Patient Information

Last Name **First Name**

Address 1 _____

Address 2 _____

City _____ **State** **Zip** _____

Phone-home: _____ **Phone-work:** _____ **Phone-cell:** _____

DOB: _____ **Sex:** ☐ M ☐ F

Marital: ☐ Single ☐ Married ☐ Divorced **Ethnicity:** ☐ White ☐ African Am. ☐ Asian ☐ Hispanic ☐ Other

e-mail: _____ **Employer Name:** _____

Responsible Party or Spouse Information

Your relationship to Responsible party? Self ☐ Child of ☐ Spouse ☐ Other ☐

Complete the following only if you did not check "Self"

Responsible Party Last Name: _____ **First Name:** _____ **MI:** ____

Address 1: _____ **Address 2:** _____

City: _____ **State:** _____ **Zip:** _____

Phone-home: _____ **Phone-work:** _____ **Phone-cell:** _____

Empl/School/Plan: _____

Sex: ☐ M ☐ F **DOB:** _____

Insurance Information

Primary - Insurance Company: _____
(plan name)

Insurance Address: _____

Insurance ID: _____ **Group/Account:** _____

Your relationship to Insured: Self ☐ Child of ☐ Spouse ☐ Other ☐

Insured's Name: _____ **DOB:** _____
(skip if Relationship is Self) (skip if Relationship is Self)

Secondary - Insurance Company: _____
(plan name of Secondary Insurance, if any)

Insurance Address: _____

Insurance ID: _____ **Group/Account:** _____

Your relationship to Insured: Self ☐ Child of ☐ Spouse ☐ Other ☐

Insured's Name: _____ **DOB:** _____
(skip if Relationship is Self) (skip if Relationship is Self)

I authorize the release of any medical or other information necessary to process claims. I am the patient, or authorized representative. I understand I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____
Signature Date

Youth & Family Counseling Service

233 Prospect Street, Westfield, NJ 07090

Patient Name _____ Date of first visit _____

This information is provided to inform you of Youth and Family Counseling policy. Please review the information and sign this form. A copy will be given to you for your records. If there are any changes in your insurance, please see the receptionist.

It is your responsibility to know your insurance coverage, and if an authorization is required.

If you have a change in your coverage it is your responsibility to notify Youth and Family Counseling prior to the effective date of change. Any copays or deductibles are the patient's responsibility and must be satisfied.

Please remember that our relationship is with you, not your insurance company or attorney. It is your responsibility to work directly with your insurance carrier to manage a delinquent claim.

Professional or Disability papers that are needed to be filled out by Youth and Family Counseling will be charged $10.00 per filing, per patient.

Late cancellations (24 hours or less) will be charged **$45**. You will also be responsible for any fees incurred when a check is returned for insufficient funds.

Your co-pay /co-insurance is based on information obtained from your insurance company. If your insurance company processes your charges differently from our initial information, it is the patient's responsibility to contact your insurance company to correct any differences.

I have read and understand the above. If there is a change I am responsible to inform Youth and Family Counseling of changes prior to the effect change.

Signature _____

Date _____

Youth & Family Counseling Service
233 Prospect Street, Westfield, NJ 07090
908-233-2042
908-654-7414 Fax
www.yfcsnj.org

Youth & Family Counseling Service Notice of Privacy

Effective April 14, 2003, federal privacy rules concerning how your health information is shared, stored, and used will be required by the Health Insurance Portability and Accountability Act (HIPAA). Youth & Family Counseling Service considers all nonpublic personal information confidential and works to protect it against unlawful use and disclosure. The Protected Health Information is designated as "PHI".

When appropriate for your care, your PHI may be shared internally with other YFCS staff members. We shall not communicate with outside sources without your explicit authorization. We also share PHI with payers of your medical benefits for the purposes of claims payment (through bills) and for utilization review (through treatment reports).

Your PHI is confidential except in certain circumstances that may include 1) intent to harm self or others; 2) neglect, abuse, or domestic violence with a minor or with a vulnerable or incompetent elder; 3) court-ordered treatment; 4) PHI that is related to national security.

You may, on written request, examine your records that are kept after HIPAA compliance becomes effective on April 14, 2003. If you would like to have an amendment, written by you, added to your record that will be done.

Parents and legal guardians of minor children may have access to the children's diagnosis and treatment goals. However, we are prohibited by law from disclosing information about pregnancy, abortion, sexually transmitted disease, contraception and/or family planning services, or substance use and abuse. Also, holders of an Estate do not hold the privilege of the deceased.

Upon your request, YFCS will disclose PHI to the extent necessary to comply with laws relating to workers' compensation, disability leaves, social security administration, and other similar programs.

STATEMENT OF ACKNOWLEDGMENT
YOUTH & FAMILY COUNSELING SERVICE
233 Prospect Street, Westfield, NJ 07090

Patient Name: _____

I have read the Youth and Family Counseling Service Notice of Privacy and accept the conditions contained there-in. I understand that I may revoke this authorization in writing, expect to the extent that Youth and Family Counseling Service has already taken action in reliance upon it.

This authorization will automatically be revoked, if not renewed, after one year from this date.

I understand that, upon request, I may receive information about disclosures of PHI made by Youth & Family Counseling Service prior to the time of my request as long as I make this request within a 6 year period following my active contact with Youth and Family Counseling Service.

I understand that I may decline to sign this statement. Youth and Family Counseling Service will continue treatment if this refusal is not deemed to impede the therapeutic process or goal.

_____
Signature of Patient/Parent/Guardian

_____
Date

AUTHORIZATION:

I give permission for my therapists at Youth and Family Counseling to speak to the following person(s):

Name_____

Name _____

Is it okay to leave a message for you on your:

Home # Yes _____ No _____ Cell # Yes _____ No _____

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