APS Advanced Psychological Specialists, LLC

NANCY JUST, PH.D., ABPP
DIPLOMATE IN CLINICAL PSYCHOLOGY
AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY
LICENSE 03382

General Information

Name: _____
Address: _____
_____
Phone: _____ O.K. to call? Yes__ No ___
_____ O.K. to call? Yes__ No ___
Email*: _____ O.K. to email? Yes__ No ___

Date of Birth: _____

Social Security #: _____

Marital Status: _____

If applicable:

Spouse's Name: _____

Children's Names and Ages:

_____

_____

_____

_____

* Note: Our email system is not HIPAA compliant and should only be used for appointment scheduling. Please do not disclose any personal information via email.

One Prospect Street, Suites 5-7, Ridgewood, NJ 07450
Phone: 201.447.2242 Fax: 201.447.4377

CONFIDENTIAL
INTAKE INFORMATION

Name_____ Today's Date_____

Place of Birth (City/State/Country)_____ Religion *(optional)*_____

Check One: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Years/Level of Education_____ Occupation_____

Employer Name_____

Emergency Contact Name & Phone #_____

Relationship to Patient_____

Nature of Assistance you are seeking (*please check one or more*):

Individual Therapy___ Couples Therapy____ Family Therapy___ Psychological Testing___ Hypnosis___ Biofeedback___ Other_____

How did you hear about this service?

Describe the difficulties or symptoms for which you are seeking assistance and when they began:

Describe any significant past or present medical or health-related conditions, including injuries or accidents. Are you currently receiving treatment for any of these conditions? If so, please explain:

Are you seeing – or have you ever seen – a psychologist, psychiatrist, counselor, social worker, psychotherapist, or received any type of personal or career counseling? If yes, when and what type of assistance have you received?

Have you ever been hospitalized for a medical or psychiatric problem? If yes, please describe where and when?

As far as you know, has anyone in your immediate or extended family ever received psychological/psychiatric assistance? If yes, please describe:

Have you or anyone in your family been identified as having had a learning difficulty or disability? If yes, please describe:

Please describe your current social functioning:

Are you working?

Do you have any supportive friends?

Do you experience your family as supportive?

Are you taking any medication? If yes, list name and dosage**:**

Do you use other non-prescription drugs or substances? If yes, please describe:

Do you drink alcohol? If yes, how much and how often?

Do you smoke? If yes, how many cigarettes per day?

Is there anything else you would like for us to know about you?

CONSENT FOR PSYCHOLOGICAL TESTING AND OFFICE POLICY STATEMENT

(Insurance)

Dr. Nancy Just (SI# 3382), Dr. Ellen Reicher (SI# 4164), Dr. Andrea Riskin (SI# 5043), Dr. Amanda Milleisen (SI# 4541), Dr. Patricia Woods (SI# 5730), and Dr. Kathleen Dumpert (SI# 6052) are Licensed Psychologists. Psychological testing sessions are charged at a rate of $330 per hour.

The practice charges for test administration time, scoring, interpreting, and writing. The number of sessions required for psychological testing varies. Your doctor will estimate the number of sessions necessary to administer the test battery but please accept that this is only an estimate influenced by multiple factors.

We typically do not participate in managed care or submit insurance claims. However, based on your unique circumstances, it is agreed that we will bill __Medicare_ for services rendered to you. You will be personally responsible for any uncovered charges, including deductibles, co-pays, and co-insurances, if applicable. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Psychological testing assumes that the person conducting the evaluation is unbiased and will give their professional opinion based on the information provided. The purpose of this assessment is for objective evaluation only- not for care, treatment or consultation. Therefore no doctor-patient relationship exists.

The testing results are completely confidential unless you sue another party on the grounds of emotional distress in which case the courts may mandate release of psychological records of all types including testing. Also, if you choose to submit your financial receipts to your insurance company for reimbursement, then your testing information will become part of your Personal Health Information and subject to the rules of HIPAA. Otherwise written reports are not generally available to nonprofessionals. However, a summary report will be available that can be forwarded by our office to any and all professionals you would like to notify. A parental summary, which differs from the professional report, can also be provided. A signed release is necessary for your file instructing us to release records to those professionals you name. By signing this paper, you are consenting to psychological testing for yourself or your minor child and agreeing to the fee and disclosure policies. It also serves as an acknowledgement that you have received the HIPAA Notice Form.

