SAGE WELLNESS CENTER

CHILD INFORMATION FORM

CLIENT INFORMATION:

Child's Legal Name: _____ Prefers to be called: _____

DOB: _____ SS#: _____ Gender: _____

Home Address: _____ City/State: _____ Zip: _____

Mom Name: _____ Mom Phone #: _____ Mom Email: _____

Dad Name: _____ Dad Phone #: _____ Dad Email: _____

Parents: □ Married □ Separated □ Divorced

Primary Contact: □ Mom □ Dad **(this will be the contact listed for all communication regarding appointments, billing, follow up, etc)**

PRIMARY INSURANCE INFORMATION:
Name: _____ ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Relationship:_____

SECONDARY INSURANCE INFORMATION:
Name: _____ ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Relationship:_____

ALLERGIES: _____

CURRENT MEDICATIONS (Both psychiatric and general health):

Name	Dose	Frequency

TREATMENT GOALS:
Please describe the concern(s) for which you are currently seeking treatment for your child:

_____

What are your <u>hopes</u> regarding your child's therapy?_____

_____

Do your child have an **Advanced Directive for Mental Health?** **YES NO**
If no, would you like information on completing one? **YES NO**
If yes, please provide us a copy to incorporate in your treatment plan.

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age, or If deceased date, age, & cause of death		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Child Lives with: _____ If separated or divorced, how old was child when separation occurred?

Who has legal custody? _____ Describe visitation schedule if any: _____

Siblings:

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No Amount: _____ Alcohol? Yes No Amount: _____ Drug intake? Yes No Amount: _____

Length of pregnancy?____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

Did you child meet the developmental milestones at/around the appropriate age? If no, please explain: _____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____Public or Private (circle one)?

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

Are you satisfied with your child's educational program? Yes No Please explain: _____

Home/Family Life

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith-based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

What are your child's strengths (things he/she is good at)? _____

What are your child's areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

HEALTH & MENTAL HEALTH INFORMATION

Primary Care Physician Name & #: _____Psychiatrist Name & # (if any): _____

Date of last complete physical exam (mo/year): _____

Does your child currently have any medical problems? _____

Has your child ever been treated for any of the following? If so please circle and describe:

Head injury	Tubes placed	Seizures	Allergies
Loss of consciousness	Vision problems	Asthma	Cancer
Frequent ear infections	Headaches	Elevated lead levels	Surgeries
Hearing problems	Meningitis	Slow/fast growth	Other:_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

Do you suspect or know if your child drinks alcohol or uses recreational drugs? If so, what kind & how often? _____

_____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family have a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

Condition	Please Circle	Family Member	Condition	Please Circle	Family Member
Anxiety (general)	Yes/No		Substance Abuse	Yes/No	
Obsessive Compulsive Behavior	Yes/No		Domestic Violence	Yes/No	
Depression	Yes/No		Eating Disorders	Yes/No	
Suicide Attempts	Yes/No		Obesity	Yes/No	
Bipolar/Manic Depressive	Yes/No		Schizophrenia	Yes/No	
Alcoholism	Yes/No		Counseling or Psychotherapy	Yes/No	
			Psychiatric hospitalization	Yes/No	

Your Child's Symptoms or Problems

How much are <u>each</u> of the following areas currently a problem for your child?

	Not at all 1	A little 2	Somewhat 3	Considerably 4	Terribly 5
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

Completed by: _____ Date: _____

Signature: _____

PROFESSIONAL DISCLOSURE AND TREATMENT CONSENT

CLIENT LEGAL NAME: _____ DOB: _____

General Information

I understand that I am voluntarily agreeing to services at Sage Wellness Center, LLC. I understand that I can revoke this consent at any time.

