Complete Counseling
Jason Heymer, MA, LPC
230 Rt 206 South - Building 3 Suite 202
Flanders, NJ 07836

NEW PATIENT INFORMATION

Please note that any and all contact information that we are supplied with is going to be considered an acceptable means of communication with you when we need to call and/or leave a message or send written correspondence. If there is a contact number that you would prefer us to use and not others, please let the staff know. Thank you.

Date _____

Name of Patient: _____ **Male** ☐ **Female** ☐

Address: _____

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

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-Mail:** _____

Date of Birth: _____ **Social Security #:** _____

Employer: _____

Employed Full-Time ☐ **Employed Part-Time** ☐ **Full-Time Student** ☐ **Part-Time Student** ☐

Marital Status: Single ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Other** _____

How did you hear about us? Internet ☐ **Friend** ☐ **Insurance Company Referral** ☐

Primary Physician ☐ **Other:** _____

Insurance Information

Insured's Name: _____
(If you, the client, are also the insured, please write: SAME AS ABOVE)

Address: _____

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

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-Mail:** _____

Date of Birth: _____ **Social Security#:** _____

Relationship to Insured: Spouse ☐ **Child** ☐ **Other** _____

Insurance Company Information

Patient's Name: _____

Primary Card Holder's Name: _____

Primary Card Holder's Address: _____

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

Date of Birth: _____ **SSN:** _____

Employer: _____

Employer Address: _____

State: _____ **Zip:** _____ **Phone #:** _____

Insurance ID#: _____ **Group/Policy#:** _____

Secondary Insurance ☐ **Not Applicable**

Secondary Card Holder's Name: _____

Secondary Card Holder's Address: _____

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

Date of Birth: _____ **SSN:** _____

Employer: _____

Employer Address: _____

State: _____ **Zip:** _____ **Phone #:** _____

Insurance ID#: _____ **Group/Policy#:** _____

Please sign and date item Number 12 and 13 on the next page.

This form (Health Insurance Claim Form) gives us permission to bill your insurance company for your sessions. It is not necessary to fill out any other part of this form. Our billing department will fill in the remaining sections.

Thank you,
Complete Counseling

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) 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. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID 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. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

Fold

NUCC Instruction Manual available at: www.nucc.org

Mfd. by Medical Arts Press

Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

Printed on Recycled Paper

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

#14710 - Medical Arts Press

Use with Envelope #14145 (gummed) or #14146 (self-seal)

Initial Page_____

Complete Counseling Services LLC
Informed Consent for Treatment

Thank you for choosing Complete Counseling Services. Your initial session will consist of an intake evaluation will take between 30-60 minutes and all others sessions will be 45 minutes (unless other arrangements are made). This document will inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask your counselor.

Your counselor, Jason Heymer has worked in community out-patient settings in Northwest New Jersey for fifteen years. With a strong background in Rational-Emotive, Behavior, and Social Skills/ Assertiveness theory, he will help you to find possibilities, options, or ways to make improvements in self, relations with others, or specific situations.

Jason specializes in teaching the benefit and application of modern assertiveness and clean communication, negotiation, and balancing the needs of you and others. He has run a variety of groups, including Anger Management, Communication, and Social Skills. He has worked with a range of populations and has extensive experience with children, those with special needs, and the elderly.

You will be given practical tools: coping skills for challenging situations, help in evaluating your options, and the means to make choices that will benefit your future.

Confidentiality

Your verbal communication and clinical records are strictly confidential except when you are a danger to yourself or others or: a) you sign a release to provide information to a psychiatrist, nurse practitioner, etc. b) to bill your insurance company (diagnosis and dates of service), c) to report abuse, d) where you sign a release of information to have specific information shared someone (parent or spouse) and e), duty to warn and protect law, f) In the event of an emergency, we have the right to disclose all of your clinical information to other mental health, substance abuse professionals, police, fire, ambulance, emergency medical, paramedics, or any person who would need this information to protect yourself or anyone else from harm. g) or when required by law.

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy or when different family members are seen individually, confidentiality and privilege do not apply between couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I have been authorized to do so by all adult family members, and/or parent(s) or guardian(s) who were part of the treatment. Disclosure of confidential information may be required by your insurance carrier (HMO/EPO/POS/PPO/ Traditional, indemnity plan, or Affordable Care Act) in order to process your claims. Your

records can be released to the court, for internal communications, or the intent to commit a crime.

