Hello Parents!

Enclosed please find our intake packet. This packet of forms was created for each parent to have a clear understanding of our services and expectations. In addition, our responsibilities as a facility are also outlined. Please review carefully and fill out entirely. We are asking that you return the packets via mail along with proof of diagnosis. Of course, if you have any questions regarding these forms please do not hesitate to contact me via phone or email. We also encourage you to make copies of the forms for your records. If you are unable we will gladly send back a copy to you.

Please send the packets back to:

First Children Services
ATTN: Adrienne Norman
330 South Ave
Fanwood, NJ 07023

Warmest Regards,

Adrienne Norman
Service Coordinator
908-654-2482 x 2445
anorman@firstchildrenservices.com

Client Insurance Questionnaire

Today's Date:

CLIENT INFO	
Client Name	Male ☐ Female☐
Date of Birth	
Social Security	
Diagnosis	
Date of Initial Diagnosis	
Parent Names	
Address	
Phone Number(s)	Home Cell
Email	
INSURANCE INFO	
Insurance Company	
Insurance Contact Info	
Policy Holder	
Policy Holder's DOB	
Group Number	
Member ID Number	
Plan Name	
Employer Name	

MISC INFO

How did you hear about us?

Current Therapies:

Birth History/ Health Concerns:

Concerns (described academic, cognitive, sensory processing, gross/fine motor, and self-help concerns):

FCS Complaint Procedure

If throughout the course of treatment, you have a question, complaint, or concern we encourage you to address it immediately. At First Children Services, we not only pride ourselves in outstanding clinical services but customer service as well. Our goal is to deliver therapy in a pleasant matter that suits the needs of your family. In the instance that you are unhappy with services or need to rectify an issue please use the proper channels to do so.

You must first contact the assigned clinician to your case than the Clinical Supervisor, Cindy Conley. If you need immediate assistance, it is best to utilize email communication. Contact information is below.

Clinical Supervisor
Cindy Conley
856-232-7325 x310 (office)
Cconley@firstchildrenservices.com

CONSUMER RESPONSIBILITY AGREEMENT

Your signature below forms a binding agreement between First Children Services, LLC (FCS) and the Consumer who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service. Consumers and Responsible Parties will be provided with a list of our charges. Charges are subject to periodic change without advanced notice.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. The person signing on behalf of the Consumer as the Responsible Party must:
Inform FCS of the current address and phone number for the patient and the responsible party.
Present all current insurance cards prior to each visit or as requested by FCS.
Must notify FCS of any Insurance changes within 5 days of receiving new Insurance Card.
Pay any required copay or deductible at the time of a visit.
Pay any additional amount owing within 30 days of receiving a statement from our office. *(When FCS receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy
If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or for any other reason, the consumer or the Consumer's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, FCS will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the consumer or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the consumer's Responsible Party, understands that FCS has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The consumer, or the consumer's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 12% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

Suspension of Service
Patient or patient's Responsible Party agrees and acknowledges the possible suspension of services if a balance owed is not settled in a timely manner. First Children Services will make every effort to collect dollars owed and work with patient or patient's responsible party to satisfy balances. First Children will notify the patient or patient's Responsible Party of dollars owed in writing and will give 15 days for the patient or patient's Responsible party to pay. If a balance is not paid by patient, patient's Responsible party or insurance carrier, First Children Services reserves the right to suspend or deny service to patient until balance is paid in full.

Staff Changes.
Should the consumer have any concerning issues with the assigned clinician please make sure to abide by the Complaint Procedure. If it should come to change in staff, we require a written 2 week notice before we change any clinician assigned to work with THE CONSUMER.

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Cancelations.

We understand situations happen where scheduled sessions must be cancelled or changed. FCS just requires the Consumer to notify FCS with a written notice within 24 hours of all cancellations or change of session times. FCS is required to inform THE CONSUMER with a written 24 hours' notice as well. Habitual cancellations will result in a fee.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_______________________________ _______________________________
Consumer Name (Please Print) **Consumer D.O.B**

_______________________________ _______________________________ ________________
Responsible Party (Please Print) **Responsible Party Signature** **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information about our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENTRIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

By signing below, you are stating that you understand the privacy terms on this page and that First Children Learning Services specifically follows the guidelines and laws under HIPAA.

______________________________ ______________________________

Consumer Name **Consumer D.O.B**

____________________________ __________________________________ _______

Responsible Party (Please Print) **Responsible Party Signature** **Date**

Emergency Contact Form

Consumer's Name:______________________ Date of Birth:___________________________

Address:_______________________________ Telephone Number:_____________________

Mother's Name/Legal Guardian: ___________________________________

Home Address:__________________________________Telephone Number:_______________________

Employer Name:________________________________Telephone Number:_______________________

Employer Address:____

Father's Name/Legal Guardian: ___________________________________

Home Address:__________________________________Telephone Number:_______________________

Employer Name:________________________________Telephone Number:_______________________

Employer Address:____

Emergency Contact Person(s)

Name and Relationship	Telephone Number
1)	1)
2)	2)
3)	3)
4)	4)

____ ___________________________

Signature of Parent Guardian Date