Client Consent:

I understand that by engaging in outpatient therapy or other services at Sage Wellness Center, there are advantages/benefits and disadvantages/risks associated with treatment. While any particular outcome cannot be guaranteed, you are likely to gain the most benefit if you are committed to the process and attend regularly. Questions and comments are welcomed about our work together and the counseling process. As part of your treatment, you may be prescribed medication that might be beneficial for your treatment. Your provider will review the potential benefits, risks and side effects of taking such medications. You understand that not all benefits, risks and side effects may be discussed. Should you choose to refuse to take any medication suggested by provider, please advise your provider so that they can discuss the potential risks with you.

You understand that Sage Wellness Center is not an emergency mental health provider. In the event of a crisis, please call your provider. If they cannot be reached, or in the event of an emergency, please call 911or visit the emergency room of the hospital nearest to you.

If at any time, a determination is made that that treatment at Sage Wellness Center is no longer clinically appropriate and/or if the practice does not offer the necessary treatments, we will offer you referrals to other providers as appropriate.

Communication and Your Privacy:

By signing this form, you consent to the use and disclosure of your protected health information (PHI) by Sage Wellness Center LLC and its business associates for the purposes of treatment, payment and health care operations. Sage Wellness Center will maintain your PHI in accordance with the practices in our Notices of Privacy Practices which also describes your rights with respect to the use and disclosure of your PHI.

By my signature below, I acknowledge that I have read and received a copy of the Notice of Privacy Practices for Sage Wellness Center LLC. In addition, it has been explained in detail the client rights and grievance policies and I have received a copy for review and have been given the opportunity to ask questions.

Based on my understanding of the benefits and risks of the services and choices that are available to me, by my signature below, I consent and authorize Sage Wellness Center to provide outpatient treatment to me and/or my child for whom I am legal guardian. I understand that my signature is required to receive treatment at Sage Wellness Center and that I may revoke this consent in writing at any time except to the extent that Sage Wellness has to take action reliant upon this consent.

CLIENT/LEGAL REPRESENATIVE SIGNATURE _____
DATE _____

SAGE WELLNESS CENTER

1901 Lakewood Road, Suite 200, Toms River, NJ 08755
(P) 732-505-4612 · (F) 732-505-4671

CONSENT FOR TELEHEALTH CONSULTATION

CLIENT LEGAL NAME: _____ CLIENT DOB: _____

1. I understand that telehealth is the delivery of health services using interactive technologies (use of audio, video or other electronic communications) between a health care provider and a client/patient who are not in the same physical location.
2. Client understands that they must be in an appropriate/private setting in order for provider to allow telehealth appointment to continue.
3. I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
4. I understand how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
5. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing within the state of NJ.
6. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
7. I give consent for my provider/clinician to sign treatment plan on my behalf.
8. I understand that telehealth may or may not be as effective as in-person therapy and results cannot be guaranteed or assured.
9. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

EMERGENCY PROCEDURES FOR TELEHEALTH

1. I understand that if I'm having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, my health care provider may determine that I need a higher level of care and telehealth services are not appropriate.
2. I agree to provide an emergency contact person to my healthcare provider that can be contacted for a life-threatening emergency only.
3. I agree to inform my health care provider each time we meet online the following information: the address I am located at, a phone number to reach me, a phone number of the nearest police department, if I am in a place where I can speak confidentially, if I expect any interruptions, or if I am experiencing any suicidal or homicidal thoughts.
4. I agree to inform my healthcare provider of the nearest mental health hospital to my primary location that I prefer to go to in the event of a mental health emergency (located where I will typically be during a telehealth session).
5. If the session is interrupted for any reason, such as technological failure, and I am having an emergency, I agree to call 911, or go to my nearest emergency room. I agree to call my healthcare provider back after I have called or obtained emergency services.

TECHNOLOGICAL DIFFICULTIES

1. If there is a technological failure and I am unable to reach provider at time of session, client agrees to contact the office at 732-505-4612 or by email at office@sagewellnessctr.com at time of appointment (within 10 minutes) to alert office of appointment issues. I understand that if I am unable to speak with someone, I will leave a message.
2. If the session is interrupted and I am not having an emergency, I agree to disconnect from the session and wait two (2) minutes for my health care provider to recontact me via the Telehealth platform we agreed to conduct therapy. If I do not receive a call back within two (2) minutes, then I will contact my health care provider using the phone number: 732 505-4612, ext 0. I understand that I am unable to speak with someone, I will leave a message. I may also email the office at office@sagewellnessctr.com.

