First Responder Status Attestation Form

Name of Patient _____

Name of First Responder _____

Date of Birth of First Responder _____

Insurance Plan ID Number _____

Status (check one): First Responder _____ Dependent of First Responder _____

If patient is a Dependent (check one) Spouse _____ Dependent Child _____

First Responder Policy Holder Employer Name _____

Badge or Identification Number _____I hereby attest that my responses and the information provided on this form are true, complete, and accurate, and I understand that this information may be used to verify my eligibility, or my dependent child's, eligibility to obtain treatment at the First Responder Partnership Health Center.

I understand that if it is later determined by my insurance carrier that I am not a first responder eligible to receive services at FRPHC that I, along with my dependents, may be subject to additional charges for treatments rendered.

PRINT NAME _____ Email: _____

SIGNATURE _____ DATE _____

Consent for Treatment

I, _____ am authorizing and hereby give my consent for the medical staff
(Patient/Guardian)
of Partnership Health Centers to examine and render care to _____.
(Name of Patient/Self)

This content shall remain in effect until further revoked in writing.
Your Privacy is of the utmost concern to us at Partnership Health Center and we strictly adhere to HIPAA regulations. These regulations do allow us to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voicemail message or a message with the person who answers the phone asking you to call us back. We do not leave Personal Health Information (PHI) unless authorized by you.

Please read the following statements and indicate your acknowledgment and/or authorization for each: (Please initial each line indicating understanding)

_____ I acknowledge that I have received/read a copy of the Center's HIPAA information.

_____ I authorize the staff of the Partnership Health Center to leave detailed messages only via voicemail on the phone number(s) provided. These messages may contain Personal Health Information (PHI) such as the results of tests done here.

_____ I authorize the staff of the Partnership Health Center to leave detailed messages containing PHI to any person answering the below indicated phone number(s):

Authorized Phone Number(s): _____ or _____.

Please indicate the people that you wish to authorize to pick up prescriptions and/or refills or other medical supplies for you AND the people you authorize with whom the Partnership Health Center staff (including providers) may discuss your medical condition(s). This will include PHI. Please circle YES or NO for each person.

Authorized Person(s)	Relationship to you	RX Pick Up		Discuss PHI	
_____	_____	YES	No	YES	No
_____	_____	YES	No	YES	No
_____	_____	YES	No	YES	No

Signature: _____ Date: _____

PATIENT: _____ DOB: _____

ADDRESS: _____

PHONE: (H) _____ (W)_____ (C) _____

PLEASE CIRCLE YOUR PREFERRED CONTACT NUMBER

EMAIL: (H) _____ (W)_____

For appointment reminders, please circle how you would like to receive messages. You may have more than one choice.

TEXT VOICE EMAIL

RACE: ☐Asian ☐African American ☐Caucasian ☐ American or Alaskan Indian

Other (specify): _____

ETHNICITY: LATINO/HISPANIC OR NON-LATINO/HISPANIC

PREFERRED LANGUAGE: _____

EMERGENCY CONTACT: _____

NAME PHONE RELATIONSHIP

PARENT/GUARDIAN/Guarantor: _____ PHONE: _____

(MINORS ONLY)

MOTHER'S MAIDEN NAME: _____

(MINORS ONLY)

PHARMACY NAME AND LOCATION: _____

OUTSIDE PRIMARY CARE PROVIDER: _____ PHONE: _____

INSURANCE INFORMATION:

MEMBER ID#_____ Subscriber DOB:_____

SUBSCRIBER: _____ Relationship to Subscriber: _____

Patient History Form

DATE:

NAME: **DATE OF BIRTH:**

PAST MEDICAL HISTORY

CONDITION:	DATE:	CONDITION:	DATE :
□ Anemia	_____	□ Hemorrhoids	_____
□ Arthritis	_____	□ Hepatitis	_____
□ Asthma	_____	□ HIV	_____
□ Bleeding Problems	_____	□ Kidney disease: _____	_____
□ Blood Pressure/Hypertension	_____	□ Kidney failure	_____
□ Broken Bones: _____	_____	□ Kidney stones (left/right/both)	_____
□ Cancer (type: _____)	_____	□ Lung disease	_____
□ Chest Pain	_____	□ Mental Health issues _____	_____
□ Chronic Pain (area:_____)	_____	□ Migraines	_____
□ Cirrhosis, liver	_____	□ Osteoporosis	_____
□ COPD, emphysema	_____	□ Seizure disorder	_____
□ Diabetes: Type 1__ or Type 2 __	_____	□ Sinusitis, recurrent	_____
□ Dementia	_____	□ Skin disorder: _____	_____
□ Depression	_____	□ Stroke (deficit:_____)	_____
□ Ear Infections, recurrent	_____	□ Sexually transmitted diseases	_____
□ Enlarged heart	_____	□ Thyroid disorder: _____	_____
□ Glaucoma	_____	□ Urinary Symptoms	_____
□ Heartburn	_____	□ Venous Clots (DVT)	_____
□ Heart disease: _____	_____	□ Other: _____	_____
□ Heart failure (Echo? _____)	_____	□ Other:_____	_____
WOMEN ONLY:			
□ Menstrual problems/changes	_____	□ Abnormal pap	_____
□ Ovarian cysts	_____	□ Breast lump/pain	_____
MEN ONLY:			
□ Prostate issues	_____	□ Erectile dysfunction	_____

HOSPITALIZATIONS AND ER VISITS:

□ I have never been hospitalized □ I have not been to the ER

DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____

SURGERIES

☐ I have never had surgery

DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____

MEDICATIONS

☐ I take no medications

MEDICATION	DOSE	# TIMES TAKEN/DAY	CONDITION

ALLERGIES

MEDICATIONS: ☐ I have no medication allergies

Medication	Reaction

FOOD: ☐ I have no food allergies

Food	Reaction

ENVIRONMENTAL EXPOSURES: ☐ I have no environmental allergies

Exposure	Reaction

IMMUNIZATIONS

Immunization:	Date:	Immunization:	Date:	Immunization:	Date:
□ Chicken pox	_____	□ Influenza	_____	□ Tdap or □ Td	_____
□ Gardasil (HPV)	_____	□ Meningitis	_____	□ Other:	_____
□ Hepatitis A	_____	□ MMR	_____	□ Other:	_____
□ Hepatitis B	_____	□ Pneumovax	_____	□ Prevnar (adult)	_____
□ Zostavax	_____				

FAMILY HISTORY

List any relatives who have the following conditions:

Diabetes _____ High blood Pressure_____
Heart attack_____ Breast cancer_____
Stroke_____ Colon cancer_____
Tuberculosis_____ High cholesterol_____
Alzheimer's_____ Melanoma_____
Prostate cancer_____ Ovarian Cancer_____
Celiac disease_____ Sickle cell/Thalassemia_____

LIFESTYLE HISTORY

Marital Status: □ Single □Married □Widowed □Divorced
□Significant other (male) □Significant Other (female)

Exercise:
How often? □ never □ 1-2 times/week □ 3-5 times/week □ nearly every day
How many average minutes each time: □ < 15 □ 15-30 □ 30-60 □ > 60
What exercise to you do? _____

Diet:
Do you drink caffeine? □ Yes □ No
If yes, how many cups/cans per day: □ 1-2 □ 3-4 □ 5-6 □ 7 or more
What do you drink? _____
Check any foods on the list that you AVOID:
□ Dairy □ Salt □ Sugar □ Gluten □ Meat □ Eggs □ Carbs □ Fats(oils) □ Other: _____
How often do you eat "fast food"?
□ Never □ Less than once a month □ Less than weekly □ Weekly □ > Once a week □ Daily

Are you sexually active? □ Yes □ No
Do you (or have you ever) used recreational drugs (cocaine, heroin, marijuana, etc…) □ Yes □ No
Do you have a lot of stress in your life? □ Yes □ No
Do you feel depressed? □ Yes □ No
Any travel outside of the U.S? □ Yes □ No If Yes, where and when? _____
_____
Any exposure to toxic chemicals or substance? □ Yes □ No What? _____
Current Occupation: _____

