# 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:** ____________________

NAME: ________________________________ DATE: _________

PERSON COMPLETING FORM: __________
RELATIONSHIP ________________________

CURRENT SYMPTOMS AND DATE SYMPTOMS BEGAN:

1. ____________________________________________________________

2. ____________________________________________________________

3. ____________________________________________________________

4. ____________________________________________________________

SCHOOL AND GRADE ATTENDED: __________________________

Accelerated Classes: Yes____ No ____
Summer School or Repeated Grade: Yes____ No ____
504 Accommodation Plan: Yes _____ No ____
Educational or Psychological Testing: Yes ____ No ____ When______

SPECIFIC SCHOOL PROBLEMS:____________________________
____________________________________________________________

BIRTH / DEVELOPMENTAL HISTORY:

Mother's Age At Birth: _________
Father's Age At Birth: _________
Full Term: Y_____ N_____
Complications: Y_____ N_____
Were Milestones On Time? Y_____ N _____
Any Early Problems In Learning or Social Development? ____________
____________________________________________________________

SOCIAL HISTORY:

Hobbies/Activities: ___________________
Strengths: ___________________________
Good Peer Relations and Support System? Y_____N____

FAMILY PSYCHIATRIC HISTORY:

**1. Any history of psychiatric problems, hospitalizations or suicide in family ? Y_______ N _______ Whom_________**

**2. Any history of substance abuse ? Y _______ N _____ Whom?______**

**3. Any history of Learning Disorders or ADD ? Y ___ N___ Whom?___**

**MEDICAL HISTORY: Height _____ Weight _________**

**Current Medical Problems:_________________**

**Current Medications: ______________________**

**Medication Allergies: ______________________**

**History of Substance Abuse: ________________**

**Any Deaths in Family under Age 50 of Cardiac Problems: ________**

**LEGAL HISTORY:**

**Are Parents: Married _________ Divorced ________ Separated _______**

**Who has Guardianship? ________________________**

**Any Legal Issues?______________________________**

**TRAUMA / ABUSE:**

**Any History of Trauma or Abuse? Y _____ N _______**

**STRESSORS:**

**Any Stressors or Triggers for Symptoms? _______________**

# 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: ______________________ 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.

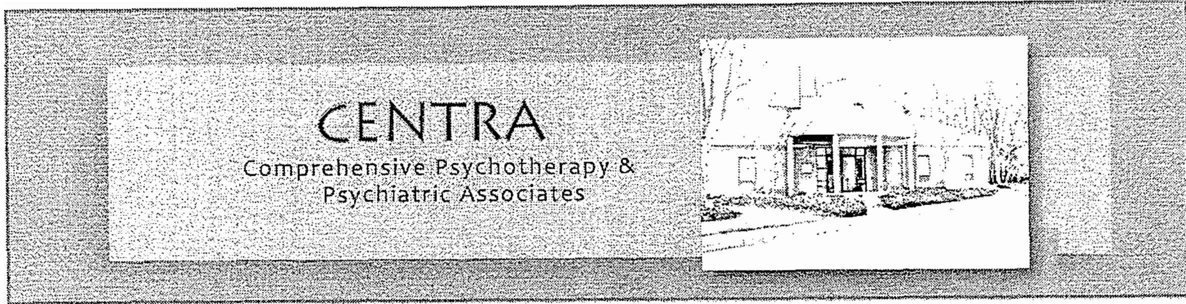
**Initial here______CONSENT TO EVALUATION AND TREATMENT**

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.**

Print Name: ______________________________ Date: ____________________

If signing for a minor please print their name: ______________________________________




# Patient Email Consent Form

Patient Name: ________________________________________________

Address: ________________________________________________

Provider Name: ________________________________________________

**Authorized Email Address**: ________________________________________________

Risk of Using Email-Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients
- Email senders can easily misaddress and email
- Backup copies of email may exist even after the sender or the recipient has deleted his/her copy
- Employers and on-line services have a right to inspect email transmitted through their systems
- Email can be intercepted, altered, forwarded, or used without authorization or detections
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment
- Emails may not be secure, including at Centra and therefore it is possible that the confidentiality of such communications may be breached by a third party
- Emails are discoverable in litigation and may be used as evidence in court

Conditions For The Use of Email – Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
- Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email
- All email will be printed and become a part of your permanent record. They will be released along with the rest of the record upon your authorization or when the doctor is otherwise legally required to do so. Office staff may receive and read your message
- The patient should not use email for communication regarding sensitive medical information
- Provider is not liable for breaches of confidentiality caused by the patient or any third party
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted

## To communicate by email, the patients shall

- Avoid use of his/her employer's computer
- Put the patient's name in the body of the email. Key in the topic (e.g., medical questions, billing questions) in the subject line
- Inform Provider of changes in his/her email address. Acknowledge any email received by the Provider
- Take precautions to preserve the confidentiality of email

## Steps that have been taken to protect the privacy of my email communication

- A password protected screen-saver on my provider's computer
- Staff has been educated on the appropriate use and protection of email
- Provider does not allow family members access to his personal work computer
- Will not forward patient email to third-parties without consent
- Will verify email addresses before sending messages

## Steps that I can take to protect my privacy

- Do not use work computer to communicate with my provider as employers have the right to inspect emails
- Do not use a shared email account to transmit messages
- Log out of your email account when you are away for your computer
- Carefully check the address before hitting sends to ensure it is sending to the intended receiver
- Avoid writing or reading emails on a mobile device, in a public place or Wi-Fi hotspots

## Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I do not receive a response from my provider in the time frame indicated __________________________ I will contact him/her by telephone if a response is needed. I will advise my provider in writing should I decide that I would prefer not to continue communicating via email. If I have any questions I may inquire with my treating Centra provider.

Make certain that your email is signed with your first and last name and to include your telephone number and date of birth to avoid possible mix up with patients with same or similar names.

Print Name ________________________________ Date ________________________________

CENTRA PC
Comprehensive Psychotherapy & Psychiatric Associates

5000 Sagemore Drive, Suite 205
Marlton, NJ 08053
(856) 983-3866 FAX: (856) 985-8148

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **PATIENT NAME** ______________________________ **DATE OF BIRTH** __________

2. **INFORMATION TO BE DISCLOSED AND RELEASED:**
   __________ All Records
   __________Only the following information:______________________________

3. **SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE**

**By signing my initials next to the specific category of highly confidential information, I am also expressly authorizing Centra PC to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above. I understand that Centra PC needs my specific authorization to release information pertaining to the items listed below.**

__________Mental/Behavioral Health Information
__________Drug and Alcohol Treatment/Dependency Information
*If you are authorizing the release of drug and alcohol records please note how much and what kind of information is to be disclosed:______________________________________________

________________________________________________________________

____HIV/AIDS Information
____Sexually Transmitted Disease Information
____Genetic Information
____Psychotherapy Notes
*(If you are authorizing the release of psychotherapy notes as well as other medical information, two separate forms must be filled out. The release of psychotherapy notes cannot be combined with the release of any other information.)

4. **PURPOSE OF RELEASE: I authorize Centra PC to release my health information for the following specific purpose:**

____At the request of the individual (i.e., the patient)
____To another healthcare provider
____For purposes of litigation

Pursuant to applicable federal and state law, I am aware of the privilege for confidential communication between a patient and a licensed mental health professional (e.g. psychiatrist, psychologist, therapist, counselor, social worker). I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

**PLEASE CHECK APPROPRIATE DISCLOSURE**

_____RELEASE

I, (Patient) ____________________________

Hereby authorize ______________________
PROVIDER

Of _____CENTRA____________ to
Release information to:

______________________________

______________________________

______________________________

______________________________
Release Date

_____OBTAIN

I, (Patient) ____________________

Hereby authorize__________________
PROVIDER

Of _________________________ to
Obtain information from:

______________________________

______________________________

______________________________

______________________________
Release Date

The information to be disclosed from your records is confidential and protected by state and federal law. I understand that once Centra PC releases my health information to the recipient listed on this Authorization, Centra PC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.
I have read and understand the terms of this Authorization and have had the opportunity to ask questions about my rights to access my health information.

**TERM/EXPIRATION:** This signed Authorization will expire in **12 months** unless an earlier date is indicated by you below. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide written revocation to Centra PC's office at the address listed above. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by Centra PC in reliance of this Authorization before it received my written notice of revocation.

I hereby authorize Centra PC to release/disclose the health information listed above for the purposes described in this Authorization.

**Print Patient Name:**_______________ **Date:** _______________

**Print Witness Name:** ___________________________ **Date:** ________________

**If the patient is a minor or otherwise unable to sign this Authorization, then obtain the signature of the authorized representative/individual below:**

Description of Authority: ________________________ Date: ________________

## NOTICE TO RECIPIENT OF INFORMATION

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials above, the following Notice applies to the information you have received pursuant to this information: Alcohol and Drug Abuse information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.