RECORDS

1. I understand and agree that telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. This includes video recording, screenshots, audio recording, etc.
2. I understand that my healthcare provider will maintain a record of our session in the same way they maintain records of in-person sessions in accordance with their policies.

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TREATMENT OF MINORS

1. I understand that I may need to assist the minor with setting up for the therapy session with instructions from my healthcare provider.
2. I agree to be available (if needed) during the session for any concerns that may arise including technical difficulties. If I am not available, I understand that another designated responsible adult needs to be available to address any concerns.
3. I agree to provide the minor with a private space without any interruptions to ensure confidentiality. This excludes emergencies and concerns regarding the minor's safety.
4. I understand that there is limited research on telehealth with minors and it may not be as effective as in-person therapy and results cannot be guaranteed or assured.
5. I understand that my healthcare provider may determine at any time that the minor is not appropriate for telehealth and may terminate telehealth services if it is in the best interest of the minor. My healthcare provider will provide me with referrals and/or other alternatives for mental health care including in-person appointments if available.

FINANCIAL POLICY

1. All telehealth fees are the same as in-person appointments. I understand that all copays are due at time of session and I agree to keep my credit card information on file per signed authorization form for any and all applicable out of pocket expenses.
2. If Sage is unable to bill for services due to technological failures once the appointment has started, I understand that I will not be responsible for any charges.
3. If client is unable to reach provider at time of session, client agrees to contact the office at 732-505-4612 or by email at office@sagewellnessctr.com at time of appointment (within 10 minutes) to alert office of appointment issues. I understand that if I am unable to speak with someone, I will leave a message. If no attempt to contact office can be verified, appointment will be considered a NO CALL NO SHOW and the associated fee will be applied to account.
4. If provider determines that client is not in an appropriate/private setting (public place, driving, etc.) to conduct the telehealth appointment, the appointment will be canceled and client will be charged the missed appointment fee. This is at sole discretion of the provider.
5. I understand that my health insurance may not cover telehealth services. I understand if I wish to continue telehealth services these services may be a private pay expense.

CONSENT TO USE DOXY.ME TELEHEALTH

Doxy.me is the technology service Sage Wellness Center will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through telehealth, Doxy.me does not provide any medical or healthcare services or advice including, but are not limited to, emergency or urgent medical services.
3. Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in Doxy.me– or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Doxy.me
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me and I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That this agreement is intended as a supplement to the general informed consent that I agreed to at the outset of services and it does not amend any of the terms of that agreement.

CLIENT/LEGAL REPRESEANTIVE SIGNATURE: _____
DATE: _____

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OFFICE POLICIES

CLIENT LEGAL NAME: _____ DOB: _____

- No smoking of any type (including vaping) is permitted on the building grounds or inside the building.
- No drugs or alcohol is permitted on the building grounds or inside the building.
- It is the policy of Sage Wellness Center that weapons including but not limited to guns, knives and explosives are forbidden at Sage Wellness Center including but not limited to those who have a license to carry a firearm.
- All employees, clients and guests will follow the current CDC guidelines as they relate to the prevention and treatment of Covid-19 and/or any other infectious disease.
- In case of a building emergency that requires evacuation, please use the nearest stairwell and proceed to the "Magnolia Commons" sign for a head count of all persons.
- Per building management policies, only ADA certified animals are permitted. All other animals, including ESA are prohibited from entering the building.
- <u>APPOINTMENT POLICY (eff 1/2025, subject to change at any time)</u>:
  - If you are unable to keep an appointment, please call at least 24 hours in advance to avoid being charged a late cancel or NCNS fee. $75 for therapy visits $150 for medication management visits. If the office is closed or no oone is available to take your call, leave a message. Sage Wellness Center reserves the right to terminate services for those clients who late cancel and/or miss three (3) or more visits for non-compliance with treatment.
  - There is a 10-minute grace period for all appointments. After 10 minutes your appointment may be canceled and you will be charged the applicable late cancel fee.
  - It is at the sole discretion of the provider to allow the appointment after the grace period.
  - Appointments will not be rescheduled until no call no show/late cancel is paid.
  - Appointment reminders are done via text only. Phone call reminders will not be made unless you have contacted the office to arrange this.
  - Appointment reminders are a courtesy ONLY. Your appointment is your responsibility whether or not you receive a reminder.
- All scheduled appointments whether they are in-person or telehealth are considered billable appointments and any and all applicable copays/deductibles will be the responsibility of the client.
- The ability to have telehealth appointments is at provider discretion. All copays must be paid prior to telehealth appointment.