Review of Symptoms

Do you have any of the following currently or have had in the last 2 weeks: (check all that apply)

□ Change in appetite
□ Nausea/Vomiting
□ Change in bowels
□ Painful Urination
□ Testicular Pain or swelling
□ Breast pain or lump
□ Fevers/chills
□ Feeling faint or almost passing out
□ Constant sinus drainage
□ Trouble swallowing
□ Swollen legs
□ Joint swelling or pain
□ Mood swings
□ Headaches
□ Changes in hair or hair loss
□ Palpitations
□ Constipation
□ Blood in Stool
□ Weight loss
□ Frequent or urgent urination
□ Vaginal discharge and/or odor
□ Bruise or bleed easily
□ Swollen glands
□ Changes in vision
□ Chronic cough
□ Short of breath lying down
□ Trouble sleeping
□ Feeling too hot or too cold
□ Head injury
□ Tingling or numbness
□ Skin rash
□ Dizziness
□ Diarrhea
□ Abdominal Pain
□ Weight Gain
□ Blood in Urine
□ Nipple discharge
□ Night Sweats
□ General body aches
□ Frequent nosebleeds
□ Recurrent gum/tooth infections
□ Short of breath with exertion
□ Muscle weakness or pain
□ Memory loss
□ Loss of consciousness
□ Panic attacks or feeling anxious
□ Chest pain
□ Coughing up blood

Health Maintenance

Please provide dates for the following:
Last Physical: _____
Cholesterol Test: _____
Colonoscopy: _____ Normal? □ Yes □ No
EKG: _____
Bone Density: _____
Complete Blood Count: _____
Thyroid Test: _____
Chest X-ray: _____

Women Only:
Last Pap Smear: _____ Normal? □ Yes □ No
Last Mammogram: _____ Normal? □ Yes □ No
Pregnancies: _____
How many children do you have? _____
Last Menstrual Period _____

Men Only:
Prostate Exam: _____

FIRST RESPONDER PARTNERSHIP HEALTH CENTER
HEALTH MAINTENANCE FORM

How often do you have a drink containing alcohol? Circle answer:

Never (0) Monthly or less (1) 2-4 times/month (2) 2-3 times/week (3) 4 or more times/week (4)

How many drinks do you have on a typical day when you are drinking?
Circle the answer: 1-2 (0) 3-4 (1) 5-6 (2) 7-9 (3) 10 or more (4)

How often have you had 6 or more drinks on one occasion in the last year?
Circle answer: never (0) monthly or less (1) monthly (2) weekly (3) daily or almost daily (4)

Smoking Status:
_____Current every day smoker packs per day ____/packs per year_____
_____Current some day smoker packs per day ____/Packs per year_____
_____Former Smoker Year you quit smoking _____ packs per day_____
_____Never a smoker

Do you use vapes or E-Cigarettes? YES NO
Quantity/frequency of Vaping/E-Cigarettes _____
Current tobacco use (chewing/cigar/pipe) YES NO
Current smoker duration _____

When was your last colonoscopy? _____

FOR FEMALES ONLY
When was your last Pap smear? _____
When was your last mammogram? _____
How many pregnancies have you had? _____
How many live births? _____
How many miscarriages? _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

RELEASE OF MEDICAL RECORDS

PATIENT DETAILS

Patient Name: _____ Date of Birth: _____

Patient Address: _____

RELEASE OF MEDICAL RECORDS CONSENT

I **hereby authorize the release of my medical records from your facility (including medical claim information and/or clinical information) to:**

Partnership Health Centers

Please fax any and all medical records for the past year to your Partnership Health Center including but not limited to:

~History & Physical Notes
~Physicians/Nurses Office Notes
~Last Hospital Visit
~Bloodwork Results/Imaging Reports

Please provide practice name and contact info so that we may facilitate on your behalf:

Practice/Provider: _____

Address: _____

_____

Tel: _____ Fax: _____

I understand that these records will be used for the purpose of my health care, including care coordination services at Partnership Health Center.

Additionally, if applicable I am requesting the cooperation of all of my health care professionals in facilitating the coordination of my health care through the Care Coordination program. This record release consent will remain in effect for so long as I am employed by _____ and under the care of Partnership Health Center.

