NewBridge Services
AN AFFILIATE OF
ChristianHealth

APPLICATION FOR SERVICES

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

Full Name (First, middle, last)	Date	Home Phone:	
		Cell:	
Address (street, city, state)	Gender	Birth date	Age
	Marital Status		
Applicant's Social Security Number	Maiden Name		
Employer & Occupation		Work Phone	
Level of Education		Combined Household Income	
Email			
Emergency Contact	Phone Number		
Name of Parent (if child is a minor)	Applicant's Religion		

(Signatures are required on following pages of the application)

OTHERS IN THE HOUSEHOLD
Please include spouse, parents, children, or anyone else physically living in the home)

Name	Birth Date	Age	Relation to applicant	Religion	Occupation

Have you ever received treatment at NewBridge Services (or Pequannock Valley Mental Health Center) before?
NO_____YES_____ When? _____

Have you ever received treatment elsewhere?
NO_____YES_____ Where and When?

_____

Where did you hear about NewBridge? Who referred you?

_____

NewBridge Services
AN AFFILIATE OF
Christian Health

INSURANCE INFORMATION

CLIENT'S NAME:_____

Primary Carrier: **Please check one and complete the information requested.**
Name and Relationship of Policyholder: [ ] SELF [ ] SPOUSE [ ] PARENT

_____
Policy Holder's Name Date of Birth Social Security Number

INSURANCE CARRIER:_____

ADDRESS: _____

_____

TELEPHONE #: _____**POLICY NUMBER**:_____

Secondary Carrier
Name and Relationship of Policyholder: [ ] SELF [ ] SPOUSE [ ] PARENT

_____
Policy Holder's Name Date of Birth Social Security Number

INSURANCE CARRIER:_____

ADDRESS: _____

_____

TELEPHONE #: _____**POLICY NUMBER**:_____

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 then 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

NewBridge Services
AN AFFILIATE OF
ChristianHealth

TO BE COMPLETED BY CLIENTS WHO ARE *UNINSURED*
AND ARE APPLYING FOR A SLIDING SCALE FEE

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.

☐ 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: _____

Signature of NewBridge representative: _____ Date: _____

NewBridge Services
AN AFFILIATE OF
ChristianHealth

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 of $186.00 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
AN AFFILIATE OF
ChristianHealth

Fee Agreement

I understand that payment is expected before each session and that my fee is as follows:

Self-pay fee of $_____

Co-pay/co-insurance fee of $_____

You are responsible for payment of any co-pay/co-insurance and deductible as determined by your contract with your insurance carrier. Amount subject to change.

If payment is not rendered, my appointment will be rescheduled.

I understand that I will be charged $_____for each session that I do not cancel 24 hours prior to the time of that session.

Name of Applicant (Please print):_____

Applicant Signature:_____

Clinician Signature:_____

Date:_____

cc: Billing Supervisor

Thank You

NewBridge Services
AN AFFILIATE OF
ChristianHealth

CLIENT'S RIGHTS AND PRIVACY

I have been informed of and have received a copy of the following:

Client's Bill of Rights and Grievance Procedure YES_____ NO_____
Privacy Policy YES_____ NO_____

Applicant Signature **Date of Signature**

X_____ **X**_____

ADVANCE DIRECTIVES FOR MENTAL HEALTH

A. I have a completed Mental Health Advance Directive (MHAD) YES_____ NO_____

B. My MHAD is registered with the Division of Mental Health and Addictions Services.
YES_____ NO_____

C. I have received information about Mental Health Advance Directives. YES_____ NO_____

D. I would like to learn more about MHADs.
YES_____ NO_____

Applicant Signature: **Date of Signature**

X_____ **X**_____

NewBridge Services
AN AFFILIATE OF
ChristianHealth

Our Mission:
NewBridge brings balance to people's lives through counseling, housing and education.