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- You understand that if you fail to make a follow up medication management appointment in a timely manner (upon leaving the office or shortly thereafter), you risk not receiving a prescription refill until you are seen again. Provider reservices the right not to send refills until he/she sees client for follow up visit.

- Requests for refills must be made AT LEAST 48 hours in advance (not including weekends or holidays).

- Requests for written correspondence and/or medical records must be submitted with the "Authorization to Release Protected Health Information" to either 732-505-4671 or to office@sagewellnessctr.com. Upon payment of any applicable cost associated with such request and/or any outstanding balance on client account, requests will be fulfilled within NJAC 13:35-6.5. Providers have the sole discretion to require the client to attend treatment for an extended period time before any requests for form completion/clearance, etc will be completed (i.e. FMLA, disability, etc). The cost for medical records shall not exceed $1.00/page or $100 for the entire records, whichever is less.

My signature below represents that I have read, understand and agree to the above policies and acknowledge that failure to follow any of these policies may result in termination of services.

CLIENT/LEGAL REPRESENTATIVE SIGNATURE: _____

DATE: _____

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FINANCIAL RESPONSIBILTY FORM

CLIENT LEGAL NAME: _____ DOB: _____

Client / Guarantor responsibility:
We will check your benefits; however, we cannot be responsible for any erroneous benefit information provided to us by the insurance company including but not limited to network status, deductible and/or copay amounts, etc. It is your responsibility to check and understand your insurance benefits. We will bill your insurance as a courtesy. However, the client is responsible for all fees regardless of insurance coverage. You are responsible for any payment due for services rendered. Payment for all professional services rendered is the responsibility of the client, parent, or guardian. Payment for all services, or the expected client responsibility, is due when services are rendered. Payment of coinsurance and deductible is done based on reasonable estimate. If additional funds are required after the insurance claim has been processed, any balance will be billed to the client. If the insurance company fails to process claims within 30 days from the date of service, the balance due may be collected from the client. If insurance issues arise, it is the responsibility of the client to resolve the issue. A client's insurance policy is a contract between the client and the insurance carrier. Sage Wellness Center is not a party to that contract and cannot act as mediator with the carrier or employer. If a referral is required for treatment, it is the responsibility of the client to obtain the referral and present it at the time of treatment. In the event that the client is treated without proper referral or authorization as required by the insurance carrier, the client assumes responsibility for payment of all fees at the time of service.
All scheduled appointments whether they are in-person or telehealth are considered billable appointments and any and all applicable copays/deductibles will be the responsibility of the client.