Emergency Situations

Please be advised that we do not provide a 24/7 answering service. If you have a mental health emergency (such as suicidal or homicidal plans), dial 911 immediately.
If a crisis or an emergency develops during your session, Complete Counseling Services has the right and legal obligation to call 911 as necessary to ensure safety. Complete Counseling Services also has the right to contact immediate family members or your emergency contact and notify them of such emergency.
If an emergency situation for which the client, parent(s) or their guardian(s) feels immediate attention is necessary, the client, parent(s) or their guardian(s) understands that they are to contact the emergency services in the community (911) or report to your local hospital for those services. Your counselor will follow up with those emergency services and support to the client or client's family in the office by appointment only. If your counselor recognizes a crisis or an emergency exists, we have the right and legal obligation to call the police and/or any emergency personnel necessary to ensure safety. No legal repercussion toward Complete Counseling Services, LLC can be sought when reasonable judgment is used to mitigate crisis situations. We have the right to contact immediate family members and notify them of emergencies. Duty to warn and protect law is applicable. If you come to this office under the influence of alcohol or drugs we reserve the right to call family, friends, associates or law enforcement officials and will not let you drive home by yourself. You as the patient are willing to blow into a fuel cell breathalyzer or submit to a urine drug screen.

The Therapeutic Process

1. Defining the problem – What are the feelings that are bothering you?
2. Measuring the problem or behavior - How big or small is the problem? How often does it occur?
3. Developing goals – You and your counselor will collaborate on developing realistic increments of change.
4. Developing a treatment plan – What will actually help you to reach your goals.
5. Determining if the treatment plan is effective - Re-examine your treatment and evaluate its effectiveness.
6. Fading treatment – Visit every other week instead of every week.
7. Termination – You have learned skills to cope autonomously with situations which previously caused problems for you.

Therapy will progress at a rate that you are comfortable with. There is no right or wrong rate of recovery. Your Therapeutic Process may differ from the above outline as determined by your counselor.

Counseling requires participation, honesty, and persistence in order to be effective. Your feedback is also important. Please share your thoughts on your progress with your counselor. Counseling can be remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, anxiety, depression, insomnia, suicidal or homicidal ideations etc. Your counselor may challenge your beliefs or perceptions and encourage you to explore other ways of processing the information. You could feel upset, angry, depressed, challenged, or disappointed. If you feel that you are in imminent risk of hurting yourself or others, you must call 911 or go to your nearest emergency room for care.

Client Satisfaction

If you feel dissatisfied for any reason, please discuss your concerns with your counselor. You have the right to contact your insurance company about any concerns. You can also contact the state licensing board at: http://www.njconsumeraffairs.gov

Vacations/Emergencies

Please be advised that when a clinician is on vacation, we leave a colleague **on call.** We will provide you with the name and phone number of the clinician when calls a re received on vacation. For general assistance please contact my colleague Paul Spergel MA, LPC who covers vacations. If you feel you cannot wait for one of us to call you back or feel that this is a psychiatric emergency please dial (911) or go to your nearest emergency room.

Financial Disclaimer

Please note, although we may accept many insurance plans, this does not guarantee payment to the Complete Counseling Services, LLC. You as the patient or patient representative are ultimately responsible for payment. All **patients** are responsible for obtaining initial authorization and/or referrals from your primary care physician regardless of your insurance company's policies concerning this matter. Obtaining authorization from your insurance company does not guarantee payment from them. Any denial of payment for any reason, payment that is pending over 30 days, deductibles or co-payments is your responsibility. Deductibles and co-payments are not negotiable and must be paid at the beginning of your session. Your bill will reflect the standard rate charged by our group for any outstanding balances which are clearly posted by our reception area. Please call your insurance carrier if you have any questions regarding your insurance policy, coverage and benefits to your plan. Complete Counseling Services, LLC is not responsible for knowing the specifics of your plan or how your plan works. Please note that by signing this form you are superseding any contract signed by the Complete Counseling Services, LLC and your insurance company concerning payment. **You are ultimately responsible for full payment.**

Any outstanding balances beyond 90 days will be charged a 1.5% interest charge and immediately be sent to collections. A minimum charge of $50 collection fee will be added to your bill if our office proceeds with collections. If your bill goes to our attorney, all attorney costs, court costs and any fees will be added to your bill. Please note that our office reserves the right to collect on outstanding debt in lieu of collection agencies. All court costs will be added to

your bill plus interest charges will apply. Please note that we are not a collections agency and our primary responsibility is to help you get well.

It is the responsibility of the patient or responsible party to notify this office 48 hours in advance in the event you need to cancel or reschedule your appointment. A full 24 hours' notice is acceptable if you are sick and can provide a physician's note for such illness. Otherwise, we reserve the right to bill you our fee of $100.00 for the missed session. If you are hospitalized or a catastrophic event happens we are willing to discuss this with you. In the event of inclement weather, our office will call you to cancel your appointment. If we do not call you and cancel your appointment, you are expected to be here for your visit. Remember that your session has been scheduled for you and you alone. No other patient can be scheduled or seen during your time slot. Please note that your insurance company does not cover missed appointments. Please understand that any reports, out of the office meetings, or hospital visits will not be covered by your insurance company. You will be responsible for payment of these charges at our usual and customary rate.