NewBridge Services
AN AFFILIATE OF
ChristianHealth

Authorization for Outpatient 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
AN AFFILIATE OF
ChristianHealth

Authorization for calling and confirming appointments:

I,_____authorize NewBridge Services to call and confirm appointments, should the need arise. I understand that this is in no way a breach of confidentiality and hereby grant NewBridge services permission to call and leave a message regarding the appointment at the numbers listed below. 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:

Home:_____
Cellular:_____
Business:_____

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

NewBridge Services
AN AFFILIATE OF ChristianHealth

MEDICAL/HEALTH HISTORY

Name: _____ Date of Birth: _____
Person completing form: _____ Relationship: _____
(If different from above) Height: _____ Weight: _____

Physician: _____ Phone: _____ Date last seen: _____

Have you ever had: (Check all that apply and give dates)

- ☐ Seizures, convulsions
- ☐ Palpitations
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Night Sweats
- ☐ Persistent Cough
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Head Injury/accident
- ☐ Asthma
- ☐ Nausea
- ☐ Vomiting
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Fainting
- ☐ Thyroid disease
- ☐ Liver disease
- ☐ Glaucoma
- ☐ Cataract(s)
- ☐ Sleep problems
- ☐ Loss of appetite
- ☐ Falls
- ☐ Difficulty concentrating
- ☐ High Cholesterol
- ☐ Eating Disorder
- ☐ Physical abuse
- ☐ Digestive problems
- ☐ Cancer: Type: _____
- ☐ Infectious disease: Type: _____ Hepatitis A or B, TB, HIV, etc.
- ☐ Alzheimer's
- ☐ Drug or alcohol Problems
- ☐ Other (specify) _____

Please indicate whether you have experienced any recent weight change Yes ☐ No ☐
Explain: _____
Known speech, language or hearing problems: Yes ☐ No ☐
Please describe: _____

Does anyone in your family have:

Diabetes	Yes ☐	No ☐	Unknown ☐	Relationship _____
High Blood Pressure	Yes ☐	No ☐	Unknown ☐	Relationship _____
Heart Disease	Yes ☐	No ☐	Unknown ☐	Relationship _____
Kidney Disease	Yes ☐	No ☐	Unknown ☐	Relationship _____
Cancer	Yes ☐	No ☐	Unknown ☐	Relationship _____
Drug, Alcohol, and/or Psychiatric problems	Yes ☐	No ☐	Unknown ☐	Relationship _____

Other _____

Have there been any deaths in your immediate family? Yes ☐ No ☐
If yes, Specify relationship and cause of death (if known).
_____

Surgical History: (List procedure and date; i.e., tonsillectomy, appendectomy, D&C (Dilation and Curettement) and/or any problem pregnancies or deliveries).
_____
_____
_____

Major Medical Illness and Hospitalizations (give dates).
_____
_____
_____
_____

NewBridge Services
AN AFFILIATE OF ChristianHealth

MEDICAL/HEALTH HISTORY

Name: _____

1. Are you currently experiencing any physical pain? Yes ____ No ____

2. If yes, reason for pain? _____

3. Describe intensity of pain on a scale of 1(lowest) to 10 (highest)

1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____

4. Describe location and duration of pain: _____

5. Dietary Restrictions (if any) _____

6. Allergies:

Type of Allergy	
Food	
Drug	
Environmental	

7. Current Prescription Medications:

Medication	Dose and Frequency	Reason	Who is prescribing?

8. Pharmacy: _____ Location: _____

9. Currrent Over the Counter Medications:

Medication	Dose and Frequency	Reason

If client is a child, is child immunized? Yes ____ No ____

We encourage you to discuss any medical/health concerns you have so that our clinical staff can help you secure the proper medical care.

Psychiatric, Please check:

Client needs pain assessment Yes ____ No ____
Client needs a physical done Yes ____ No ____

Client : _____ Date: _____
(Parent or Guardian if Client is a Minor)

Clinician: _____ Date: _____

Reviewed: _____ Date: _____
Psychiatrist Signature

NewBridge Services
AN AFFILIATE OF
ChristianHealth

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