****We do not bill workers compensation or accident policies (auto, personal, etc) for coverage. If insurance claim is denied for an open claim, you will be billed privately for the service.*****

Assignment of Insurance Benefits and Financial Responsibility Guarantee:
I hereby assign any and all insurance benefits due and payable to me/us by my insurance policy for services rendered to Sage Wellness Center, LLC. I further understand and agree that this assignment is non-revocable. I authorize Sage Wellness Center, LLC to release to my insurance carrier the paperwork necessary for processing payments related to any claims related to my treatment. I authorize any holder of my personal medical information to release to Sage Wellness Center, LLC**.** any required information needed to determine insurance benefits. If required by my insurance carrier, I agree to provide all pertinent information necessary for completion of my treatment plan(s) and for the issuance of timely payments. I understand that I personally guarantee to be financially responsible to pay Sage Wellness Center, LLC for any and all charges not covered by this assignment. All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements. If my insurance carrier sends me payment for services incurred in this office, I understand that I am required to deliver the full payment to Sage Wellness Center, LLC immediately upon receipt.

Cancellation Policy:
I further understand and agree to abide by the cancellation policy of Sage Wellness Center, LLC. Any cancellation or re-scheduling request must be made with at least 24 hours' notice. If the office is closed or no one is available to take your call, please leave a message. Failure to provide at least 24 hours' notice will result in a missed appointment fee of $75.00 individual session for therapy and $150 for medication management sessions which is not reimbursable under insurance. I hereby agree to pay the missed appointment fee under these circumstances and understand this fee is considered payable immediately. I understand that these fees are subject to change at any time. Clients may not be scheduled for further sessions until any outstanding balances are paid in full. This is at the sole discretion of Sage Wellness Center LLC.

My signature below represents that I have read, understand and agree to the above terms and understand these terms can be changed or updated at any time by the provider.

CLIENT/LEGAL REPRESENTAIVE SIGNATURE: _____

DATE: _____

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Please sign and complete this form to authorize Sage Wellness Center, LLC to apply charges to your credit card listed below.

By signing this form you give Sage Wellness Center, LLC permission and authorization for all of the following:

- Permission for my credit card to be charged for co-payments/charges due for services rendered
- Permission for my credit card to be charged missed appointments/NCNS if not canceled 24 hours in advance.
- Permission for my credit card to be charged for balances greater than 30 days from date of service including any and all balances not covered by insurance.
- Permission to keep this information on file for future transactions on my account

---

Please complete the information below:

I, _____ (cardholder name) for _____ (client name) authorize Sage Wellness Center, LLC to charge my credit card account indicated below for payments as outlined above.

Billing address _____ Phone #_____

City, State, Zip _____ Email _____

Account Type:	Debit VISA MasterCard Discover AMEX
Cardholder Name	_____
Account Number	_____
Expiration Date	_____ CVV _____

CARDHOLDER SIGNATURE _____ DATE _____

I authorize the above name business to charge the credit card indicated on this authorization form according to the terms and conditions above. This payment authorization is for goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company; so long as the transactions correspond to the terms indicated on this form.

Credit card payments may incur a processing fee of 3%.

SAGE WELLNESS CENTER

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CLIENT DISCLOSURE AUTHORIZATION

CLIENT LEGAL NAME: _____ **DOB:** _____

☐ DO NOT RELEASE INFORMATION TO ANYONE

OR

I authorize the release of my information including but not limited to the diagnosis, records and claims information to the following additional individuals:

Primary Care Physician (PCP) name & address: _____

Phone: _____ Fax: _____

Therapist name & address (IF NOT AT SAGE WELLNESS CENTER):

_____

Phone: _____ Fax: _____

Psychiatrist name & address (IF NOT AT SAGE WELLNESS CENTER):

_____

Phone: _____ Fax: _____

I authorize the release of my information including but not limited to the diagnosis, records and claims information to the following additional individuals:

Spouse: _____

Children: _____ _____

Parent/Guardian: _____

Other: _____

_____ _____

CLIENT SIGNATURE **DATE**

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do IN WRITING and present my revocation to the office manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to receive treatment. I understand that I many inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Sage Wellness Privacy office at 732-505-4612. Refusing to sign does not negate Sage Wellness Center's responsibility outline in the Notice of Privacy Practices.

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BILL OF RIGHTS

All clients receiving outpatient services from Sage Wellness Center have the following rights which will be protected:

1. The right to be free from unnecessary or excessive medication. (See 10:37-6.54.)

2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV.)

