Marie E. Chece, MSW, LCSW
Licensed Clinical Social Worker
New Jersey License # 44SC05296300 / New York License # 070546-1
NPI # 1104007749
18 Kings Highway, Suite 104
Middletown, New Jersey 07748
Phone: 732-671-8700 - Fax: 732-671-8704

Email: mchece@verizon.net

## **NEW CLIENT INTAKE PACKET**

Please check that you have read, completed and signed the following forms included in this intake packet:
Client Communication Preferences – Form I
Client Financial Responsibility – Form II (2 pages)
Insurance Information – Form III
Initial Client Information – Form IV (2 pages)
Consent for Treatment – Form V
Client Rights – Form VI (2 pages)
Notice of Privacy Practices – Form VII (3pages)

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## **CLIENT FINANCIAL RESPONSIBILITY**

Client agrees to pay for all portions of services due in full **at the time services are provided by our office** and as outline below. You are required to present a valid insurance card at <u>every</u> visit and as needed throughout your care.

Prior to your first visit, you should have contacted your insurance carrier, if applicable, to understand your In-Network and Out-of-Network benefits for Mental Health/Behavioral Health/Substance Abuse.

## **Clients who do not have health insurance:**

Our Regular Fee Schedule payment is due at time services are rendered.

### **Clients with health insurance:**

#### In Network:

<u>Commercial Insurance Carriers</u>: We bill most insurance carriers for you if the insurance information paperwork we provide to you is completely filled out and returned to us promptly. **Any outstanding balances, copayments and deductibles are due prior to the start of your appointment.** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. We will not balance bill you for any amount greater than our agreed upon rate with the insurance carrier.

This office does not participate is in Original Medicare or Medicaid..

#### Out of Network:

#### I. If payment is assigned to this provider:

If prior arrangement has been made with the provider and the insurance information paperwork we provide to you is completely filled out and returned to us promptly, we will bill insurance for you. When an Out of Network deductible exists, **you pay our Regular Fee Schedule at the time of service**. Once payment has been received, we will submit a claim to your insurance carrier. This notifies the insurance company that your deductible, if one exists, should be reduced by what you pay at each visit. If and when the deductible is met, your plan will most likely switch to co-pay or coinsurance status and you are responsible for payment of your co-pay and/or coinsurance at the beginning of each visit. Since you have assigned payment to us we will accept the balance of the payment from the insurance carrier. We have and reserve the right to bill for the balance not paid by insurance and your co-pay.

### II. If payment is not assigned to this provider:

1. You pay our Regular Fee Schedule, **at the time services are rendered**. When payment is made in full, we will submit a claim to the insurance company on your behalf so that reimbursement will be made to you.

## Payment, Cancellation and Returned Check Policy

Payment for services, co-pays, deductibles and/or coinsurance payment is expected at the time services are rendered. Our office accepts the following payment methods: Cash, Personal Check, Credit Cards (Visa, MasterCard & AMEX)

**Billing Fee:** We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any **balance (regular fee, co-pay, deductible or co-insurance) that has to be billed will be assessed our billing fee.** For each month that your account has to be billed, a billing fee of \$2.50

#### **CLIENT FINANCIAL RESPONSIBILITY – continued**

OR 1.25% of any outstanding balance, **whichever is greater**, will be assessed to your account. If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, client agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

**24-Hour Cancellation policy**: We have 24-hour cancellation policy. If you are unable to keep your appointment for any reason, we request that you do so at least 24-hours in advance. You will be billed for cancelled or missed appointments that do not adhere to this policy.

