North Jersey Health & Wellness

Comprehensive and Preventative Health Care

4 Forest Ave, Paramus, NJ 07652
46 N Central Ave, Ramsey, NJ 07446
171 Ridgedale Ave, Suite N, Florham Park, NJ 07932
241 Maple Ave, Red Bank, NJ 07701
Phone: 201-588-3491 Fax: 201-357-4222

Date: _____

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____**(M)** _____(H)

SS#: _____ **Occupation:** _____ Employer: _____

Sexual Identity: ____ Male / ____ Female / _____ Other **Sexual Orientation:** _____

Marital Status: _____ If Married, Name: _____ / Phone: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Primary Care Provider: _____ **Location:** _____ **Phone:** _____

INSURANCE INFORMATION

Do you have Insurance? _____ YES / _____ NO Insurance Name: _____

Policy ID #: _____ Group #: _____

Emergency Contact(s)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ Relationship: _____ Phone: _____

Reason for Appointment: _____

How did you hear about us? _____ If referred, by who? _____

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PATIENT INFORMATION *(CONTINUED)*

Height: _____ **Weight:** _____ **Allergies:** ____ YES / ____ NO

If yes, please list all allergies: _____

Tobacco Use: _____ YES / _____ NO / _____ FORMER

If yes, how much/how often? _____

Alcohol Use: _____ YES / _____ NO / _____ FORMER

If yes, how often/how much? _____

Surgical History

_ _ tonsils __ appendix __ gallbladder _ _ wisdom teeth _ _ knee __ _ c-section
_ _ hernia _ __ shoulder _ _ other_____

Procedure(s) and Date(s): _____

_____

Current Medical Issues

Current Medications: _____

___ hypertension ___high cholesterol ___asthma __ _ head injury ___ _ tremor
___ _ heart d/o ___ migraines ___ lyme disease __ _ thyroid d/o __ __ dementia
___ _ blood clotting ___ multiple sclerosis ___ HIV __ _ hepatitis ___ _ bleeding d/o
___ _ auto-immune d/o ___ diabetes ___ erectile d/f ___ kidney d/o ___ BPH
__ _ lyme disease ___ arthritis(ra) ___ parkinsons ___ heart attack ____ concussion

Other(s): _____

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FAMILY HISTORY

Mental Health / substance abuse: _____ YES / _____ NO

If yes, specify who: _____

Medical Issues? (who / what) _____

SOCIAL HISTORY

Who lives at home with you (name, age, relationship to you):

_____

Highest level of Education Completed: _____ **Do you have:** ___ IEPs / ___ 504s **Do you have developmental delays?** _____ YES / _____ NO

If yes, what? _____

PAST PSYCHIATRIC HISTORY

Age of onset mental health symptoms: _____

Previous treatment with psychiatrist/psychotherapy: _____

Inpatient admissions / Detox: _____

Past psychiatric medications: _____

History of self-harming? _____ YES / _____ NO

Previous suicide attempts? _____ YES / _____ NO

History of Eating Disorder _____ YES / _____ NO If yes, what? _____

Abuse History? _____ YES / _____ NO If yes, ____ physical / ____ sexual / _____ emotional

Substance Abuse History _____ YES / _____ NO If yes, what? _____

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TREATMENT CONSENT FORM

* Billing & Payments
* Treatment Fees
* Client Bill of Rights
* Out Of Network Practice Status
* Sessions
* Referrals
* Medications / Receiving medication history
* Legal Fees / Professional Services
* Summary of Medicare Acceptance
* Contacting Us
* Insurance Reimbursements
* COVID- 19 Informed consent
* Confidentiality
* Client Grievances
* Privacy Practices
* Introduction / Psychotherapy
* Cancellation / No-Show Policy
* No Harm Contract / Video Surveillance
* Injections / Testosterone Replacement
* Consent to receive appointment reminders (voice/text)
* Professional Records
* Assignment & Release of Benefits
* Tele-medicine
* Minor Child Treatment Consent

Your signature below indicates you have read the treatment consent and are aware you can receive a copy if requested, which contains information on clinical services, professional fees, cancellation and no show policies, billing and payments, insurance reimbursement, authorization and release of benefits, contacting us, professional records, no harm contract, client bill of rights, client grievances, policies, confidentiality, Medicare acceptance, appointment reminders, out of network status, video surveillance, referrals, minor child consent, and medications/testosterone replacement / injections, and you agree to abide by its terms during our professional relationship. For minor children, please initial the line below in addition to signing this form.