Signature: _____ Date: _____
(Parent/Guardian signature if under age 18)

Print Name: _____

NOTICE OF PRIVACY PRACTICES

Date printed:03/18/22

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

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclosure your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. **For health care operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds: or when ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

D. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your requires, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care Operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you
$10 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Integrity Health LLC: 76 West Gilbert Street, Red Bank, New Jersey 07701; Tel: (609) 606-7000 Fax: (609) 228-6107.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on May 14, 2018.

Tele-therapy Consent and Policy Form

This document outlines Partnership Health Centers' office policies related to use of Tele-therapy as either a substitute for or in addition to in office, face to face visits. It will help you to understand the variety of issues involved in telehealth, including but not limited to: Benefits, Risks and Limitations; Method of Delivery of Tele-Therapy; Assessment and Reassessment of Progress and Effectiveness; Procedures When Interruption of Services Occurs; Emergency Procedures/Verification of Location; Appropriate Environment/Conduct/Privacy/Confidentiality, Telephone Sessions

If you have any questions about anything within this document, Partnership Health Centers encourages you to discuss them with your licensed clinician at any time. As new ethical guidelines and laws are developed this policy may be amended and you will be notified of any policy changes both verbally and in written form.

Benefits, Risks and Limitations of Tele-Therapy
Under most circumstances, tele-therapy, AKA remote counseling/psychotherapy, should not be viewed as a substitute for face-to-face counseling; however, certain circumstances may arise that lead us to determine that short or longer term tele-therapy is clinically indicated and in your best interest.

Typically, remote counseling is used as an adjunctive treatment option in the event that our licensed clinician or you, the client, are unable to travel to the office. These situations include, but are not limited to, illness, inclement weather, or some emergency situations such as a natural disaster.

Inherent in the use of tele-therapy are certain risks and limitations, including, but not limited to:

- Lack of visual and/or audio cues, leading to misunderstanding/misinterpretation;
- Delayed responses;
- Technology failures that lead to disruptions and decrease the quality of the service;
- Unsuitability for clients experiencing a psychological crisis, acute psychosis, or suicidal or homicidal thoughts;
- Confidentiality breaches.

Research supports tele-therapy as an effective psychotherapy tool. It has shown to have similar results as traditional face-to-face, in office therapies. But, as with in-office treatment, it varies depending on the person accessing services. There are many potential benefits to engaging in remote psychotherapy services including but not limited to:

- **Flexibility and Convenience**: With tele-therapy, it's almost always in the comfort of your own home or office. It can reduce scheduling barriers and reduce the wait time for an appointment;
- **Privacy**: when special safeguards are adhered to (see below), it can be as secure as face-to-face sessions;
- **Efficiency**: It eliminates the need to get in the car, on the train or ride the bus to your appointment. As long as you are in a private and secure space, your commute can be steps away;
- **Accessibility**: Remote psychotherapy allows for those who would otherwise be unable to receive mental health services. Such as individuals who experience transportation barriers due to illness, physical limitations, child-care challenges, lack transportation options, or reside in rural or remote areas. Additionally, tele-therapy may also be a useful temporary substitute when the weather creates dangerous travelling conditions;

Assessment and Reassessment of Progress and Effectiveness
As with face-to-face, in office treatment, your remote psychotherapy treatment plan will be individualized and will be assessed/reassessed on a regular basis. We need to carefully monitor the effectiveness of the treatment platform and evaluate your overall progress. As with your face-to-face, in office visits, our licensed clinician may ask you to complete brief questionnaires/assessments about your thoughts, feelings and behaviors. Homework may be assigned on a more regular basis in order to supplement the work we are doing remotely.

Method of Delivery of Tele-Therapy
Tele-therapy with Partnership Health Center will be provided through a HIPAA Compliant, synchronous, video-conferencing platform. There will be no fee for clients to utilize these platforms.

