THERAPY CENTER *of* NEW YORK

PCP: ☐Y / ☐N

PATIENT REGISTRATION FORM

Care Provider Name: **Date:**

PATIENT INFORMATION:

LAST NAME:	FIRST NAME:		MI:
ADDRESS:	APT#:	CITY:	
STATE:	ZIP CODE:	MAIN PHONE:	PHONE TWO:
PHONE THREE:	BIRTH DATE:	SEX:	MARITAL STATUS: ☐M ☐S ☐D ☐OT
PATIENT SOCIAL SECURITY #:		PATIENT DRIVER LICENCE #:	
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE:	
EMERGENCY CONTACT RELATIONSHIP:			

DO YOU HAVE A PRIMARY CARE DOCTOR? ☐Yes ☐No (IF NO, DO NOT FILL OUT PCP FORM)

INSURANCE & GUARANTOR INFORMATION:

NAME OF INSURANCE CO:		PHONE#:
ID#:	GROUP #:	CO PAY:
GUARANTOR NAME:		RELATION TO INSURED:
ADDRESS (If different from your own):		
GUARANTOR'S SOCIAL SECURITY #:		BIRTH DATE:
EMPLOYER:		WORK #:

***PAYMENT IS DUE AT THE TIME OF EACH VISIT- CHECK, DEBIT AND CREDIT CARDS ARE ACCEPTED (VISA, MASTERCARD, DISCOVER, AND AMEX)**

***COMMUNICATE WITH YOUR DOCTOR OR THERAPIST ONLY DURING SESSION, PHONE EMERGENCIES ARE AN EXCEPTION. PHONE TEXTING OR E-MAILING IS NOT ALLOWED TO PROTECT YOUR PRIVACY.**

ACKNOWLEDGEMENT AND CONSENT:

I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for collection of an ***allowable fee, if my appointment is not cancelled 2 business days before the scheduled appointment, during my office hours.*** *Effective April 14,2003 the U.S. government regulators established a privacy rule; Health Information portability and accountability acts (HIPAA) GOVERNING PROTECTED PATIENT HEALTH INFORMATION. We are required by law to protect the privacy of health information that may reveal your identity, and provide you with this notice that describes the health information privacy practices of this practice. A copy of this notice will always be posted. By signing below, I acknowledge that I have been informed of the privacy practice of this practice, and I have been informed that I must check my co-pay, deductible, and any limits to my benefits with my insurance company. I have also been informed of my responsibility for all collection costs, attorney and court costs, and any additional processing fees, if my account becomes delinquent.*

_____

Patient Signature

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***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 ASSESSMENTS 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:	**DOB:**

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:		**PHONE:**	**FAX:**
ADDRESS:		**SUITE/FLOOR:**	
CITY:	**STATE:**	**ZIP CODE:**	

SECTION C. PATIENT CLINICAL INFORMATION:

1. This patient is being treated for the following behavioral health problem(s): (Check 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): (Check 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 PATIENT'S 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**

NAME ON CREDIT CARD: _____

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

Patient Financial Information – Rules & Requirements

Welcome! We are honored that you have entrusted Therapy Center of New York (TCNY) 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 TCNY.

How to Contact Us

Please contact TCNY if your address or other personal details have changed, and for any other administrative matters (see below for further details on common situations).

(1) E-mail us using the "Contact Us" form on the TCNY website: https://therapycenterofny.com/index.php/contact-us. Write your name, provider's name, and your situation or issue. We will respond within one (1) business day.

(2) Call us at (914) 946-4700 and if you need to leave a voicemail, say your name & provider, and state your situation or issue. We will call back within one (1) business day.

Know Your Insurance Benefits

Your health insurance policy is a contract between you and your health insurance company (or your employer, with the health insurer as administrative agent). Please be aware that it is your responsibility to know your insurance benefits, rules and 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 review your plan's details online (most insurers have web portals), contact your insurer, or speak with your employer to learn about your benefits and responsibilities (including coverage limits, deductibles, co-payments, co-insurance, or any other form of out-of-pocket payments).

Confirm TCNY Provider's Insurance Plan Participation

Our providers are in-network with many insurance plans, but plan participation differs by provider. Therefore, you must speak with TCNY before your first session to confirm any provider's plan participation.

Provide Copy of Insurance Card to TCNY

Please provide TCNY a copy of your current insurance card during your intake process with the TCNY administrative team (which is prior to your initial visit).

Send us a scanned copy or pictures of your insurance card (*front and back*), your name and your provider's name, using one of the following secure methods:

(1) Secure e-mail a copy to forms@therapycenterofny.com (*please note this e-mail address is non-reply and any text will not be read, and only attachments are received*), or

(2) Secure fax a copy to (914) 285-5723

TCNY Verifies Your Insurance Benefits

Our office will then verify your insurance benefits, provide you with a cost estimate and inform you of your benefits and responsibilities (and guide you through, if necessary, your out of network benefits and responsibilities).