**Returned checks** we assess a \$25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

## All Must Sign:

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILTY

The client is ultimately responsible for all fees for services. I have read, policy for payments of professional fees.	understood and agree to the above financial
Signature of responsible party (Client or Parent/Guardian)	Date
Sign only if <u>assigning insurance benefits</u> to the pr	rovider:
ASSIGNMENT AND RE	LEASE
I certify that I have insurance coverage with(Name of insurance)	e company)
coverage is primary. I agree to complete the Insurance Information for to correctly bill the insurance company. I hereby assign directly to Mar I understand that I am financially responsible for all <b>charges whether</b> Marie E. Chece, MSW, LCSW to release all information necessary to the benefits. I authorize the use of this signature on all insurance submission billing to my insurance company by Marie E. Chece, MSW, LCSW.	ie E. Chece, MSW, LCSW all insurance benefits. For not paid by insurance. I hereby authorize the insurance company to secure the payment of
Print Client Name	
Signature of responsible party (Client or Parent/Guardian)	Date
Relationship to Client	

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## **INSURANCE INFORMATION**

Chent Last Name		First Name	N11
Date of Birth		<u></u>	
□No Insurance – Se	elf Pay		
		Γ BE FILLED OUT COMPLETELY, RANCE IS BEING USED	
INSURANCE:		r insurance card(s) for our records. surance, please write NONE.	
PRIMARY Insurance Co	ompany	Phone #	
Plan Name & Billing Add	lress		
Subscriber		ID/Policy #	
Subscriber Date of Birth			
Effective Date of Coverage	ge:		
SECONDARY Insurance	ce Company	Phone	#
Plan Name & Billing Add	lress		
		ID/Policy #	
Subscriber Date of Birth			
RESPONSIBLE PART	<b>Y</b> Complete this section i	if you are not the client but are responsible for	the bill.
Responsible Party Name	:	SS#:	
Relationship to Client :			
Home Address		Apt#	
City	State	Zip	
Home Phone #		Work Phone #	
		Occupation	
for by my insurance as outli deductible, copayments, coi read and signed the Client F	rmation is correct. I understa ned in the Client Financial R nsurance or non-covered ser Financial Responsibility Polic	cation & Acknowledgement and that I am personally financially responsible Responsibility Policy. I am also responsible for any a rvices as may be required by my insurance plan. I als cy – Form III.  or Guardian acting on Client's behalf	pplicable annual
_	-	_	
Printed Name:			on – Form III - Page 1 of 1

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## **INITIAL CLIENT INFORMATION**

Last Name	Firs	st Name	Middle Initial
	<u></u>		SS#
		_	Apt#
			Zip
-			Phone#
Employer /Scho	ool Name		Occupation
Employer /Scho	ool Address		
			Zip
Relationship :			
Marital Status :	Married /Years	ILY INFORMA  Never Marrie  Widowed/Yea	d Separated
		IVING SITUAT	TION
# in Household:	Live Alone	Live wi	th Partner and/or Children
Live with Parent	ts/Other Family	Live wi	ith Roommate(s) Other
Group Home/Re	esidential Treatment Center	Homel	ess
Will Family or (	Others Participate in your Couns	seling?	
If so, who will	• •	o:	
-	1	Rel	lationship:
Name:		Rel	lationshin:

## INITIAL CLIENT INFORMATION CONTINUED

# **WORK / EDUCATION INFORMATION** Profession / Type of Work: Years in Current Field of Work /School: Years Formal Education: Work / Education Goals: MEDICAL AND OTHER INFORMATION Please List any Medical Problem You Are Being Treated For: **REFERRAL INFORMATION** How did you come to contact Marie E. Chece, MSW, LCSW . (Please Check One) Employee Assistance Program: Website: Telephone Directory: Juvenile Court Referral: \_\_\_\_\_ Psychiatrist Referral: Family / Friend Referral: School Referral: Hospital Referral: Other Therapist/Mental Health Agency: Other (Please List): Please verify that all of the information above is correct and sign the Certification: **My Certification** I certify that the above information is correct.