Logging in
You will be sent a link. In some cases, you may need to click on the camera, microphone, and audio icon to set up your camera, microphone, and speakers. Most computers, tablets and smartphones will automatically detect its internal camera, microphone, and speaker. If there is any difficulty you can call your clinician who will guide you through the steps to connect to them. We suggest that you sign on at least 5 minutes prior to your session start time. You are responsible for initiating the connection with our licensed clinician at the time of your session.

Testing out your device, internet browser, etc.
We recommend you attempt to connect your device ahead of time to get familiar with how your device operates and to avoid unnecessary time spent with your clinician. Your licensed clinician will be available to connect with you ahead of time during your first session, so if you have any difficulty, it can be addressed then. There are multiple videos and articles to help you better understand each videoconferencing platform. You can also test your device by following the directions on each platform.

Before our first scheduled session using a videoconferencing platform, we will schedule a time (5 minutes or less) to briefly test it out in the event that we need to troubleshoot any technical issues. In the past, these are the issues that have arisen and what is recommended to rectify them:

- Internet browser connectivity issues
- Choppy or frozen screen: find a location that is close to your internet router. You may need to find a space that consistently gets good reception;
- Low/no volume: make sure that your volume button on your device is turned on and all the way up;
- No picture: your camera access is turned off.

Procedures When Interruption of Services Occurs
In the event that technology fails or a disruption or decrease in the quality of the session occurs while we are engaged in remote psychotherapy, we may decide that it is best to discontinue the telehealth session. If this occurs, we agree that you can contact your clinician and re-start the session. If your clinician doesn't hear from you, he/she will contact you by telephone to discuss options. Therefore, it is recommended that you always have a phone available to you and that I am advised of the best number to reach you at the outset of each session.
These options may include:

- ending the treatment session;
- trying to re-connect to the video-conferencing platform;
- continuing the session by phone;
- MEET IN PERSON.

Emergency Procedures/Verification of Location
Your safety is our primary concern. As such, your licensed clinician will want to know the location (address) in which you are during our session. Your licensed clinician will ask you to provide this information each time, but if your clinician neglects to ask you, we request that you inform your clinician of your current location. We are requiring this information in the event that your clinician has reason to believe that you are experiencing an emergency and they need to assist you in receiving immediate, life-saving care. In addition to providing your licensed clinician with your location at the outset of each remote session, you agree to provide your clinician with the name and contact information of a person whom your clinician is permitted to contact in the case that they have reason to believe you are at imminent risk.

Depending on your clinician's clinical, professional assessment of risk, your clinician may be required to verify that your emergency contact person is able and willing to go to your location in the event of an emergency, and if necessary, call 911 and/or transport you to a hospital. In addition, your clinician may assess, and therefore require, that you create a safe environment at your location during the entire time that you are in treatment with your licensed clinician. This may mean disposing of all firearms and excess medication from your location.

Appropriate Environment/Conduct/Privacy/Confidentiality
Clients and Partnership Health Center both agree to:

- Avoid using mind altering substances during/prior to session;
- Dress appropriately;
- Conduct the session in an suitable room, such as a kitchen, living room or office (not a bedroom);
- Be in a private, confidential and secure location (closed door) in order to preserve confidentiality;
- Refrain from having any other individuals present in in the room or online while the remote session is being conducted;
- Not having anyone else participate in the session unless it has been previously agreed upon prior to the start of the session;
- Not conduct other activities while in engaged in a remote psychotherapy session, such as driving, cooking, texting or working;
- Not audio or video record sessions without first obtaining Partnership Health Center's explicit, written consent;
- Client to be located in the state of New Jersey;
- Clinician to be licensed in the state of New Jersey;
- If you are living in a long-term care facility, please find a private place to meet with your clinician away from roommates, staff, and other personnel. In the event that you can't find a private setting or are unable to access one, a headset is recommended. Please discuss this with your clinician and they will attempt to make such arrangements;
- In circumstances where you are unable to have privacy, you are free to communicate to your clinician that you want the session either stopped or completely terminated.

Telephone Sessions
The telephone is considered an asynchronous telecommunication platform and therefore does not meet the criteria for tele-therapy. Please discuss the option of telephone sessions with your clinician if you do not feel comfortable with or are unable to participate in tele-therapy using a computer, phone etc.

