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FINANCIAL POLICY

We require payment in full, which is due at the time of service unless we participate with your insurance company or prior arrangements have been made. ***You are ultimately responsible for payment and knowing what is or is not covered by your insurance policies.*** If you have an HMO, you are also responsible for confirming that we have authorization to see your prior to all of your appointments. We will file claims to insurance companies with which we have a contract. We will file claims with non-participating and secondary insurance companies as well. However, payment for all services will revert back to the patient if non-contractual insurance payments are not made to this office within 30 days of the claim being filed. We collect all copayments, so-insurance, and deductibles at the time of services. We accept cash and credit cards, excluding Amex.

MISSED APPOINTMENTS: You may be subject to a $50 charge for missed appointments if appointments are not cancelled at least 24 hours in advance.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services to be rendered to the patient, he/she must hereby individually obligates himself/herself to pay the account of the physician in accordance with the regular rates and terms of the mental healthcare professional. Should the account be referred to an attorney for collection, the undersigned shall pay all the attorney fees and all collection expenses.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____.
Name of Insurance Company

I assign directly to Brick Psychiatric Services, Inc. all medical benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance (within the practice's contractual agreement).*** I hereby authorize Brick Psychiatric Services to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions.

MEDICARE AUTHORIZATION:
I require that payment of authorized Medicare benefits be made either to me, or on my behalf, to Brick Psychiatric Services, Inc. for any services provided to me. I authorize any holder of medical information about me to release to the Brick Psychiatric Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requires that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item of the HCFA-1500 form, or elsewhere on approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency show. In Medicare assigned cases, the physician or supplier agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Please sign this assignment of benefits and financial policy/agreement

_____ _____

Signature of Patient Date

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SOCIAL HISTORY

Do you have a history of:

Suicidal behavior:	Yes ☐	No ☐
Assaultive behavior:	Yes ☐	No ☐
Inpatient psychiatric treatment:	Yes ☐	No ☐
Drug Abuse:	Yes ☐	No ☐

If you answered yes to any of the questions above, please explain in detail (describe any attempts, include number of hospitalizations, number of rehabilitations, if applicable):

_____

Race: Please mark all applicable
- ☐ Caucasian
- ☐ African American
- ☐ Asian
- ☐ Hispanic
- ☐ Other: _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other: _____

Employment:
- ☐ Full time
- ☐ Part time
- ☐ Unemployed
- ☐ Other: _____

Highest level of Education:
- ☐ High School
- ☐ College Graduate
- ☐ Post-Graduate Degree
- ☐ Other: _____

Nutrition:
- ☐ Poor Diet
- ☐ Average Diet
- ☐ Excellent Diet
- ☐ Vegetarian

Exercise:
- ☐ Everyday
- ☐ Weekly
- ☐ Infrequently
- ☐ Never

Sexual Activity:
- ☐ Not Active
- ☐ Sexually Active
- ☐ Monogamous
- ☐ Safe Sex

Number of Children: _____
Number of Siblings: _____

If sexually active, do you use contraception? ☐ Yes ☐ No If **yes**, what type of contraception do you use? _____

Do you have a history of smoking? ☐ Yes ☐ No If **yes**, do you presently smoke? ☐ Yes ☐ No **Packs a day:** _____

Do you drink alcohol? ☐ Yes ☐ No If **yes**, how often: _____

Do you currently serve, or have you ever served in the military? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Current living situation: _____

If you **are** currently working, what is your occupation? _____

If you **are not** currently working, what type of work have you performed in the past? _____

Family Psychiatric History:

_____

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MEDICAL HISTORY QUESTIONNAIRE: CHECK ALL THAT APPLY

ILLNESS:	PATIENT (INCLUDE DURATION)	FATHER	MOTHER	SIBLING (S)	CHILDREN
Diabetes Mellitus					
Hypertension					
Heart Disease					
Kidney Disease					
HIV/AIDS					
Hepatitis					
Cancer/Tumors					
Respiratory/Lungs					
Blood Diseases					
Stomach Ulcers					
Arthritis					
Stroke					
Neurological					
Cataracts					
Macular Degeneration					
Seizures					
Head Injuries					
Thyroid Disease					
History of Falls					
Other					

Have you been vaccinated for the Influenza virus within the past year? ☐ Yes ☐ No
Have you been vaccinated for Pneumonia within the past year? ☐ Yes ☐ No

Surgeries: _____

Medical Allergies: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Please list all prescription, over the counter, herbal, vitamin/mineral/dietary (nutritional) supplements. Include the name of the medication, dosage, frequency, and route of administration (oral, intravenous, etc.)

_____
_____
_____
_____