THERAPY CENTER *of* NEW YORK

***OFFICE USE*: COMPLETED REGISTRATION PACKETS MUST INCLUDE:**

1. PAGE 1 OF THE REGISTRATION FORM (COMPLETELY FILLED OUT AND SIGNED BY PROVIDER AND PATIENT) 2. PCP FORM (IF THE PT HAS A PCP) **3.COPY OF PTS INSURANCE CARD AND LICENSE 4. WELLNESS ASSENSMENTS FORMS (**IF APPLICABLE)

Behavioral health practitioners and providers are required to coordinate treatment with other behavioral health practitioners and providers, primary care physicians (PCPs), and other appropriate medical practitioners involved in a patients care. Please complete this form so it may be sent to the appropriate care provider so the best and most comprehensive care may be provided.

PATIENT NAME «Patient.FirstName» «Patient.LastName»	**DOB: «Patient.BirthDate»**

SECTION A. TREATING BEHAVIORAL HEALTH CLINICIAN/ FACILITY INFORMATION:

NAME: Therapy Center of New York		**PHONE:** 212-725-0192	**FAX:** 914-285-5723
ADDRESS: 34 South Broadway	**SUITE #:** 711	**CITY:** White Plains	**STATE:** NY **ZIP CODE:** 10601

SECTION B. PRIMARY CARE PYSICIAN/ MEDICAL CLINICIAN/ FACILITY INFORMATION:

NAME: «PrimaryCareProvider.FirstName»«PrimaryCareProvider.LastName»		**PHONE:** «PrimaryCareProvider.Phone»	**FAX:** «PrimaryCareProvider.Fax»
ADDRESS: «PrimaryCareProvider.Address1»		**SUITE/FLOOR:** «PrimaryCareProvider.Address2»	
CITY: «PrimaryCareProvider.City»	**STATE:** «PrimaryCareProvider.State»	**ZIP CODE:** «PrimaryCareProvider.ZipCode»	

SECTION C. PATIENT CLINICAL INFORMATION:

1. **This patient is being treated for the following behavioral health problem(s): (Circle all that apply)**

☐**ADHD/Behavior D/O** ☐**Substance Abuse** ☐**Psychotic D/O** ☐**Bipolar D/O**
☐**Depressive D/O** ☐**Anxiety D/O** ☐**Eating D/O** ☐**Adjustment D/O**
☐**Personality D/O** ☐**Other**

2. **This patient is taking the following prescribed psychotropic medication(s): (Circle all that apply)**

☐**Antidepressant- SSRI** ☐**Antidepressant-Tricyclic** ☐**Antidepressant-MAOI** ☐**Antidepressant-Wellbutrin** ☐**Lithium**
☐**Antipsychotic-Atypical** ☐**Antipsychotic-Typical** ☐**Stimulant** ☐**Anxiolytic** ☐**Anticonvulsant/Mood Stabilizer**
☐ **Other (indicate medication name):**

Expected length of treatment: ☐**<3 months** ☐**3-6 months** ☐**6-12 months** ☐**>1year**
Coordination of care issues/ other significant information impacting medical or behavioral health care:

DATE MAILED OR FAXED TO OTHER CLINICIAN/ FACILITY: _____
(A COMPLETED COPY OF THIS FORM IS TO BE PLACED IN THE PATIENTS MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above (SECTION A.) to release the information contained on this form to the practitioner/provider listed above (SECTION B.). I understand the reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

Patient Signature **Provider Signature**

I do not want to have my information shared with:

☐**My PCP/medical practitioner** ☐**My other behavioral health practitioner/provider** ☐**Not currently receiving services from a PCP**

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FOR PATIENTS RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

To the party receiving this information: this 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 disclosure 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.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

1.) Patient Emergency Treatment Plan and Agreement

The Therapy Center of New York is committed to providing the best treatment possible to all our patients. Everyday patients are treated and cared for without incident by mental health practitioners. The safety of every patient is valued by providers. In the event of an emergency it is vital to be prepared. In case of an emergency call 911 immediately. You may attempt to reach your psychiatrist/therapist at this time, but please do so AFTER calling 911, as your safety is of the utmost importance.

- When contacting your psychiatrist/therapist, please do so by phone, NEVER by text messaging or email, this will ensure timely and confidential communication.
- Having a proper emergency plan, knowing the actions that are necessary, and knowing that you have to carry out the plan, will most certainly ensure a safe and successful outcome.

2.) MISSED VISIT/CANCELLED APPOINTMENT POLICY

THERE WILL BE A FULL VISIT FEE (UP TO $250) FOR AN APPOINTMENT NOT CANCELLED PRIOR TO **2 BUSINESS DAYS.**

3.) PAYMENT IS DUE AT THE TIME OF YOUR VISIT

IT IS MY RESPONSIBILITY TO INFORM THE OFFICE AND MY DOCTOR OF ANY INSURANCE CHANGES OR UPDATES (INCLUDING COVERAGE TERMINATIONS, DENIALS, ETC). IF ANY SERVICE IS DENIED OR NOT COVERED BY MY INSURER, I WILL BE CHARGED OUR FULL VISIT FEE.