Signed\_

(Signature of client or person acting on client'sbehalf)

Printed Name :

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

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## **CONSENT FOR TREATMENT**

1.	I have been fully informed of my rights as a client of this office, the extent and limits o confidentiality in therapy, and the goals associated with therapy. With that knowledge, request and consent to receive therapy from Marie E. Chece, MSW, LCSW.
	Initials:
2.	I understand that Marie E. Chece, MSW, LCSW may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow Marie E. Chece, MSW, LCSW to provide some information about my therapy to a referring agency and/or an insurance company or other payor, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.
	Initials:
X 5	Signature of Client / Responsible Party / Parent or Guardian acting on Client's behalf Date
Pri	nted Name:

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## **CLIENT RIGHTS FORM**

1.	I understand that I have the right to decide not to enter therapy (although depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue. Initials:
2.	I understand that I have the right to a safe environment during therapy, free from physical, sexual and emotional abuse. Initials:
3.	I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress.  Initials:
4.	I understand that I have the right to information about the professional capabilities and limitations of any clinicians) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. Initials:
5.	I understand that I have the right to written information about fees, payment methods, copayments, length and duration of sessions and treatment.  Initials:
6.	I understand that my confidentiality will be protected, and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which <i>must</i> be disclosed. Initials:

/.	supervisors or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. Initials:
8.	I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. Initials:
9.	I understand that I have the right to request the release of my clinical information to any agency or person I choose. Initials:
Χ_	Signature of Client / Responsible Party /Parent or Guardian acting on Client's behalf Date
Pri	nted Name:

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## **Notice of Privacy Practices**

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

Client health records contain personal information about the client and their health. This information, which may identify the client and relates to their past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how the office of Marie E. Chece, MSW, LCSW may use and disclose the client PHI in accordance with applicable law. It also describes client rights regarding how they may gain access to and control their PHI.

We are required by law to maintain the privacy of PHI and to provide clients with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide clients with a copy of the revised Notice of Privacy Practices by sending a copy to them in the mail upon request, or providing one to the client at their next appointment.

#### YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding client personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to us, Marie E. Chece, MSW, LCSW, 107 Tindall Road  $2^{nd}$  Floor, Middletown, NJ 07748

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about client care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to the client. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you feel that the PHI that we have about the client is incorrect or incomplete, you may ask us to amend the information, although Marie E. Chece, MSW, LCSW is not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain amount of the disclosures that we make to client PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the
  use or disclosure of the PHI for treatment, payment, or health care operations. We are not required
  to agree to your request.

• **Right to Request Confidential Communication.** You have the right to request that Marie E. Chece, MSW, LCSW communicate with you about medical matters in a certain way or at a certain location.

#### YOUR RIGHTS REGARDING YOUR PHI continued

- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- Electronic Transactions Standards.

#### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT THE CLIENT:

**For Treatment.** The client's PHI may be used and disclosed by us for the purpose of providing, coordinating, or managing the client's health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** Marie E. Chece, MSW, LCSW may use or disclose PHI so that we can receive payment for the treatment of services provided to the client. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, the client's PHI in order to support our business activities including, but not limited to, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, and conducting or arranging for other business activities. For example, we may share the client's PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of the PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must make disclosures of the client's PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining Marie E. Chece, MSW, LCSW's compliance with requirements of the Privacy Rule.

# The following list of categories of uses and disclosures is permitted by HIPAA without an authorization.

Abuse and Neglect Judicial and Administrative Proceedings

**Emergencies** Law Enforcement

National Security Public Safety (Duty to Warn)

**Without Authorization.** Applicable law and ethical standards permit us to disclose information about the client without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the marriage and family licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**<u>Verbal Permission.</u>** We may use or disclose client information to family members that are directly involved in the treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

#### **COMPLAINTS**

If you believe that the client's privacy rights have been violated and wish to file a complaint with our office, you have the right to file a complaint in writing to us at: Marie E.Chece, MSW, LCSW,107 Tindall Road, 2<sup>nd</sup> Floor, Middletown, NJ 07748. You may also send a written complaint to the Secretary of Health and Human Services at: 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. You have specific rights under the privacy rule. We will not retaliate against the client for exercising your right to file a complaint.

I acknowledge that I have read and understand the above information:		
X		
Signature of Client / Responsible Party / Parent or Gu		
Printed Name:		
The effective date of this Notice	01/01/2014	