

# CENTRA

PC

We appreciate the confidence you have placed in us. Please fill out the following information.

CLINICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Name of parent/guardian (if under 18 years):

Last: \_\_\_\_\_ First: \_\_\_\_\_ Phone: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

For the purposes of communicating test results, prescription refill requests, and other protected health information, I authorize my physician and/or his/her designee to utilize the following mechanism/s:

- ( ) On my home answering machine (# \_\_\_\_\_)  
( ) On my cell phone message system (# \_\_\_\_\_)

PRIMARY PHYSICIAN: \_\_\_\_\_

Name:

Telephone:

PHARMACY NAME: \_\_\_\_\_ Telephone #: \_\_\_\_\_

\*Referred by: \_\_\_\_\_

Website  Internet  Mailing  Advertisement: \_\_\_\_\_

Responsible Party:  Self  Other: Name: \_\_\_\_\_

Address: \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

24 Hour Notice is required for Cancellation  
Failure to do so will result in a full charge for the missed appointment.

Patient/Guardian Signature: \_\_\_\_\_

## **HIPAA Notice of Privacy Practices**

**CENTRA, PC**

**5000 Sagemore Drive, Suite 205**

**Marlton, New Jersey 08053**

**(856) 983-3866**

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

### 1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office, that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the Health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: 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 contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# OFFICE POLICY STATEMENT

## Initial here \_\_\_\_\_ APPOINTMENTS AND CANCELLATIONS

All sessions are arranged by appointment only. Please be prompt to best use the time reserved for you. Sessions cannot be extended if you arrive late. To help us serve our patients effectively with the limited number of sessions available, we require advanced notice of 24 hours for cancellations. This policy extends to cancellations for any reason except hazardous driving conditions (snow and ice) or contagious illness. **You will be charged the full fee for cancelled or missed sessions unless we receive over 24 hour notification.** Please be aware that insurance companies will not reimburse for missed visits, making you responsible for the charged fee.

## Initial here \_\_\_\_\_ FEES & PAYMENTS

Charges differ depending on the nature of the service delivered. Inquiries regarding our fees should be directed to your clinician. **Payment for the appointment fee and any ancillary charges are expected at the time of service.** You will be provided with the insurance billing information for you to submit.

## Initial here \_\_\_\_\_ ANCILLARY CHARGES

**We may charge for the time we spend providing care** for you or your child, such as preparation of forms, letters or reports. Generally ancillary services, such as these, will not be reimbursed by medical insurance and will be your sole responsibility.

## Initial here \_\_\_\_\_ TELEPHONE ACCESS

Calls to our office are typically answered by your clinician, the office staff or a 24-hour voicemail system. In emergencies clinicians can be reached by following the urgent notification instructions in the voice mailbox. It may not be possible for our clinicians to respond immediately. **If you are in crisis and your clinician does not return your call in a timely fashion or your situation requires an immediate response please call 911 or go to the nearest hospital emergency room.**

## Initial here \_\_\_\_\_ MEDICAL INSURANCE

We do not participate in provider networks including Medicare. **It is your responsibility to verify that your plan will cover our services as an out of network provider.** Centra staff can typically help that process. It is also your responsibility to follow any plan requirements that apply to you. Most plans limit the services for which they will reimburse. Some services we provide may be later denied by your insurance company or its administrative agent (i.e. not pre-authorized, considered medically unnecessary, beyond benefit limit, etc.). You should know that insurance companies may request treatment information from us. If you want to use your healthcare benefit to help reimburse for our services, then the release of confidential treatment information may be required before payment is made. **Your receipt, following payment, contains the necessary information to submit to your medical insurance plan.**

## Initial here \_\_\_\_\_ PROCESS OF TREATMENT

Treatment goals will be discussed with you based on concerns or problems you or your child are presenting. For certain conditions medications may be helpful. This can be discussed as part of your treatment plan and periodically during treatment. Successful therapy is the result of a joint effort and a good working alliance. However, much of the responsibility for change remains with you. If you are dissatisfied we encourage you to discuss your concerns with your clinician.

