



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

CLIENT INFORMATION FORM

Today's Date: _____

CLIENT INFORMATION:

Legal Name: _____ Prefers to be called: _____

DOB: _____ SS#: _____ Gender: _____ Marital Status: _____

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

Primary Phone: _____ Other Phone: _____

E-mail: _____ *Email used for appointment confirmations, insurance/billing questions, portal access, etc.

In case of emergency, I authorize the following person to receive notification:

Name	Relationship	Phone
_____	_____	_____

INSURANCE INFORMATION:

Insurance Company: _____ ID#: _____ Group #: _____

Name of Insured: _____ Relationship to you: _____ DOB of insured: _____

Are you seeking services due to the result of an auto accident or worker's compensation incident? Yes No

If yes, please provide insurance information: _____

***Proper authorization must be submitted before treatment so that claims can be submitted properly.
Failure to do so, may result in out-of-pocket expense for services. ***

ALLERGIES: _____

PHARMACY INFORMATION:

Name: _____ Phone #: _____ Address: _____

Prescription Plan ID (if different from regular insurance): _____ (**Please note that we can't assist with prior authorizations or fax prescriptions to mail order pharmacies for you without this information**)

CURRENT MEDICATIONS (Both psychiatric and general health):

Medication	Dose	Start Date	Symptoms Addressed	Prescriber
_____	_____	_____	_____	_____

PSYCHIATRIC MEDICATION HISTORY:

Medication	Dose	How helpful did you find the medication?
_____	_____	_____

TREATMENT HISTORY:

Provider	Dates	Reason(s)
_____	_____	_____

TREATMENT GOALS:

Please describe the concern(s) for which you are currently seeking treatment:

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

Signature of Client/Representative

Date



PROFESSIONAL DISCLOSURE AND TREATMENT CONSENT

CLIENT 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 911 or 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 SIGNATURE _____

DATE _____



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

CONSENT FOR TELEHEALTH CONSULTATION

CLIENT 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.



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

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.
3. I agree to provide the minor with a private space without any interruptions to ensure confidentiality.
4. I understand that there is limited research on telehealth with minors and it may not be as effective as in-person therapy.
5. I understand that my healthcare provider may determine at any time that the minor is not appropriate for telehealth.

FINANCIAL POLICY

- 1. All telehealth fees are the same as in-person appointments. I understand that all copays are due at time of session.
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.
4. If provider determines that client is not in an appropriate/private setting to conduct the telehealth appointment, the appointment will be canceled.
5. I understand that my health insurance may not cover telehealth services.

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.
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.
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 SIGNATURE: _____

DATE: _____



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

FINANCIAL RESPONSIBILTY FORM

CLIENT NAME: _____

DOB: _____

Client / Guarantor responsibility:

If you have insurance in which we are a participating provider, we will bill your insurance as a courtesy. However, the client is responsible for all fees regardless of insurance coverage. 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.

We strongly advise you check your benefits as it is your responsibility to ensure you understand what your benefits are. 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 contact the insurance company, group plan administrator, or employer representative for resolution. 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. As required by insurance mandates, it is the responsibility of the client to obtain any necessary authorization for medical treatments. 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.

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. 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/\$50 group session 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 SIGNATURE: _____

DATE: _____



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

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 owed not paid by the 15th of the month
- ✓ 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%.



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

CLIENT DISCLOSURE AUTHORIZATION

CLIENT NAME: _____

DOB: _____

DO NOT RELEASE INFORMATION TO ANYONE

I ALLOW permission to contact my PCP

I REFUSE Permission to contact my PCP

Primary Care Physician (PCP) name & address: _____

Phone: _____

Fax: _____

I ALLOW permission to contact my therapist

I REFUSE Permission to contact my therapist

Therapist name & address: _____

Phone: _____

Fax: _____

I ALLOW permission to contact my psychiatrist

I REFUSE Permission to contact my psychiatrist

Psychiatrist name & address: _____

Phone: _____

Fax: _____

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

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

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 may 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.



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

OFFICE POLICIES

CLIENT 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 are prohibited from entering the building.
- APPOINTMENT POLICY (eff 3/2022, subject to change at any time):
 - 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 and \$50 for group therapy sessions. 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 15-minute grace period for all evaluations. After 15 minutes your appointment may be canceled and you will be charged the applicable late cancel fee.
 - There is a 15-minute grace period for therapy appointments. After 15 minutes your appointment may be canceled and you will be charged the applicable late cancel fee.
 - There is a 10-minute grace period for medication appointments. After 10 minutes your appointment may be canceled and you will be charged the applicable late cancel fee.
 - Appointments will not be rescheduled until no call no show/late cancel is paid.
 - It is at the sole discretion of the provider to allow the appointment after the grace period.
 - 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.
- Medication management appointments are in person only. Any change to this policy is at provider discretion only. 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 reserves the right not to send refills until he/she sees client for follow up visit.



