



NewBridge Services, Inc.

APPLICATION FOR SERVICES

All information MUST be filled out completely. If items are not applicable, write "N/A".

Date: _____

| | | |
|--|--|--|
| Full Legal Name (First, Middle, Last) | Preferred Name | Home Phone |
| | Preferred Pronouns | Cell |
| | | Email |
| Address (street, city, state, zip code and 4 digits) | Sex assigned at birth | Gender |
| | Birth date | Age |
| | Applicant's Social Security Number | |
| Marital Status | Maiden Name | Name of Parent (if child is a minor) |
| Employment status <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Not in Labor force <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired | | Work Phone (if applicable) |
| Education Status <input type="checkbox"/> Enrolled in school/higher education <input type="checkbox"/> Enrolled in a vocational training program <input type="checkbox"/> Not enrolled in any educational programs | Number of Individuals in Household (living with) | Combined Household Income (Monthly) – required if applying for sliding scale fee |
| Emergency Contact Name | Emergency Contact Relationship | Emergency Contact Phone Number |
| Supportive Person (other than Emergency Contact) Name | Supportive Person Relationship | Supportive Person Phone Number |

| | |
|--|--|
| <p>Applicant's Race¹ (select all that apply)</p> <p><input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native and White <input type="checkbox"/> Black or African American and White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other Multi-Racial <input type="checkbox"/> Asian and White <input type="checkbox"/> American Indian or Alaskan Native and Black or African American <input type="checkbox"/> Declined to specify</p> | <p>Applicant's Ethnicity Group¹</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Declined to specify</p> |
| | <p>Applicant's Ethnicity¹ (Country of origin/ethnicity)</p> |
| <p>Applicant's Primary Language (spoken at home)</p> | <p>Applicant's Religion</p> |

(Signatures are required on following pages of the application)

Have you ever received treatment at NewBridge Services before?

NO _____ YES _____ When? _____

Have you ever received treatment elsewhere?

NO _____ YES _____ Where and When?

Where did you hear about NewBridge? Who referred you?

What services are you requesting at NewBridge Services?

Why are you interested in those services?

Acknowledgements:

I understand that I am expected to attend my appointments as scheduled with my Provider and that I will notify my Provider in the event that I have to cancel the appointment. I understand that I may be subject to a charge of \$25 for each session that I do not cancel 24 hours prior to the time of that session.

I understand that I am responsible for payment of any co-pay/co-insurance and deductible as determined by my contract with my insurance carrier. Amount subject to change.

I have read and agree with the statements above. I **certify** that the **information** submitted in this application is **true** and **correct** to the best of my knowledge.

¹ Completion of information about race and ethnicity is voluntary and will not affect provision of services. This information will be used for aggregate reporting on demographic data and programming purposes only.

Name (Print)

Signature

Date Signed

INSURANCE INFORMATION

Client's Name: _____

Primary Carrier: Please check an option for 'relationship of policy holder' and complete the information requested:

Relationship of Policy Holder: Self Spouse Parent

Policy Holder's Name: _____

Date of Birth: _____

Social Security #: _____

Insurance Carrier: _____

Address: _____

Telephone #: _____

Policy #: _____

Secondary Carrier: Please check an option for 'relationship of policy holder' and complete the information requested:

Relationship of Policy Holder: Self Spouse Parent

Policy Holder's Name: _____

Date of Birth: _____

Social Security #: _____

Insurance Carrier: _____

Address: _____

Telephone #: _____

Policy #: _____

The following must be signed in order for us to bill any insurance carrier. Failure to sign both would require us to collect our standard full agency fee at the time service is rendered.

Assignment of Benefit (Must be signed if fee is less than our standard fee)

I authorize payment to be made directly to NewBridge for professional services rendered to me.

Signature: _____ Date: _____

Authorization for Release of Information: I authorize the release of information to my insurance carrier which may be necessary to process my claims.

Signature: _____ Date: _____

**TO BE COMPLETED BY CLIENTS WHO ARE UNINSURED
AND ARE APPLYING FOR A SLIDING SCALE FEE OR
WHO MAY BE ELIGIBLE FOR SUPPLEMENTAL
ASSISTANCE**

Statement of Income

I, _____ am attesting that my **MONTHLY** income and additional information provided below is as follows (Please provide documentation to support reported income amounts):

Disability: _____

Family/Relative: _____

Pension/Retirement: _____

Work First NJ: _____

SS Benefits: _____

Unemployment: _____

Wages: _____

Self-Employment: _____

Tips: _____

SSI: _____

Income – Other: _____

Gross Family Income: _____

Household Size: _____

Number of Dependents: _____

OR

I, _____ am attesting that I am **not working** and have **no income** at this time. My daily source of living is noted below. (*If this statement applies, proceed to Statement of Support*).

Statement of Support

I am currently living with friends, relatives, or others that are providing me with food, shelter, and other necessities. I do not have funds available to pay for these services.