## Initial here \_\_\_\_\_ CONFIDENTIALITY

You should have received a copy of Health Insurance Portability and Accountability Act (HIPPA).

We maintain a record of your treatment. You have certain rights with regards to accessing that record. Please direct your inquiries about access to your records to us. All issues discussed in the course of therapy are strictly confidential with the following exceptions:

1. Consultation with other current health care providers as pertinent to treatment.
2. Instances where the patient may be an imminent threat to self or others, unable to take care of basic needs, or in cases of suspected child or elder abuse/neglect.
3. When ordered by a court.
4. Some treatment information such as name, diagnosis, date of service and charge is routinely given to your insurance company to facilitate reimbursement.

Some companies request additional information for treatment authorization.

If you have questions regarding these issues we encourage you to discuss them with us.

Initial here \_\_\_\_\_ **EMAIL AND OTHER COMMUNICATION**

**(Please note that not all clinicians use these forms of communication. Please check with your clinician regarding their communication preference)**

Email, texting and other forms of electronic communication are appropriate for routine, non-urgent matters such as scheduling. We do our best to keep all communications secure, however; digital communication cannot be guaranteed to be confidential. Please note standard email communication services, such as Google, Verizon, etc...are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals. All email communications are part of the medical record. By signing this document you acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. By signing, you indicate that you have been given the opportunity to discuss electronic communication as an adjunct to in-person office visits with our healthcare team, you hereby consent to electronic communication via non-secure email services. You may revoke your consent to communicate electronically in writing at any time by notifying the practice in writing but the revocation will not have an effect on actions your healthcare provider or team has already taken in reliance on your consent. You agree and release your provider and Centra P.C. from any and all liability that may occur due to electronic communication over a non-secure network. You further agree to be held accountable and to comply with patient responsibilities as outlined in this consent. Your initiating contact with your clinician via electronic communication will serve as acknowledgement of the above even in the absence of your initialing this section.

**(Please read and initial if you will be seeing a psychiatrist)**

Initial here \_\_\_\_\_ **PRESCRIPTION(S)**

Generally medication prescriptions will be provided in-person during a scheduled visit with a physician. Prescription refills will be provided at the next in-person visit. In rare circumstances a prescription refill may be needed prior to the next in-person visit. You must personally call to request a refill. **Before a refill will be provided, a follow up physician visit will need to be scheduled.** Some prescriptions can only be provided in writing and must be picked up. If you need a refill before your next scheduled session please call at least 5 business days before you run out of your medications. Also, please note that some insurance companies require prior authorization documents to be completed and submitted for certain medications. Please have your pharmacy fax us the prior authorization form. The submission of a prior authorization document does not guarantee approval by the insurance company. In some cases prior authorization may take weeks to complete.

Initial here \_\_\_\_\_ **CONSENT TO EVALUATION AND TREATMENT**

I (self as an adult or guardian of minor child) voluntarily consent that I (or my minor child) will participate in a mental health evaluation and/or treatment by a Centra clinician. I understand that following the evaluation and/or treatment information will be provided concerning each of the following areas as appropriate: The benefits of the proposed treatment as well as alternative treatment modes and services, the manner in which treatment will be administered, expected side effects from the treatment, expectations regarding the length of treatment, frequency of treatment, risks or side effects from medications and possible consequences of not receiving treatment. Evaluations and/or treatment will be conducted by a clinician. Treatment will be conducted within the boundaries of New Jersey or Pennsylvania laws, depending on the location of service, for mental health services. Evaluation and treatment may be administered via clinical interviews, psychological assessment or testing, psychotherapy, medication management, or other treatment modalities.

**I have read and agree to statements I have initialed above.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If signing for a minor please print their name: \_\_\_\_\_