Roberta Sloan LCSW, LLC
145 Witherspoon Street
Princeton, NJ 08542

Personal Demographic Information

Name:_____**Date:**_____

Address:_____

_____**Zip:**_____

Home Phone:_____**Cell Phone:**_____

Work Phone:_____**Email:**_____

Date of Birth:_____**Age:**_____**Marital Status:**_____

No. of Children_____

Soc. Sec. #_____**Occupation:**_____

Employer_____

Spouse/Significant Other's Name:_____

Spouse/Significant Other's Address (if different):_____

_____**Zip:**_____

Other Family Members / Persons Living at Home

Name	Date of Birth	Occupation/School

Emergency Contact Information

Name/Relationship:_____**Phone:**_____

Email_____

Primary Care Physician:_____**Phone:**_____

Insurance Information

Insurance Company/HMO:_____**Policy No.:**_____

Member ID#_____**Group#**_____

Subscriber:_____**Employer:**_____

Insurance Company Address:_____

_____**Zip:**_____

Insurance Phone:_____**Fax:**_____

Request for Counseling

Please briefly describe your reason(s) for requesting counseling at this time:

_____

_____

Referral Source:_____

Phone:_____**May I contact this person?**_____

Have you attended psychotherapy before?_____

Do you presently have any significant health problems?_____

If so, please explain_____

_____

Please list your medication(s):

_____

_____

The information above is correct to the best of my knowledge.

_____

Signature **Date**

Roberta Sloan LCSW, LLC
145 Witherspoon Street
Suite C-1
Princeton, NJ 08542
609-430-0450

Client and Therapist Statement of Understanding

Welcome to my practice. I am pleased to have the opportunity to work with you and hope the following information will answer some of the questions you may have regarding my services. Please feel free to ask questions at any time.

1. I understand that in case of emergency I may not be able to reach my therapist. In this situation, I agree not to harm myself or others in any way, and if necessary I will call or go to the nearest hospital emergency room. The **Mercer County Crisis Center** can be reached **at 609-396-HELP** twenty-four hours per day, seven days a week.
2. I also understand that the information concerning my treatment will be held in confidence by my therapist unless I give specific written consent in writing for the release of information. In the event of an emergency, the therapist is authorized to request a release of information necessary for the emergency treatment.
3. I also understand that the following types of information may be contained in patient files including identifying demographic information, the reason for referral, initial diagnosis, treatment plans, services provided during my treatment, treatment progress, and status at termination.
4. I also understand that a minimum of 24 hours notice is required for all cancellations. I understand that if an appointment is cancelled with less than 24 hours notice, I will be charged a $60.00 fee.
5. Co-pays are expected at the time of service. Roberta Sloan, LCSW, LLC will file claims to your insurance company on your behalf, and you are responsible for any payments make directly to you for my service, in addition to any co-pays, co-insurance or deductibles. Please notify me promptly of any change in your name, address, phone or insurance coverage.
6. In the event that your account is past due and payment has not been received within 90 calendar days, your account may be sent to a collection agency. Once your account is sent to collections, it will then accrue collection fees. You agree to reimburse us for the fees of any collection agency, and all costs, expenses, including reasonable attorney's fees we incur in such collection efforts. Collection fees will include service charges, interest at the legal rate, billing fees, rebilling fees and late charges.

Client/Parent or Guardian Signature_____

Date_____

Roberta Sloan LCSW, LLC
145 Witherspoon Street
Suite C-1
Princeton, NJ 08542
609-430-0450

Informed Consent for Treatment

I,_____ agree and consent to participate in behavioral health services offered by Roberta Sloan, LCSW, LLC, a behavioral health provider. I understand that I am consenting and agreeing only to those services that my clinician is qualified to provide given the scope of their license, certifications and training.

No promises can be made as to the results of treatment or any of the procedures provided by the clinician.

Federal law permits Roberta Sloan, LCSW, LLC to disclose information in the following circumstances without your permission: If you make a serious threat to harm yourself or another person, the law requires Roberta Sloan, LCSW, LLC to protect you or that other person. In addition, the law requires Roberta Sloan, LCSW, LLC to report any suspected child or elder abuse or neglect to the appropriate authorities.

If you have any questions regarding your treatment or our policies, please feel free to ask your therapist.

I hereby acknowledge that I have read (or have had read to me) the information above and I understand and give my consent to participate in treatment with Roberta Sloan, LCSW, LLC.

Signature of Patient Date

Signature of Clinician Obtaining Consent Date

Roberta Sloan LCSW, LLC
145 Witherspoon Street
Suite C-1
Princeton, NJ 08542
609-430-0450

Informed Consent for Treatment of a Minor Child

Child's Name:_____Date of Birth:_____

I,_____, agree and consent to Roberta Sloan, LCSW, LLC, a behavioral health provider, to provide treatment and therapy determined to be necessary or advisable for my child who is named above. I understand that I may stop treatment for my child at any time and that Roberta Sloan, LCSW, LLC may also stop treatment after discussion for the reasons for termination and referral to other professionals, if needed. I understand that I am consenting and agreeing only to those services that my clinician is qualified to provide given the scope of their license, certifications and training.

No promises can be made as to the results of treatment or any of the procedures provided by the clinician.

I realize that my child's treatment is confidential. Information may not be released without my written consent except a) in the event that an issue is raised which, in the therapist's judgement, would endanger my child's welfare, or b) if my child threatens to seriously harm himself/herself, or another person, or c) to report suspected child/elder abuse or neglect to the appropriate authorities.

My child's therapist may determine with my child that my participation is needed to treat a specific problem. In that event, I am prepared to participate in my child's treatment as requested.

If you have any questions regarding this treatment or our policies, please feel free to ask your therapist.

I hereby acknowledge that I have read (or have had read to me) the information above and I understand and give my consent for my child to participate in treatment with Roberta Sloan, LCSW, LLC.

Signature of Parent / Legal Guardian Date

Signature of Clinician Obtaining Consent Signature of Child (14 or older)

NOTICE OF PRIVACY PRACTICES

Roberta Sloan, LCSW, LLC
145 Witherspoon Street
Suite C-1
Princeton, NJ 08542

Effective Date: August 2016

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

How This Practice May Use or Disclose Your Health Information

This practice collects health information about you and stores it in a chart and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this practice, but the information in the record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We will use and disclose your protected health information to provide; coordination or manage your health care related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with

the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Payment. We use and disclose information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Appointment Reminders. We may use and disclose information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When This Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

Complaints

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Roberta Sloan (609) 430-0450 for further information about the complaint process.

Roberta Sloan, LCSW, LLC
145 Witherspoon Street
Suite C-1
Princeton, NJ 08542
Tel. 609-430-0450
Fax 609-430-0452

ACKNOWLEDGE OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below I am acknowledging that I have been provided with a copy of the notice of privacy practices. I have therefore been advised of how health information about me may be used and disclosed by the staff of Roberta Sloan, LCSW, LLC and how I may obtain access to and control of this information.

_____

Name

_____ _____

Signature Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) 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. RESERVED FOR NUCC USE
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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* complete items 9, 9a and 9d.	

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. 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. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								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. Rsvd for NUCC use
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.		