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 □ Employed Full-Time □ Not in Labor force □ Employed Part-Time □ Unemployed □ Retired		Work Phone (if applicable)
Education Status □ Enrolled in school/higher education □ Enrolled in a vocational training program □ 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

Applicant's Race[1] (select all that apply) □ American Indian or Alaskan Native □ Black or African American □ White □ American Indian or Alaskan Native and White □ Black or African American and White □ Asian □ Native Hawaiian or Other Pacific Islander □ Other Multi-Racial □ Asian and White □ American Indian or Alaskan Native and Black or African American □ Declined to specify	Applicant's Ethnicity Group[1] □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ Declined to specify Applicant's Ethnicity[1] (Country of origin/ethnicity)
Applicant's Primary Language (spoken at home)	Applicant's Religion

(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: ____________________

Pension/Retirement: ____________

SS Benefits: __________________

Wages: ______________________

Tips: ________________________

Income – Other: _______________

Household Size: _______________

Family/Relative: ____________________

Work First NJ: ______________________

Unemployment: _____________________

Self-Employment: ___________________

SSI: _______________________________

Gross Family Income: ________________

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.

☐ 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

NewBridge Services Administrative Offices • P.O. Box 336 • Pompton Plains, NJ 07444
Phone 973.839.2520 • Fax 973.686.2240 • www.newbridge.org

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

Terms and Conditions

NewBridge Services has an appointment reminder system. You can receive phone messages and/or text messages reminding you of your individual therapy or medication management appointments. The reminder phone message/text is sent out 2 days before your appointment. Message and data rates can apply. Please contact your treatment office for assistance with the appointment reminder.

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 the treatment office.

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