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

- Requests for refills must be made AT LEAST 48 hours in advance (not including weekends).
- Requests for written correspondence and/or medical records must be submitted with the “Authorization to Release Protected Health Information” to either 732-930-2225 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 c-1. 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).

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 SIGNATURE: _____

DATE: _____

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 not 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.



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

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 be 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



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

Division of Child Protection and Permanency (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.



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

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, electroconvulsive 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.

Beck Inventory

Name: _____

Date: _____

On this questionnaire are groups of statements. Please read each group of statements carefully, then pick out one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY: Check the number beside the statements you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad
 1 I feel sad
 2 I am sad all the time and I can't snap out of it
 3 I am so sad or unhappy that I can't
2. 0 I am not particularly discouraged about the future
 1 I feel discouraged about the future
 2 I feel I have nothing to look forward to
 3 I feel the future is hopeless and that things cannot improve
3. 0 I do not feel like a failure
 1 I feel I have failed more than the average person
 2 As I look back on my life all I can see is a lot of failures
 3 I feel I am a complete failure as a person
4. 0 I get as much satisfaction out of things as I used to
 1 I don't enjoy things the way I used to
 2 I don't get real satisfaction out of anything anymore
 3 I am dissatisfied or bored with everything
5. 0 I don't feel particularly guilty
 1 I feel guilty a good part of the time
 2 I feel quite guilty most of the time
 3 I feel quite guilty all of the time
6. 0 I don't feel I am being punished
 1 I feel I may be punished
 2 I expect to be punished
 3 I feel I am being punished
7. 0 I don't feel disappointed in myself
 1 I am disappointed in myself
 2 I am disgusted with myself
 3 I hate myself
8. 0 I don't feel I am any worse than anybody else
 1 I am critical of myself for my weaknesses or mistakes
 2 I blame myself all the time for my faults
 3 I blame myself for everything bad that happens
9. 0 I don't have any thoughts of killing myself
 1 I have thoughts of killing myself, but I would not carry them out
 2 I would like to kill myself
 3 I would like to kill myself if I had the chance
10. 0 I don't cry any more than usual
 1 I cry more now than I used to
 2 I cry all the time now
 3 I Used to be able to cry, but now I can't cry even though I want to
11. 0 I am not more irritated now than I ever am
 1 I get annoyed or irritated more easily than I used to
 2 I feel irritated all the time now
 3 I don't get irritated at all by the things that used to irritate me
12. 0 I have not lost interest in other people
 1 I am less interested in other people than I used to be
 2 I have lost most of my interest in other people
 3 I have lost all my interest in other people
13. 0 I make decisions about as well as I ever could
 1 I put off making decisions more than I used to
 2 I have greater difficulty in making decisions than before
 3 I can't make decisions at all anymore
14. 0 I don't feel I look worse than I used to
 1 I am worried that I am looking old or unattractive
 2 I feel that there are permanent changes in my appearance that make me look unattractive
 3 I believe that I look ugly
15. 0 I can work about as well as before
 1 It takes an extra effort to get started at doing something
 2 I have to push myself very hard to do anything
 3 I can't do any work at all
16. 0 I can sleep as well as usual
 1 I don't sleep as well as usual
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
 3 I wake up several hours earlier than usual and cannot get back to sleep
17. 0 I don't get more tired than usual
 1 I get tired more easily than I used to
 2 I get tired from doing almost anything
 3 I am too tired to do anything
18. 0 My appetite is no worse than usual
 1 My appetite is not as good as it used to be
 2 My appetite is much worse now
 3 I have not appetite at all anymore
19. 0 I haven't lost much weight, if any, lately
 1 I have lost more than 5 pounds
 2 I have lost more than 10 pounds
 3 I have lost more than 15 pounds
 4 I am purposely trying to lost weight by eating less
20. 0 I am no more worried about my health than usual
 1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation
 2 I'm very worried about physical problems & it's hard to think of much else
 3 I am so worried about my physical problems that I cannot think about anything else
21. 0 I have not noticed any recent change in my interest in sex
 1 I am less interested in sex than I used to be
 2 I am much less interested in sex now
 3 I have lost interest in sex completely

Name: _____

Date: _____

BECK ANXIETY INVENTORY

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY BUT IT DIDN'T BOTHR ME MUCH	MODERATELY IT WASN'T PLEASANT AT TIMES	SEVERELY IT BOTHER ME ALOT
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaking/unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint/lightheaded	0	1	2	3
Face Flushed	0	1	2	3
Hot/cold Sweats	0	1	2	3
COLUMN SUM				