It should be noted that if we do not participate in your particular insurance plan our office would be considered as an out of network provider. Our office will attempt to contact your insurance company to verify benefits but you are ultimately responsible for contacting your insurance company to obtain authorization and/or benefit information. We may not be aware of your deductible, co-insurance, or co-pays. It is your responsibility to know your plan and how it is administered. You will be responsible for any balances. You will be billed at our regular rate toward your deductible until our session fees have been met. Out of network patients will be held responsible for our full fees for each session. Our fees are posted in by our reception area and you can request a copy of them by asking our office staff or clinician. We accept checks for payment, however if your check is returned to us for insufficient funds or non-payment a fee of $45 will be charged per returned check. Your responsibility is to make your appointment on time, call our office if you are going to be late to a session, call us within 48 hours if you are going to miss your appointment and to ensure that reimbursement is made to this office. By signing this you agree to the terms listed above.

Termination

Our sessions together will end when our treatment goals are met or due to a decision on your part or ours or both. In counseling, the relationship is an important part of the process. Therefore, we find it most effective when we can plan for at least one session to terminate treatment. We do not accept clients who we cannot help. In such a case, you will be provided a number of referrals. You may also call your insurance company for additional lists of names of providers. You have the right at any time to consult another professional.

Bill of Rights

1. Complete Counseling Services, supports a Patient Bill of Rights and Responsibilities and holds that compliance with these contributes to effective and appropriate patient care and responsibility. All activities related to providing healthcare services are to be conducted with an overriding concern for the patient and the community and above all with the recognition

of the patient(s) dignity as a person who has the right to determine his/her own destiny in a socially responsible manner.

2. The patient has the right to considerate, respectful, appropriate and timely services.

3. The patient has the right to participate in the development of his/her service goals and service plan.

4. The patient has the right to obtain from his/her service provider, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person on his/her behalf.

5. The patient has the right to receive from his/her service provider, information to make informed consent prior to the start of any procedure and/or treatment. This shall include such information as: the significant risks involved with any procedure and service provider. Where clinically appropriate, alternatives for care or treatment should be explained to the patient.

6. The patient has the right to refuse any and all treatment to the extent permitted by law and to be informed of any of the psychological and/or medical consequences of his/her actions.

7. The patient has the right to every consideration of confidentiality and privacy concerning his/her own care limited only by state statues, rules, regulations or imminent danger to the individual or others

8. The patient has the right to be advised if the clinician, hospital, and/or clinic proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research.

9. The patient has the right to examine and receive an explanation of his/her bill

The patient's responsibilities are as follows:

1. The patient has the responsibility to give their providers of care complete and accurate information related to their condition and their past and current care.

2. The patient has the responsibility to comply with the treatment plan, which they and their provider of care have mutually developed. Patients are responsible for the medical consequences, which may result, from refusing recommended treatment or for not following the instructions of the provider of care.

3. The patient has the responsibility to be considerate and respectful to the provider and provider's staff who are committed to assisting all parties in providing effective care.

4. The patient has the responsibility to give complete and accurate insurance coverage information in a timely fashion and to pay for services promptly, so that the provider of care can continue to service the community effectively.

5. The patient has the responsibility to read and sign all forms provided to them to provide continuity of care, payment for such care and to cover all insurance issues.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

Notice Of Privacy Practices

This is a summary of Complete Counseling Services Notice of Privacy Practices. Complete Counseling Services promises to maintain the confidentiality of your protected health information ("PHI"). PHI is health information about you that we have in our records. **This notice describes how mental, behavioral, medical and other health care information about you may be used and disclosed, and how you can get access to this information. Please review it carefully**.

Uses and disclosures of health information

Except as described in this Notice, it is our practice **to obtain your authorization** before we disclose your PHI to another person or party. You may revoke an authorization, at any time, in writing. If you revoke an authorization, we will no longer use or disclose your PHI. However, we cannot undo any disclosures we have already made.

We use health information about you for **treatment** (supervision, referral, recording details of your treatment plan and your progress), to obtain **payment** (submit claims to billing services, collection agencies, or insurance, and deposit checks into a business account) and for **administrative** purposes (mailings, appointment reminders).

We may use or disclose PHI about you **without your authorization** for several other reasons. To comply with certain requirements, we may give out PHI without your authorization for public health purposes, for auditing purposes, for research studies and, to comply with specific laws and to avert a serious threat to health or safety. For example, we are required to report or disclose PHI related to child abuse or neglect. We may use or disclose your PHI in an emergency situation when use and disclosure of the PHI is necessary to prevent serious risk of bodily harm or death to you. Only specific information pertinent to the relief effort and the emergency may be released without your authorization.

We may apply a change to our policies at any time. Before we make a significant change in our policies, we will provide you with a notice.

Individual Rights

You have the right, following a written request and agreed upon date and time, to look at, get a copy of or receive electronically protected health information about you that we use to make decisions about you. If you request copies, we will charge you at our cost for each page. You

also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we amend the existing information.

You may request in writing that we restrict and/or not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice, according to The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We are also required to comply with any state laws that may be more stringent than the HIPAA Privacy Regulations. We will comply with the laws that provide the greatest protection for your health information.

Signature:_____Date:_____

Counselor:_____ Date: _____