_____ _____

Person responsible for payment Date

_____ _____

Patient Date

Medicare Patients

(2021 - Testing)

Please be advised that our office does participate with traditional Medicare and accepts assignment as payment for services covered by Medicare. However, if you have an HMO Medicare plan such as Medicare Advantage or if any of your coverage involves Medicaid, we are out-of-network and unable to treat you. In order to protect you from uncovered medical bills, please notify us immediately if this is the case.

We will bill Medicare for all covered services. Medicare pays our office 80% of the approved amount. You are responsible for the remaining 20% of the charges. If you have a secondary plan, please be aware that your secondary plan may require a co-insurance payment. It is your responsibility to know what your insurance plan covers. By law, the patient is responsible for the entire Medicare fee, less payments from Medicare and their secondary carrier, if any. If a claim for service is denied by Medicare, you are responsible for payment in full.

The Medicare rates for the most common services provided by this office are listed below.

Service	Code	Fee	Co-Pay
Initial Interview	90791	$181.99	$36.40
Neurobehavioral Status Exam	96116	$ 99.06	$19.18
Psychological Testing - 1st hour	96130	$121.54	$24.31
Psychological Testing -additional hrs	96131	$ 91.66	$18.33
Psychological Testing by computer	96146	$ 2.64	$ 0.53
Neuropsychological Testing - 1st hour	96132	$136.38	$27.28
Neuropsychological Testing - additional hrs	96133	$107.20	$21.44
Neuropsych Test Admin+Score - 1st 30 min	96136	$ 49.55	$ 9.91
Neuropsych Test Admin+Score - additional 30 min	96137	$ 45.01	$ 9.00

By signing below, you are indicating that you understand and will cooperate with this policy.

Patient Signature: _____

Date: _____

Below is an assignment of benefits

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Psychological Specialists, LLC for any services furnished me. I authorize any holder of medical/psychological information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____

Date: _____

Payment is due at the time services are rendered

(2021 Testing)

This office participates with Traditional Medicare. However, if you have an HMO Medicare plan such as Medicare Advantage or if any of your coverage involves Medicaid, we are out-of-network and unable to treat you. In order to protect you from uncovered medical bills, please notify us immediately if this is the case.

Please note that sometimes a secondary carrier will pay the patient directly or may pay only part of the Medicare coinsurance, leaving a patient responsibility. By law, the patient is responsible for the entire Medicare fee, less payments from Medicare and their secondary carrier, if any. If a claim for service is denied by Medicare, you are responsible for payment in full.

Therefore, in order to avoid costly collection procedures, we request that all patients provide a back-up VISA or MasterCard number and authorization for use if payment is not received within 60 days of the date that services were rendered.

By signing this waiver, I give authorization for charges to be made to my credit card by Advanced Psychological Specialists, LLC *in the event that I fail to pay for services within 60 days of the date that they were rendered.*

Medicare Co-payment:

Initial Interview	90791	$36.40
Neurobehavioral Status Exam	96116	$19.81
Psychological Testing - 1st hour	96130	$24.31
Psychological Testing -additional hrs	96131	$18.33
Psychological Testing by computer	96146	$ 0.53
Neuropsychological Testing - 1st hour	96132	$27.28
Neuropsychological Testing - additional hrs	96133	$21.44
Neuropsych Test Admin+Score - 1st 30 min	96136	$ 9.91
Neuropsych Test Admin+Score - additional 30 min	96137	$ 9.00

Card Type: VISA MasterCard (Please circle one)

Card Number: _____

Expiration date: _____ V-Code: _____

Address where the bill for this credit card is received:

Name: _____

Address: _____

City, State: _____

Zip Code: _____

NEW JERSEY NOTICE FORM - HIPAA

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Please note that your psychologist may elect to keep a second set of records called referred to as "Psychotherapy Notes". These Notes are for the psychologist's use only and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your PHI. They may also include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your PHI. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else. In very rare circumstances, you Psychotherapy Notes may be released to third party payors with your explicit Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Division of Child Protection and Permanency.

- **Adult and Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

- **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- **Worker's Compensation**: If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, and you are an active patient, I will inform you of the changes in policy in person. If you have discontinued services, I will provide you with a revised notice upon request.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Nancy Just at 201.447.2242, Option #1.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Dr. Nancy Just at One Prospect Street, Suites 5-7 Ridgewood, NJ 07450.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 15, 2003.