Promptly Pay Co-Payments/Co-Insurance/Deductibles

You are required to pay your required co-payment, any co-insurance and/or any amount to be credited towards your deductible at the time of each appointment.

Use Flexible Payment Methods

Payment is due at the time services are provided (and) upon receipt of a statement from TCNY. For your convenience, we accept payment in various forms including credit card (American Express, MasterCard, Visa and Discover), debit card or check. If checks are returned for any reason, there will be an additional bounced check fee of $15.00 added. We do not accept traveler's checks.

THERAPY CENTER *of* NEW YORK

Patient Financial Information – Rules & Requirements (Continued)

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

If you plan to use an HSA or similar account for payments, you must provide us details about this account in advance of your first session. These accounts typically 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 each visit, as well as be aware of what constitutes an acceptable charge to this account (i.e., can you charge an out-of-network visit to this account, etc.). Your continued cooperation is necessary in this matter so that you do not accrue a balance (or) overpay for your services. If you are not sure how your HSA or similar account works, please speak with your company's human resources department.

Non-Medical Fees

Additional fees apply in the following situations:

- 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

Cancellation Policy & Missed Sessions

TCNY requires cancellation at least **2 business days** prior to a scheduled session (for example, if you have a 3:00pm session on Wednesday, then you must cancel by 3:00pm latest on Monday). Please note that weekends and federal holidays are not considered business days. If you miss your session, or do not cancel with the required minimum notice, you will be charged a $250.00 missed session fee.

Out-of-Network Claims

- 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, co-insurance or co-payment 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 plan 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. In such situations, TCNY will establish an out-of-pocket payment plan where you pay TCNY for services and then receive the insurance reimbursements directly.

Refunds

Refunds are issued (less any outstanding balances) when a patient overpayment situation has been identified. If you believe a refund is due, please contact the TCNY administrative team. An updated patient statement will be uploaded to your patient portal within one (1) business week (preferred method) or e-mailed (or) mailed at your specific request. Refunds are primarily issued after you have completed your course of care with a TCNY provider, or for services completed in the prior calendar year (as each calendar year may have different benefits and deductibles).

Failure to Pay

If you do not pay out-of-pocket amounts that you owe, 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.

THERAPY CENTER of NEW YORK

Patient Financial Information – Rules & Requirements (Continued)

Annual Insurance Verification (January – February)

The New Year can bring many changes to your deductible, copay, or coinsurance. In the months of January and February, insurance companies receive an overwhelming number of calls from doctors' offices. Insurance agents are often unable to quote benefits in a timely manner. Online verification methods that rely on insurer data feeds often provide outdated (or) incorrect information, as many online databases are not completely updated with information about new or updated plans until after February of each year. Therefore, please be patient with the TCNY administrative team during this time. We estimate a three (3) business day turnaround period for benefits verification during the first quarter of every New Year. We need to verify the insurance benefits for every patient returning for services each New Year.

New (or) Updated/Changed Insurance

TCNY does not want any insurance issues to interfere with your therapeutic relationship. Therefore, we ask that you cooperate with our office as best as possible whenever you have new insurance (or) become aware of any updates or changes to your existing insurance plan.

New Health Insurance

Whenever you receive new health insurance, please send us a scanned copy or pictures of your insurance card (*front and back*), your name and your provider's name, using one of the following methods:

(1) Secure e-mail a copy to forms@therapycenterofny.com (*please note this e-mail address is non-reply and any text will not be read, and only attachments are received*), or

(2) Secure fax a copy to (914) 285-5723

Updates or Changes to Existing Health Insurance

Whenever you become aware of any changes to your existing health insurance, please call or e-mail us using the following methods:

(1) E-mail us using the "Contact Us" form on the TCNY website: https://therapycenterofny.com/index.php/contact-us. Write your name, provider's name, and note that your existing insurance has been changed/updated.

(2) Call us at (914) 946-4700 and if you need to leave a voicemail, say your name & provider, and state that your existing insurance has changes or updates.

The administrative team will then verify your new or updated benefits with your insurer directly.

Important: any time TCNY is not aware of your current policy type, policy number, or benefits, can result in delayed billing (or) billing to the wrong insurer (or) incorrect billing that can often result in a denial of service from your insurance company. TCNY may not be privy to changes in your insurance plan until we receive denied claims. Any denial of service that cannot be successfully appealed will result in a full visit fee levied to you that is your responsibility to cover. In addition, any copay, co-insurance or deductible changes that result in a patient balance will be billed to you. The sooner you notify us of any new health insurance policy (or) any changes/updates to your existing plan, the sooner we can verify your benefits or rectify any issues.

Policy and Fee Changes

The policies included in this "Patient Financial Information – Rules & Requirements" document are subject to change and update. TCNY will keep you informed of any modifications or updates through the company website.

If you have any questions about these policies, please ask the TCNY administrative team for more details.

_____

Patient Signature