Name of Patient (printed):

_____

Date: _____

Signature of Patient (or legal guardian)**: X** _____

PROVIDER: North Jersey Health and Wellness / Derek Berberian MD

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ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I certify that I, and/or my dependents, have insurance coverage with: _____ and assign directly to NORTH JERSEY HEALTH AND WELLNESS all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature or the signature of my dependents on all submissions.

I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interest to North Jersey Health & Wellness, hereafter referred to as "the medical provider" to pursue and obtain payment from the above named Insurance carrier. I, assign to the medical provider, all my rights and benefits under the Insurance contract for payment for services rendered to me. I, the patient, do hereby understand and acknowledge that if I refuse to comply with reasonable requests of the Insurance carrier, any denied claims I will be held responsible for same. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other Insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) five days of the receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier or from me if I fail to pay. To prevent the Insurance carrier and/or the vendor designed by the Insurance carrier from refusing to accept my Assignment or submitting challenge to my Assignment as being Invalid, I execute this Special Power of Attorney to appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name. This Assignment serves as a limited retained agreement between me and the chosen attorney by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. The above-named Care Center/Physician(s) may use my health information and may disclose such information to the above-named Insurance Company (companies) and their agents for the purpose of obtaining payment for related services.

I also acknowledge that if I do not provide benefit checks received by me within 30 days of the confirmation of checks being sent to me, my credit / debit card provided on intake will automatically be charged for the visit.

Patient Name: **Signature of Patient (or legal guardian):**

_____ _____

Date: _____

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CREDIT OR DEBIT CARD TO KEEP ON FILE

Please be advised that a credit/debit card is **required** regardless of insurance coverage/method of preferred payment due to the office's late cancellation / no show policy.

Patient's Name: _____ Date of Birth: _____

Type of Card: _____ VISA _____ MC _____ AMEX _____ DISCOVER _____ OTHER

Name on Card: _____

Card Numbers: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

How would you like your receipt? _____ TEXT _____ EMAIL

Cell Phone: _____ Email Address: _____

_____

Signature

All payments are collected at time of service and are non-refundable. Signature on receipt is legally binding that service was rendered and patient waives right to dispute charges with their bank. Any disputes must take place within 7 days or patient waives their right to dispute charges. A $75 fee will be charged for administrative time spent on any credit card disputes. All services are non-refundable. If there is a question regarding a charge, contact the office for resolution to avoid a fee for administrative time spent responding to dispute. I acknowledge if I dispute a claim NJHW has the right to release my PHI to square for the purposes of disputing the claim. I have authorized North Jersey Health and Wellness to charge my card or any future credit cards provided for services rendered / fees incurred. I understand all charges are non-refundable and that I'm charged at the time of service. I understand my card will be stored for future transactions. I acknowledge there may be a processing fee involved for credit card charges.

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Acknowledgement of Procedure for Scheduling and Medication Refills

Please read each statement and sign below.

I am responsible for calling the office to schedule my follow-up appointments. _X_

I am responsible for giving a 24-hour notice to cancel/reschedule my appointment. If I do not cancel in advance or if I do not show for my appointment, I agree to pay a fee of $100.00-$180.00. _X_

I understand that my medications will **not** be refilled without speaking to my provider during my scheduled appointment. _X_

I understand that I am responsible for informing the office staff of any changes to my insurance and/or payment information prior to scheduling an appointment. _X_

I understand (if applicable) that my medicinal marijuana script will only be renewed during my scheduled appointment with Derek Berberian. _X_

I understand and agree to the terms listed above.

Name of Patient: _____

Signature of Patient (or Parent/Guardian)**:** _____

Date: _____

Failure to comply with these procedures may result with discharge from the practice and liability for all balances owed.