   If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(2)

3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however, that a client in Inpatient Care may be restrained or isolated in an emergency pursuant to the provisions of N.J.S.A. 30:4-24.2d(3). (See N.J.A.C. 10:37-6, Article XV.)

4. The right to be free from corporal punishment.

5. The right to privacy and dignity.

6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

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CLIENT GREIVANCE PROCEDURE

1. Any client, his/her representative (guardian) may file a grievance or complaint concerning his/her treatment, behavior of other clients, staff members, theft of property, etc. without fear of threat or reprisal in any form.

2. Clients will be informed of grievance/complaint policy/procedure in writing at time of initial intake paperwork. A copy is also posted in each office.

3. Initial verbal and/or written grievance or complaint should made to the treating therapist. If the problem is not resolved between said parties, the therapist shall forward the grievance/complaint to the Program Director for review and resolution.
    a. In the event the grievance/complaint is not resolved, it shall be forwarded to the Financial Manager by the Program Director for review and resolution.
    b. Sage Wellness Center has designated the Financial Manager to act as the Agency Ombudsperson. The responsibilities of the Agency Ombudsperson are as follows:
        i. Receive consumer complaints.
        ii. Act as advocate for consumers who make complaints.
        iii. Attempt to negotiate resolution of issues raised by client (investigate and negotiate within five working days).
        iv. The Agency Ombudsperson shall submit a written report of findings/resolutions and/or recommendations to the Executive Director and client within seven working days of the complaint. If the complaint is resolved to the client's satisfaction, the grievance process shall end at this time.
        v. If the complaint is not resolved to the client's satisfaction, the client has the right to contact an external advocacy service (this may also be done at any time during the grievance process)

4. External advocacy services are also available to all consumers at all times. Consumers have a right to file a grievance at any time. Consumers do not have to go through the internal review process prior to going to outside agencies. An advocacy agency can be contacted at any time.

Community Health Law Project
1 Main Street, Eatontown, NJ 07853
(732) 380-1012
Satellite Office is:
44 Washington Street, Suite 2 C
Toms River, NJ 08753
(732)349-6739

Ocean County Mental Health Board
Dept. of Human Services
Assistant Mental Health Administrator
Tracy Maskel
Building 2, PO Box 2191
1027 Hooper Avenue, Bldg.
Toms River, NJ 08754-2191
(732) 506-5309

Disability Rights New Jersey (DRNJ)
210 South Broad Street, 3rd Floor Trenton, NJ 08608
(609) 292-9742 or (800) 922-7233 in NJ Only

Division of Mental Health Advocacy
State of New Jersey
Division of Mental health Advocacy
Justice Hughes Complex
25 Market Street, Trenton, NJ 08625
(877)285-2844

Division of Mental Health and Addiction Services (DMHAS) Ombudsperson
Susanne Mills
5 Commerce Way
PO Box 362, Hamilton, NJ 08625
609-438-4321

SAGE WELLNESS CENTER
1901 Lakewood Road, Suite 200, Toms River, NJ 08755
(P) 732-505-4612 · (F) 732-505-4671

Division of Child Protection and Permancy (for child abuse/neglect)
1510 Hooper Avenue, Suite 210
Toms River, NJ 08753
732-255-8015
1-855-463-6323

Ocean County Board of Social Services (To report adult abuse)
1027 Hooper Avenue, P.O. Box 547
Toms River, NJ 08754-0547
732-349-1500
After hours number (732)240-6100

5. Responsibility of the County Mental Health Board:
   a. The County Mental Health Board, through its administrator, shall receive and review complaints referred from the Regional Director within five working days.
   b. The County Mental Health Board shall make its finding and recommendation known to the Regional Director and consumer within seven working days of the complaint. If the consumer is not satisfied with the recommendation of the Board, or the agency's response to the recommendation, the consumer may request a review by the Division.

