

JOSEPH J. ZIELINSKI, PH.D., ABPP(CL), ABN, FICPP
New Jersey Licensed Psychologist 35SI 001300
1101 North Kings Highway, Suite #302
Cherry Hill, New Jersey 08034
(856) 438-5695
FAX (856) 438-5694

Dr. Zielinski's Registration Package

Included please find:

Patient Registration Form
HIPPA Agreement Forms by Federal Law
HIPPA Compliant Consent Forms to release insurance claims to your insurance company
Current Medications List
Current Physicians' List
Patient Responsibility Form
For Children patients: Childhood Developmental Questionnaire

Please fill these out completely and bring them with you to your first appointment.

Additional consent forms will be required whenever any communication about you goes out or is requested to come in from any other entity, physicians, attorneys, schools.

Thanks,
Joseph J. Zielinski, Ph.D.
Karen Whirledge, Office Manager

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Patient's Rights and Responsibilities Statement

Patients have the right to: be treated with dignity and respect; fair treatment regardless of their race, religion, gender, ethnicity, age, disability, or source of payment; have their treatment and other member information kept private -- only where permitted by law, the records be released without member permission; easily access timely care; know about their treatment choices -- this is regardless of cost or coverage by the members benefit plan; share in developing their plan of care; receive information in a language they can understand; a clear explanation of their condition and treatment options; information about their insurance company, its practitioners, services, and role in the treatment process; information about clinical guidelines used in providing in managing their care; ask the provider about their work history and training; give input on the members rights and responsibilities policy; know about advocacy and community groups and prevention services; freely file a complaint or appeal and to learn how to do so; know their rights and responsibilities in the treatment process; receive services that will not jeopardize their employment; request certain preferences in a provider; have provider decisions made about their care without regard to financial incentives.

Patients have the responsibility to: treat those giving them care with dignity and respect; give providers information they need -- this is so the providers can deliver the best possible care; ask questions about their care -- this is to help understand their care; follow the treatment plan -- the plan of care is to be agreed upon by the patient and provider; follow the agreed-upon medication plan; tell their provider and primary care physician about medication changes, including medications given to them by others; keep their appointments -- members should call their therapist as soon as they know they need to cancel a visit; let their provider know when the treatment plan is not working for them; let their provider know about problems with paying fees; report abuse and fraud; openly report concerns about the quality of the care they receive.

My signature below shows I have been informed of my rights and responsibilities, and I understand this information.

Patient's Signature

Date

The signature below shows that I explained this statement to the patient and have offered the member a copy of this form.

Joseph J. Zielinski, Ph.D.

Date

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Informed Consent for Treatment

I, _____, agree and consent to participate in behavioral health care services offered and provided by Joseph J. Zielinski, Ph.D., a licensed psychologist and behavioral health care provider. I understand that I am consenting and agreeing only to those services that Dr. Zielinski is qualified to provide within the scope of his license, certifications, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this individual.

I understand and agree to the following:

- Payment for services, deductibles, and co-pays are due at the time services are rendered. Inform the office immediately if financial difficulties arise.
- Inform the office if there are any phone/address contact or insurance changes.
- Inform Dr. Zielinski of any medication changes.
- Make appointments with care and consideration and keep these appointments. We do not make tentative appointments. Appointments are a commitment of our time.
- Late cancellations (within 24 hours) or missed appointments are chargeable to the client at the full fee of \$150.00/\$125.00 for psychotherapy and \$200.00 per unit for neuropsychological testing. **Your insurance will not pay for any of this charge.**
- A nominal fee may apply for short letter requests and we may need three business days to complete them. Advance notice is appreciated.

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____

Licensed Psychologist
Certified School Psychologist
New Jersey & Pennsylvania

Diplomate in Clinical Psychology
American Board of Professional Psychology
Diplomate in Clinical Neuropsychology
American Board of Professional Neuropsychology

Board Certified Diplomate -
Fellow in Psychopharmacology
Prescribing Psychologists' Register

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT
CAREFULLY.