_____ _____

Patient Signature **Provider Signature**

4.) **AGREEMENT FOR PRE-ARRANGED CREDIT CARD PAYMENTS**

PATIENT NAME: «Patient.FirstName» «Patient.MiddleInitial». «Patient.LastName» SOCIAL SECURITY #: «Patient.SSN» DOB: «Patient.BirthDate»

I hereby authorize my doctor or designated assignee to initiate payment from my credit card account. The payment is for services provided to me and or for missed visit fees, co-pay fees and or insurance yearly deductible fees. This authorization to charge my credit card will remain in effect until my treatment is complete.

CREDIT CARD TYPE: ☐VISA ☐MASTERCARD ☐DISCOVER ☐AMERICAN EXPRESS

CREDIT CARD NUMBER:_____

EXPIRATION DATE:_____ SECURITY CODE:_____ ZIP CODE ASSOCIATED WITH CARD:_____

I waive my right to receive advance notice of the deduction associated with my mental health services and authorize the charge to my credit card. I acknowledge the above stipulations of this agreement and will abide by this agreement.

_____ _____

Patient Signature **Provider Signature**

Provider keep document in clinical chart. (Private and confidential)

THERAPY CENTER of NEW YORK

Therapy Center of New York

Patient Financial Information Sheet

Welcome! We are honored that you have entrusted Therapy Center of New York with your mental health needs and we are committed to providing you with the best care possible.

Healthcare benefits and coverage have become complex, so we have created this information sheet, to assist you in understanding your responsibilities as a patient of Therapy Center of New York.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please be aware that it is your responsibility to know your insurance rules or regulations. You should be knowledgeable of any deductibles, copayments and/or coinsurance. If you are not clear about your current health insurance policy benefits you should contact your insurer or employer to learn about the details of your benefits, out of pocket fees and coverage limits.

Insurance Coverage

It is important that you provide us with your current insurance plan at the time of your visit along with their corresponding cards. We will copy and scan into your electronic medical record. Should your insurance change please notify us immediately and provided updated information.

Our providers are members of many insurance plans but participation differs by provider, therefore, you must contact our billing office before first visit with any provider is scheduled. Our office will be able to provide you with a cost estimate, and inform you of your benefits, guide you through, if necessary your out of network benefits.

Contact Information

Please advise us anytime there is a change to your address, phone or other contact information.

Co-Payments/Co-Insurance/Deductibles

You are expected to pay your co-payments and any co-insurance and/or deductible amounts as advised by the billing office at the time of your appointment.

Payments

Payment is due at the time services are provided or upon receipt of a statement from our billing office. For your convenience, we accept payment is various forms, cash, check or credit card (American Express, MasterCard, Visa and Discover). If checks are returned for any reason there will be an additional fee of $15.00 add along with original charge. We do not accept traveler's checks.

Health Savings or Reimbursement Accounts (HSAs, HRAs, FSAs, MRAs, HFAs etc.)

If you have an HSA or similar account that can be used for payments, you must provide us details about this account in advance of your first session. These accounts work in one of three ways:

- You may be issued a credit card to use for payments
- Insurance claims may be paid directly from this account when the claim processes
- You may have to submit to your insurer/company to be reimbursed after you have separately paid for your service

In these cases, it is your responsibility to know what the available balance in the account is at the time of your visits, as well as be aware what constitutes an acceptable charge to this account (i.e. can you charge an out-of-network visit to this account). Your continued cooperation is necessary in this matter so that you do not accrue a balance (or) overpay for your services.

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Non-Medical Fees

Additional fees may apply to the following:

- Returned Checks -- $15.00
- Completion of disability or other forms -- $15.00
- Copying of medical records -- please inquire with the office
- Prescription requests outside of scheduled sessions -- $50.00

Missed Appointments

Office requires a 48-hour (**2 business day**) cancellation notice for most office visits. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice you will be charged $250.00.

Out of Network Providers

- You will be quoted an out-of-pocket fee before your appointment. This fee is estimated based on your out of network deductible, deductible accumulation, coinsurance or copayment as quoted by your insurance company.
- Payment of the quoted out-of-pocket fee is due at the time of each appointment.
- The out-of-pocket payments collected on your dates of service are estimates that are subject to change. The final amounts due are ultimately determined by your insurance firm after processing of your insurance claims, and you may be eligible either for a refund (see below) or required to provide a top-up payment.
- Depending on your insurance plan, your insurer may send payments directly to you. Please hand any check and explanation of benefits (EOB's) you receive to your provider during your next visit.

Refunds

Are issued (less any outstanding balances) when an overpayment has been identified. If you feel a refund is due and you have not received one, please contact our billing office 914-946-4700.

Failure to Pay

If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle balances. If any service is denied or not covered by your insurer, you will be responsible for paying a full visit fee for each denied service or session.

Policy and Fee Changes

These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

If you have any questions about these policies, feel free to ask any or our staff for more details.

_____

Patient Signature