6. State level review by the Division: 1-800-382-6717
   a. A consumer may request a review by the Division directly, and in confidence, at any time. Consumers shall be encouraged by the Division; however, to seek an agency-level review first and will be asked to justify omission of an agency or county level review. The Division will advise the agency or the County Mental Health Board of all the complaints received directly, or indirectly, unless the consumer, on notice, refuses consent to such disclosure.

7. The Division may convene a professional review committee, when needed, consisting of an interdisciplinary team appropriate to the subject of the complaint. The designees shall receive and review the complaints referred by a consumer within five working days and shall submit a written report within five working days and shall submit a written report of its findings and recommendation to the Division within two more days.

8. The Division Director shall review this report and submit recommendations to the Program Director and the consumer within seven working days. The Division shall determine if any formal State remediation/funding compliance action is necessary based on the agency's response to these recommendations.
   a. Procedures not to limit access to other remedies: These procedures are intended to be in addition to, rather than in placement of, any other remedies available to consumers for the negations or redress of complaints service delivery. It is not the intention of the Division that consumers be required to exhaust these procedures before seeking negotiation or redress for complaints in any judicial or administrative forum.
   b. No suspension of agency action during review: An agency action which is subject to a consumer complaint need not be suspended pending review under this procedure. All consumers, however, may request expedited, direct review by the Division at any time, and such review shall be completed within 72 hours of the request.
   c. Confidentiality: A consumer who requests assistance with or review of a complaint by an Agency Ombudsperson, Program Director, Executive Director, County Mental Health Board or the Division, shall be required to consent to the disclosure of relevant records, in order to authorize persons providing assistance of review to discuss the subject of the complaint the relevant agency staff is necessary.

9. Under all circumstances, clients not accepted for services will be informed immediately of the Statewide advocacy services available to them.

SAGE WELLNESS CENTER LLC
NOTICE OF PRIVACY PRACTICES
Effective Date: June 15, 2020

This Notice applies to individuals receiving services from Sage Wellness Center LLC and does not require your response. **THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

YOUR RIGHTS:

- **Right to see and copy your records.** In most cases, you have a right to view or get copies of your records. If you request records that the provider or facility deems may be harmful to you, they may deny you access. These records are often mental health records. They cannot be withheld just because the provider believes they will upset you. But you can be denied if the provider thinks you will do harm to yourself because of their outcome. You must make your request in writing. We will provide a response to your request within thirty (30) days. You may be charged a fee for the cost of copying your records.
- **Right to an electronic copy of your PERSONAL HEALTH records.** If your information is maintained in an electronic format, you may request that your electronic records be transmitted to you or another individual or entity. We will respond to your request within thirty (30) days.
- **Right to correct or update your records.** You may ask us to correct your health information if you think there is a mistake. You must make your request in writing and provide a reason for your need to correct the information.
- **Right to choose how we communicate with you.** You may ask us to share information with you in a certain way. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You don't have to explain a reason for the request. We may deny unreasonable requests.
- **Right to get a list of disclosures.** You have a right to ask us for a list of disclosures made after April 14, 2003. You must make a request in writing. This will not include information shared for treatment, payment or health operation purposes. We will provide one accounting a year free of charge, but may charge a cost for additional lists provided within the 12 month period.
- **Right to get notice of a breach.** You have a right to be notified upon a breach of any of your protected health information.
- **Right to request restrictions on uses or disclosures.** You have a right to ask us no to disclose information. You must make the request in writing.
- **Right to revoke authorization.** If we ask you to sign an authorization to use or disclose your information, you can cancel that authorization at any time. You must make that request in writing. Your request will not affect information that has already been shared.
- **Right to get a copy of this notice.** You have a right to ask for a paper copy of this notice at any time
- **Right to file a complaint.** You have a right to file a complaint if you don't agree with how we have used or disclosed your information.
- **Right to choose someone to act for you.** If someone has been legally designated as your personal representative, that person can exercise your rights and make choices about your health.

