WELCOME

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5 HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

6 MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

7 HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

8 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Melissa Rivera Marano, Psy.D., LLC
License # 4007

MRM Psychological Testing & Clinical Services

Thank you for choosing MRM Psychological Testing & Clinical Services as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care. We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or up to date. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Divorced Parents: The parent bringing the child to our office will be responsible for required co-payments, deductibles, etc. at the time of service, unless a court order has been provided or contracted otherwise.

You agree that you will pay any deductible and/or co-payment and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. For your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur, and are responsible for the payment of any of the additional charges. These charges may include (but are not limited to):

- o Charge for returned checks - $30.00 fee
- **o Charge for missed appointments without 24 hours advance notice - $50.00 fee**
- o Charge for phone consultations – billed at $80.00 per half hour of phone consult
- o Charge for the copying and distribution of patient medical records - $10.00 processing fee + $1.00/page
- o Charge for Forms completion. *Ex: School Forms, Work Forms, FMLA, Disability Forms* - $45.00 fee + 5.00 per side, if additional time is needed, this will be billed at $80.00 per half hour of time
- o Any costs associated with collection of patient balances – To be determined.

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance. **Any account with a balance older than 90 Days, will be charged to Credit Card left on file.**

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

MRM Psychological Testing & Clinical Services

Patient Authorizations

By my signature below, I hereby authorize MRM Psychological & Testing & Clinical Services and the physicians, staff, to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care. I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:

☐ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.
☐ Psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, progress notes, consultations, treatment plans, and/or evaluations.

By my signature below, I hereby authorize assignment of financial benefits directly to (Insurance company) _____ and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
By my signature below, I authorize MRM Psychological Testing & Clinical Services personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____
Signature of Patient or Guardian and Date

Waiver of Patient Authorizations:

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____
Signature of Patient or Guardian Date

MRM Psychological Testing & Clinical Services

Policy for Electronic Communications & Preferences

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. Many of these common modes of communication put privacy at risk and can be inconsistent with the law and with the standards of our professional practice. We generally and expressly recommend against using electronic forms of communication as an aspect of your treatment. This policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. Each provider at this practice retains the right to make specific exceptions to this policy as determined on a case to case basis with the individuals they serve. If you have any questions about this policy, please feel free to discuss this with your clinician.

Email Communication and Text Messaging

This office will not initiate communication using email, except with client permission when specifically pertaining to payment of services, or unless under usual circumstances (e.g., we are unable to contact you by any other means in an emergency). Your clinician will only use email communication and text messaging with your verbal permission (this will be documented in treatment notes) and only for administrative purposes unless we have made another agreement. It is preferable to use email communication and text messages only for administrative services since these methods are not typically secured. That means that email exchanges and text messages with this office should be limited to changing appointments, billing matters and other related issues. Do not use PHI (personal health information such as name, date of birth, etc.) when using electronic communication, because access to electronic information is not assumed to be protected or private. Please do not use email or texting for treatment-related issues. Please note that our support staff routinely reviews incoming email. They are bound by agreement of employment by our practice that requires them to follow our HIPPA Policy and privacy practices.

Social Media

We do not communicate with, or contact, any clients through social media platforms like Twitter and Facebook. In addition, electronic relationship status will be cancelled if a clinician discovers that an online relationship has been accidentally established. This is because these types of casual social contacts can create significant security risks for you. If you have an online presence, there is a possibility that you may encounter your clinician by accident. If that occurs, please discuss it during the next scheduled session.

Websites

We have a website that you are free to access (www.mrmtestingandtherapy.com). It is used for professional reasons to provide information to others about our practice. You are welcome to access and review the information that you find on our website and, if you have questions about it, please discuss this during your therapy sessions.

MRM Psychological Testing & Clinical Services

Web Searches
Your clinician will not use web searches to gather information about you without your permission, because this constitutes a violation of your privacy rights. If you encounter any information about your clinician through web searches, reviews, or in any other fashion, please discuss this during your next session as it may potentially impact your treatment.

Other Providers and Individuals
If other providers or individuals contact this office about you by means of electronic communication (email, texting, etc.) we will not respond without your express written consent. If you anticipate this, please complete a written authorization today. Please note that a written consent does not imply that electronic communications can be made private or secure.

Please sign below if you understand our policy regarding electronic communications:

_____
Client Signature Date

_____
Guardian/Power of Attorney Signature Date

Preferred method of communication, Please circle yes or no and information if needed:

Mail: YES / NO Address: _____

Texting: YES / NO Cell #: _____

Calling & Leaving messages: YES / NO Number: _____

Email: YES / NO Email: _____

Notice of Privacy Practices

MRM Psychological Testing and Clinical Services

Melissa Rivera Marano, Psy.D., LLC

NJ licensed psychologist #4007

I, _____ am committed to keeping everything you share completely confidential. Whatever you speak about will not be shared with anyone else without your written permission. However, there are certain limits to this confidentiality that I would like you to know about.

1) If you have been referred by the court or any agency of the court, I may be required to furnish information to them.
2) If you are involved in certain kinds of litigation, such as worker's compensation, and inform the court of the services you have received from us, you may be waiving your right to have your records remain confidential. This would need to be clarified with your attorney.
3) If you threaten to harm yourself or someone else, I am obligated to inform potential helpers or victims. Information would be divulged only if I perceive that there is imminent danger to a readily identifiable victim, yourself, or the public. I am obligated to warn and protect if I believe you intend to carry out serious violence, even if you have not made a specific verbal threat.
4) If I have reason to suspect there is child abuse or neglect, I am obligated by law to report this to the appropriate state agency.
5) If I reasonably believe that a vulnerable adult is being abused, neglected, or exploited, I may report this information to the county adult protective services provider.
6) If you are a minor, your parents or guardians will be informed of your progress, if they ask. However, I will not reveal specific details of our conversations without your permission unless I determine that your safety is at risk.
7) Your health care insurance may require information to process claims or to authorize benefits.
8) If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

If you are concerned about some of your information, you have the right to ask me not to use or share it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I may not be able to agree to these limitations. However, if I do agree, I promise to comply with your wishes. You will be told if your information is shared per the privacy limitations listed above.

You have the right to request to receive confidential communication by alternative means and at alternative locations. For example, you could request that bills/statements be sent to a different address if you didn't want a family member to know about them.

You can request to inspect, obtain a copy of, or amend information about yourself in our mental health or billing records. Under certain circumstances, your request may be denied, but you may be able to have this decision reviewed.

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please discuss them with me. You can also send a written complaint to the Secretary of the US Department of Health and Human Services.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent), and I will comply with your wishes about using or sharing your information from that time on. However, if I have already used or shared some of your information, I cannot change that. Please sign and date this sheet to acknowledge that you have read and understood this notice of privacy policies. This form complies with federal regulations (HIPAA).

Client Name: _____ Parent/Guardian (if minor): _____

Signaure of Client or Parent/Guardian: _____ Date: _____

Melissa Rivera Marano, Psy.D., LLC
License # 4007

MRM Psychological Testing & Clinical Services

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ❑ Amount to process:	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	Security Code:
Client Name:	
Cardholder Name & Address (from credit card billing address):	
Email address for receipt:	

I, _____, authorize MRM Psychological Testing and Clinical Services. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date