I do not have a place to stay, and am provided with food from the local social agencies. I do not have funds available to pay for these services.

Statement of Income and Insurance Coverage Page 2

I am a temporary resident at a shelter and they are providing me with food and shelter. I do not have funds available to pay for these services.

I am declaring the information provided above and attested to is a true accounting of my present status.

Statement of Insurance Coverage

I am also certifying that:

I am not covered by health insurance through myself or through the policy of any relative with whom I may or may not reside (eligible for discounts on all NewBridge fees)

OR

I am covered by health insurance; however said insurance does not pay for Partial Care services (eligible for discounts only on Partial Care monthly fees).

I certify that these statements are true, and fully and accurately represent my insurance coverage. I understand that making fraudulent statements is subject to penalty.

Signature of client: _____ Date: _____



NewBridge Services, Inc.

INSURANCE REIMBURSEMENT POLICIES

Thank you for choosing NewBridge Services as your mental health provider. The services delivered to you imply a financial responsibility, and require you to ensure payment in full for any service you receive. This includes responsibility for paying deductibles, co-pays, co-insurance, or any other patient responsibility indicated by your insurance policy. Co-payments are due at the time of your visit.

You are responsible for knowing your insurance policy, and for being aware of any/all limitations of your plan, including benefit limits. Verification of benefits, including precertification, authorization, and payment information is not a guarantee of payment. Your insurance provider will send an Explanation of Benefits (EOB) after a claim has been submitted, detailing payment rendered by the carrier and client responsibility. You are required to reimburse NewBridge Services for any portion of the fee determined to be client responsibility by your insurance carrier. This requirement is assumed upon accepting the terms of the policy agreement you hold with your insurance carrier.

You are expected to **ASSIGN INSURANCE BENEFITS** directly to NewBridge Services regardless of any "out of pocket" payment made per session (i.e. co-pay, co-insurance, etc.). In certain circumstances when payment is made in excess of the maximum fee, the additional monies will be reimbursed to you by NewBridge Services. If you receive payment for services directly from your insurance carrier, you are expected to endorse the check over to NewBridge Services, unless the service has been paid for in full at the time of the session.

If you wish to submit claims directly to your insurance carrier (without going through NewBridge), you will be responsible for paying the full standard agency fee prior to each session. Upon request, NewBridge may provide you a Statement of Services rendered, to be included in your claims submission for consideration by your Insurance Carrier.

You authorize NewBridge Services to release to your insurance carrier, medical record information including but not limited to evaluations, progress notes, and treatment plans, for purposes of claims processing and payment.

It is expected that you will notify NewBridge Services immediately upon any changes to your insurance coverage. Failing to do so may result in unpaid claims. You will be held responsible for the full fee for services not paid by your insurance carrier due to unreported changes in coverage. **NewBridge Services does not assume responsibility for the validity of insurance information provided to us.**

By signing below, I am agreeing to all of the aforementioned terms and conditions.

Signed: _____

Date: _____

Please contact the billing department at 973-686-2263 if you have any question

Authorization for Treatment Consent Form

I hereby give consent for my treatment

Applicant's Signature

Date

For all Applicants 14 years old and under and Applicants who have a Legal Guardian:

I, _____ authorize the staff of NewBridge Services to treat and/or
counsel _____

Parent or Guardian Signature

Date

This consent will remain in effect during the time the client is attending NewBridge Services. Client stated/restated in his/her words, indicating that she/he understood, and provided signature acknowledging same.

Applicant Signature

Date

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Staff Signature

Date

*****Note: If there is a court order or other legal documentation involving custody or guardianship of the child, please bring a copy of the court order or the legal documents to the appointment*****



NewBridge Services, Inc.

Authorization for automatic appointment reminders:

I, _____ authorize NewBridge Services to send me automatic appointment reminders. I understand that this is in no way a breach of confidentiality and hereby grant NewBridge Services permission to call and leave a phone message, and/or send a text regarding my upcoming appointment(s) at the number(s) listed below. I will be able to confirm or cancel my appointment through the same method(s).

NewBridge Services will not release any information that is protected under state and federal guidelines. I understand that I can revoke this authorization at any time by notifying NewBridge Services in writing.

Please use the following numbers [Check one or multiple depending on your preference]:

Home Phone - for phone call / voice mail:

Mobile - for phone call / voice mail:

Mobile - for Text message:

I do not authorize NewBridge Services to contact me to confirm appointments.

NewBridge Services, Inc.

SureScripts Medication History Authorization Form

I _____ authorize NewBridge Services, Inc. to access any benefit information, medication history information, and prescription information that has been compiled about me through the SureScripts electronic database. By consenting to this authorization, I understand that NewBridge can, through their electronic prescribing service, obtain information aggregated by SureScripts from Pharmacy Benefit Managers (PBM) or from any pharmacy who has dispensed medication on my behalf.

Signature

Date