OUR DUTIES
Sage Wellness Center LLC functions as a mental health care provider for you and your family. Consequently, we must collect information about you to provide these services. We are required to protect your information according to federal and state law and will abide by the terms of this notice. We may use and disclose information without your authorization for the following purposes:

- **Treatment Purposes.** We may use or disclose your information to health care providers who are involved in your health care.
- **Payment.** We may use or disclose your information to get payment or pay for health care services you received or will receive.
- **Health Care Operations.** We may use or disclose your information in order to manage our business, improve your care and contact you when necessary.
- **As Required by Law.** We will disclose information to a public health agency that maintains vital records, such as births, deaths and some diseases.
- **Abuse and Neglect Investigations**. We may disclose your information to report all potential cases of abuse and/or neglect.
- **Health Oversight Activities**. We may use or disclose your information to respond to an inspection or investigation by state officials.
- **Government Programs.** We may use and disclose your information for the management and coordination of public benefits under government programs.
- **To Avoid Harm**. We may use and disclose information to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

- **For Research**. We may use and disclose your information for studies and to develop reports. These reports will not specifically identify you or another person.
- **Business Associates**. We may use and disclose your information to our business associates that perform functions on our behalf, if necessary, to complete those functions.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose your information to the appropriate military authority.
- **Workers Compensation**. We may use or disclose your information for workers compensation or similar programs providing benefits for work-related injuries or illnesses.
- **Data Breach Notification Purposes**. We may use or disclose your information to provide legally required notices of unauthorized access or disclosure of your health information.
- **Lawsuits and Disputes.** We may use or disclose your information in response to a Court or Administrative Order, subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose your information to law enforcement if the information: 1) is in response to a court order, subpoena, warrant or similar process; 2) limited to identify or locate a suspect, fugitive, material witness or missing person; 3) about a victim of a crime under very limited circumstances; 4) about a death potentially resulting from a crime; 5) about criminal conduct on any DHS property and; 6) is needed in an emergency to report a crime or facts surrounding a crime.
- **Coroner, Medical Examiners and Funeral Directors**. We may disclose your information to a Coroner or Medical Examiner to identify a deceased person or determine the cause of death. We may release your information to a Funeral Director as necessary for their duties.
- **National Security and Intelligence**. We may disclose your information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose your information to authorized federal officials so that they can provide protection to the U.S. President; other authorized persons or foreign heads of state, or to conduct special investigations.
- **Inmates or Individuals in Custody**. If you are an inmate, we may release your information to a correctional institution if that information would be necessary for the institution to: 1) provide you with health care; 2) protect your health and safety or the health and safety of others or: 3) for the safety and security of the correctional institutions.
- **Disclosure to Family, Friends and Others**. Per your HIPAA Designation Disclosure Release, or any other written release of information authorization, we may disclose your information to your family members, friends or other persons who are involved in your medical care. We may also share your information with someone legally designated as your personal representative.

Other Uses and Disclosures that Require Your Written Authorization

- **For All Other Situations.** We will ask for your written authorization before using or disclosing information for any other purpose than what is mentioned above. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes and for the sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, please contact us at the number below. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.
- **As Required by Other Laws.** We will ask for your written authorization to comply with other laws protecting the use and disclosure of your information.

FILING A COMPLAINT

You may use the contact information below if you want to file a complaint or to report a problem regarding the use or disclosure of your health information. Treatment or services being provided to you will not be affected by any complaints you make. Sage Wellness Center LLC opposes any retaliatory acts resulting from participation in a HIPAA investigation.

Sage Wellness Center LLC
1901 Lakewood Road; Suite 200
Toms River, NJ 08755
Sage Wellness Center LLC representative will respond to your communication within thirty (30) days.

CHANGES TO THIS NOTICE

In the future, Sage Wellness Center LLC may change its Notice of Privacy Practices. Any change could apply to information we already have about you, as well as information we receive in the future. A copy of a new notice will be posted in our offices and provided to you as required by law. You may ask for a copy of our current notice or get it online on our website.