1. Assignment of Benefit Release

I hereby agree to treatment and release of payment by my insurance plan to Tri-County Behavioral Care, LLC for services rendered. I understand that I am financially responsible to Tri-County Behavioral Care, LLC for charges which are not covered by my benefit plan.

DATE **SIGNATURE OF PARENT/GUARDIAN** **SIGNATURE OF PATIENT**

2. Missed Appointment Fee

I hereby acknowledge the 24-Hour Cancellation Fee as follows: you must notify the office within 24 hours if you have an appointment you are unable to keep. The missed appointment fee will be $25 for each appointment that is missed without 24 hours' notice given. If you miss 2 consecutive appointments, we cannot guarantee your standing appointment time will be held for you.

DATE **SIGNATURE OF PARENT/GUARDIAN** **SIGNATURE OF PATIENT**

3. Notice of Privacy Practices

I hereby acknowledge that I have read a copy of the Notice of Privacy Practices. If I request a written copy of this notice, then I will be given one. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Tri-County Behavioral Care, LLC at 973-691-3030.

DATE **SIGNATURE OF PARENT/GUARDIAN** **SIGNATURE OF PATIENT**

4. Written & Verbal Correspondence Fee

I hereby acknowledge that I will be charged $75 for any written or verbal communication requested of my therapist regarding my care. This includes, but is not limited to, correspondence with my: school, lawyer, doctor, other referral sources, references, DCPP work or investigator, insurance, disability, court.

DATE **SIGNATURE OF PARENT/GUARDIAN** **SIGNATURE OF PATIENT**

PATIENT INFORMATION FORM

Today's Date:	Referred By:

PATIENT INFORMATION

NAME:			
ADDRESS:		CITY:	
STATE:		ZIP CODE:	
CELL PHONE #:		Work #:	
E- MAIL ADDRESS:			
AGE:		DOB:	
SS#		MARITAL STATUS:	
NAME OF EMPLOYER:		OCCUPATION:	

PHYSICIAN INFORMATION

NAME OF PRIMARY PHYSICAN:	
CONTACT NUMBER:	
NAME OF PSYCHIATRIST:	
CONTACT NUMBER:	

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE:			
ID#:	GROUP#:		
NAME OF POLICY HOLDER:			
SS# OF POLICY HOLDER:		DOB OF POLICY HOLDER:	

EMERGENCY CONTACT

NAME:		RELATIONSHIP:	
PHONE #:		EMAIL:	

DATE	SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PATIENT

Authorization for Electronic Communication

As a convenience to me, I hereby request that Tri-County Behavioral Care communicate with me regarding my treatment, appointments and billing via electronic communications (e-mail or text message). I understand that this means Tri-County Behavioral Care and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Tri-County Behavioral Care shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Tri-County Behavioral Care to me. After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Tri-County Behavioral Care to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Tri-County Behavioral Care, I may revoke this authorization by providing written notice to:

Tri-County Behavioral Care
191 Woodport Road Suite 206
Sparta, NJ 07871
973-691-3030
intake@tcbllc.org

I agree that Tri-County Behavioral Care may communicate with me electronically unless and until I revoke this authorization by submitting notice to them in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties. I hereby authorize the transmission of my protected health information electronically as described above.

DATE	PATIENT NAME	SIGNATURE OF PATIENT