CONCLUSION
Thank you for taking the time to review Partnership Health Center's **Use/Consent of Tele-therapy Policy**
If you have questions or concerns about any of these policies and procedures or how our video-conferencing platforms work, we encourageyou to bring them to your clinician's attention so that you can discuss them.

Use of Tele-therapy Policy signature page

Date: _____
Client Name: _____
Parent/Guardian Name: _____
Client DOB: _____

On_____I received a copy of the document entitled Use of Tele-therapy Policy for Partnership Health Center. I have been given an opportunity to review this document and my questions about this policy have been answered.

_____ _____
Signature of Client 1 Date

_____
Please Print Name

_____ _____
Signature of Parent, Guardian or Personal Representative 1* Date

_____
Please Print Name

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____
CLINICIAN'S SIGNATURE DATE

Patient Financial Policy

Thank you for choosing the team of ***First Responder Partnership Health Center*** ***(FRPHC)*** as your health care provider. We are committed to providing you with quality medical care and excellent customer service. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to contact our billing department at 609.249.7073, ext. 5019. Please take time to carefully review the following information and return this form with your signature and today's date.

INSURANCE

It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will make a copy for our records. We will request a copy at each office visit thereafter. Please bring your insurance card to each visit at FRPHC.

Your insurance policy is a contract between you and your insurance company. Pursuant to contractual obligations, we file all your claims for you. If you have any questions or concerns, we are happy to assist you.

CO-PAYS

- For all First Responders and their dependents covered under the New Jersey State Health Benefit Plan, there is **no co-pay due**.
- A copay may apply for all other insurance carriers depending on your individual plan.
- If we do not participate with your insurance carrier (out of network), the following fees will apply and be collected at the time of service:

    - Physician/Allied health provider visit New - $200
    - Physician/Allied health provider visit Follow-up - $100
    - Physical Therapy visit - $67
    - Chiropractor visit - $100
    - Behavioral Health Counsellor Visit - $75

UN-PAID/OUTSTANDING BALANCES

- If there is an outstanding balance for any reason, we ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office.
- If your insurance company (other than NJSHBP) has not paid the balance in full, you may receive a statement notifying you of the amount due.
- You may call our billing office at 609.249.7073, ext. 5019 to set up payment arrangements if necessary.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**. If you happen to miss 3 or more appointments without contacting us, we may charge a missed appointment fee of $25.

CREDIT BALANCES

From time to time, you may accrue a credit balance on your account. If your account reflects a credit balance of $5.00 or less, FRPHC's policy is to carry the balance on the account until your next appointment or your transfer from the organization.

If your account reflects a credit balance of more than $5.00, First Responders will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive refund. All refunds are reviewed and processed every 45 days, if you make a request please allow ample time for review of your entire account and processing through our accounting department. You can contact our billing department at 609.249.7073, ext. 5019 regarding any credits on your account.

MEDICAL RECORD COPIES

Please reference the details below regarding the cost associate with the copying of a patient's medical record according to the New Jersey State Administrative Code. All patients have access to their medical records through our patient portal. Utilization of this portal is free and is encouraged. However, if you should choose to have us print paper copies of your records, the following fees will apply.

If you request a copy of your medical records, you will be charged the following fees:

a) With respect to data recorded on paper, the following amounts apply:
   i) $1.00 per page or $200.00 for the entire record, whichever is less.
   ii) If the record requested is less than 10 pages, a flat fee of $10.00 will be charged.

b) With respect to X-rays (or any other material within a patient's record which cannot be routinely copied or duplicated on a commercial photocopy machine):
   i) $15.00 per printed image or $30.00 per compact disc (CD), or digital video disc (DVD)
   ii) An administrative fee of the lesser of $10.00 or 10% of the cost of the reproduction.

We are pleased to have the opportunity to meet your health care needs and encourage you to contact our billing department 609.249.7073, ext. 5019 with any questions or concerns.

I have read the First Responder Partnership Health Center's (FRPHC) Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

Patient Name (please print)	Patient Date of Birth
Patient/Responsible Party Signature	Date