Effective date: April 15, 2003

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you and records it in a health record
- During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purposes:

- We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.
- We verify insurance coverage prior to your first appointment and obtain prior authorization and precertification when required to do so by your policy coverage.

An example of use of your health information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. There will be a charge, payable in advance, for copying your PHI.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact:

Joseph J. Zielinski, Ph.D.
1101 N. Kings Highway, Suite 302
Cherry Hill NJ 08034

in person, or in writing, during normal business hours. He/She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The provider is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the following person:

Joseph J. Zielinski, Ph.D.
1101 North Kings Highway, Suite 302
Cherry Hill NJ 08034

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the following person:

Joseph J. Zielinski, Ph.D.
1101 North Kings Highway, Suite 302
Cherry Hill NJ 08034

You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services. For information call 800-356-1561.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Uses and Disclosures

We have Business Associates with whom we may share your protected health information.

- For example, in preparing our annual financial statement, auditors may need to review samples of medical care given. We may disclose your health information to the accounting firm to prepare this material.
- For example, during our routine health care operations, we may need to hire computer technicians and software vendors. We may disclose your health information to these vendors to maintain daily functioning in our health care operations.

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners

We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Marketing

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

We may disclose your protected health information to public authorities as required by law to report abuse or neglect.

Law enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order. To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other uses

Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

By signing below, I acknowledge that I have read and been given the option to receive a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Signature of Personal Representative of Patient: _____

Description of Representative's Authority to Act on behalf of Patient: _____

I opt not to receive a signed copy of this Notice. Please initial here patient here _____

**CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION TO OTHER
PROVIDERS/ATTORNEYS/INSURANCE CARRIERS/HOSPITALS**

Joseph J. Zielinski, Ph.D.
1101 North Kings Highway, Suite 302
Cherry Hill, NJ 08034

Telephone: (856) 438.5695
Fax Number: (856) 438.5694

PATIENT'S NAME (First, Middle, Last)

DATE OF BIRTH

ADDRESS (number, street, city, state, zip)

***** I understand that I have the option to refuse to sign this release at my discretion.**

I do hereby consent to and authorize Joseph J. Zielinski, Ph.D. to disclose to PRIMARY CARE PHYSICIAN: _____

Protected health information from my record to carry out treatment, payment, and health care operations relating to my identity, diagnosis, prognosis, treatment and condition, including:

1. Psychological or Psychiatric impairment
2. Drug abuse and/or Alcoholism
3. Acquired Immunodeficiency Syndrome (AIDS) and/or test or infection with human Immunodeficiency virus (HIV).

Release is to be limited to the specified report(s) within the specified date(s) of treatment detailed below. I understand that this consent shall operate as a complete release of liability to Dr. Joseph Zielinski, his agents and employees for the release of information as specified.

This consent is subject to revocation (withdrawal) by my written request at any time except to the extent that Dr. Zielinski has released or disclosed information because I have signed this consent. Once information has been released by Dr. Zielinski's office, information may be redisclosed by the recipient of the information and may no longer be protected. If I do not revoke this consent, it will terminate one year from the date of signature or as indicated below.

 RELEASE TO PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

Purpose of Disclosure: ___ Billing ___ Case Management ___ Forensic
 ___ Clinical ___ Insurance/Disability Ins. ___ Other

Type visit & treatment dates: ___ Outpatient dates from: _____ to _____

Specified Reports: ___ Outpatient Consultations
 ___ Office Progress Notes
 ___ Office Billing
 ___ Evaluations/Report

PATIENT/REPRESENTATIVE SIGNATURE

DATE SIGNED

REPRESENTATIVE'S RELATIONSHIP TO THE PATIENT

Copy given to patient

PATIENT REGISTRATION FORM

NAME OF PATIENT _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

TELEPHONE: (HOME) _____ (WORK) _____ (CELL) _____

HOW SHALL WE IDENTIFY OURSELVES: _____

BIRTHDATE _____ AGE _____ GENDER _____ OCCUPATION _____

SOCIAL SECURITY# _____ Single / Married / Divorced / Widowed (circle one)

EMPLOYER _____ DRIVERS LIC. # _____

REFERRED BY: _____ FAMILY DOCTOR _____

INSURANCE CARRIER _____ INSURANCE ID# _____

SUBSCRIBER NAME _____ BIRTHDATE _____ SS# _____

CASE MANAGER/REHAB NURSE _____ PHONE _____

ATTORNEY _____ PHONE _____

WE MUST HAVE THE NAME, ADDRESS, DAY & EVENING PHONE NUMBER OF A PERSON YOU AUTHORIZE YOUR THERAPIST TO CONTACT IN CASE OF AN EMERGENCY.

NAME OF EMERGENCY CONTACT _____

ADDRESS OF EMERGENCY CONTACT _____

DAY PHONE # _____ EVENING PHONE# _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE) FRIEND PARENT SPOUSE CHILD GUARDIAN OTHER _____

PATIENTS WHO COME TO OUR OFFICE HAVE A VARIETY OF INSURANCE CONTRACTS AND IT IS OUR POLICY TO COMPLETE THE PROVIDER PORTION OF THE APPROPRIATE FORMS. THE REMAINDER OF THE FORM IS THE PATIENT'S RESPONSIBILITY.

PLEASE NOTE THAT YOUR INSURANCE COMPANY WILL NOT PAY FOR MISSED APPOINTMENTS. THE FULL FEE FOR A SCHEDULED APPOINTMENT (\$150/\$125.00 FOR PSYCHOTHERAPY/ \$200.00 FOR NP TESTING) WILL BE CHARGED TO THE PATIENT/RESPONSIBLE PARTY WITHOUT AT LEAST 24 HOURS NOTICE.

NO E-MAIL COMMUNICATIONS REGARDING PATIENT CARE WILL BE SENT OR ACCEPTED BY THIS OFFICE AS THE INTERNET IS NOT A SECURE ENVIRONMENT.

THE FINAL RESPONSIBILITY FOR CHARGES INCURRED IS ALWAYS THE PATIENT'S RESPONSIBILITY. PAYMENT OF ROUTINE CHARGES, CO-PAYMENTS, AND DEDUCTIBLES ARE EXPECTED AT THE TIME SERVICES ARE RENDERED. ONE (1) MONTHLY STATEMENT OF YOUR ACCOUNT WILL BE PROVIDED AT THE PATIENT'S REQUEST TO ASSIST WITH PATIENT'S REIMBURSEMENT; A \$10 FEE PER ADDITIONAL COPY WILL BE CHARGED TO THE PATIENT.

I HEREBY AUTHORIZE THE RELEASE OF HEALTH /CLINICAL INFORMATION TO THE HEALTHCARE PROFESSIONAL WHO REFERRED ME TO JOSEPH J. ZIELINSKI, PH.D. FURTHERMORE, I AUTHORIZE THE RELEASE OF HEALTH INFORMATION TO MY INSURANCE COMPANY, CASE MANAGER, AND/OR REHABILITATION NURSE WHICH THEY MAY REQUIRE TO PROCESS ANY CLAIMS, AND/OR MY ATTORNEY FOR SPECIFIC LITIGATION PURPOSES. I ALSO AUTHORIZE MY THERAPIST TO CONTACT THE PERSON I HAVE IDENTIFIED ABOVE AS MY EMERGENCY CONTACT SHOULD HE OR SHE DETERMINES IT TO BE CLINICALLY NECESSARY.

Patient's Signature

Signature of responsible party, if different from patient

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Name: _____

Date: _____

Please provide a list of providers who have been involved with your care to date.
Please include address and phone number for each provider.

REASON FOR VISIT

DOCTOR: _____

DOCTOR: _____

DOCTOR: _____

DOCTOR: _____

OTHER: _____

