EVERS PSYCHOLOGICAL ASSOCIATES, P.C.

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Psychologists
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Joanne Lamanna, LCSW #44SC00044800
Justine A. Harris, LCSW #44SC04647500
Fatima E. Covino, PhD, LCSW #44SC05297900

Office Policies

Office Hours

The business office is open between 9 a.m. to 9:00 p.m. Monday through Thursday and 9 a.m. to 3:00 p.m. on Friday. Therapy sessions are scheduled by appointment with your clinician. Appointment times can be confirmed by calling the business office. Saturday appointments are available on a limited basis.

Cancellations

A **full fee visit charge** will be made for any appointment missed or cancelled without **48 hours notice**.

Telephone

The main office number is **(732) 528-5334** and 'Kids Korner' office number is **(732) 223-3535.** Both can be called at any time to leave a message. The phones will be answered during business hours at the front desk. At other times a message can be left on the answering machine.

The emergency on-call number is (732) 528-5304
****THE WEEKEND EMERGENCY ON-CALL STARTS AT 3:00 p.m. on FRIDAYS****

Please be sure to leave your phone number when leaving any message and disable any call blocking you may have on your phone.

Billing

Statements are mailed monthly, by the 15th day of the month. Any billing questions should be directed to our billing department.

Payment is expected at time of service unless other arrangements have been made in advance. Please be prepared to supply insurance information if you want us to file insurance for you. Payments can be made in cash, check, or charged to your Visa, MasterCard, American Express or Discover account. A service charge of $25.00 will be made for returned checks.

Every reasonable effort will be made to assist you in collecting your claims, but **all charges incurred are the responsibility of the patient regardless of the insurance coverage or reimbursement.** Outstanding balances should be resolved promptly. ***If the insurance company does not pay within 60 days of claim filing, then full amount is immediately due from the patient and the patient will become responsible for handling their own insurance.*** We reserve the right to place an unpaid account for collection or pursue other collection methods.

PLEASE FEEL FREE TO CALL IF YOU HAVE ANY QUESTIONS!

WELCOME TO OUR OFFICE

EVERS PSYCHOLOGICAL ASSOCIATES, P.C./KIDS KORNER, INC.

732-528-5334/732-223-3535

TODAY'S DATE:

Thank you for choosing our office.

In order to serve you properly, we will need the following information (PLEASE PRINT).

ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL

PATIENT NAME:_____ **SEX:** ___MALE ___FEMALE **MARITAL STATUS:** ___SINGLE ___MARRIED ___SEPARATED ___DIVORCED ___WIDOWED

EMAIL ADDRESS:

PATIENT ADDRESS (INCLUDING CITY, STATE AND ZIP CODE):

PATIENT HOME PHONE: **WORK PHONE:** **CELL PHONE:** **BIRTHDATE:** **SOCIAL SECURITY#:**

PATIENT EMPLOYMENT STATUS:
___FULL-TIME ___PART-TIME ___NOT EMPLOYED
___RETIRED ___SELF-EMPLOYED

PATIENT STUDENT STATUS:
___FULL-TIME ___PART-TIME
___NOT A STUDENT

IF CHILD, PARENT'S OR GUARDIAN'S NAME:

WHOM MAY WE THANK FOR REFERRING YOU? **PRIMARY CARE PHYSICIAN?**

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME:

RESPONSIBLE PARTY'S HOME PHONE: **WORK PHONE:** **RESPONSIBLE PARTY'S SOCIAL SECURITY#:**

INSURANCE INFORMATION

INSURANCE COMPANY NAME:

INSURED'S NAME: **INSURED'S SOCIAL SECURITY #:**

INSURED'S ADDRESS:

INSURED'S BIRTHDATE: **SEX:** ___MALE ___FEMALE

INSURED'S EMPLOYER'S NAME & ADDRESS (INCLUDING CITY, STATE AND ZIP CODE):

GROUP #: **POLICY #:** **MEDICARE#:**

WHAT IS YOUR CHIEF COMPLAINT?

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS INCLUDING DOCUMENTATION REQURED BY MY MANAGED CARE (PPO OR HMO) SHOULD MY PLAN REQUIRE IT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE AND THAT A CHARGE CAN BE MADE FOR ANY APPOINTMENTS MISSED WITHOUT ADEQUATE NOTICE (48 HOURS). I UNDERSTAND THAT ALL SERVICES ARE PROVIDED BY LICENSED PROVIDERS OR UNDER THEIR DIRECT SUPERVISION. SHOULD MY CASE REQUIRE CONSULTATION WITHIN THE PRACTICE BETWEEN DIFFERENT PROVIDERS OR CONTACT WITH MY PRIMARY CARE PHYSICIAN, THIS RELEASE AUTHORIZATION EXTENDS TO THAT CONSULTATION AND RESULTANT INSURANCE FILINGS IF APPLICABLE.

PATIENT, PARENT OR GUARDIAN
SIGNATURE:_____ DATE:_____

Evers Psychological Associates, P.C.
Request for Confidential Handling of Health Information

I, _____ request that
(PRINT FIRST AND LAST NAME OF PATIENT)

EVERS PSYCHOLOGICAL ASSOCIATES, P.C. handle my
(Psychologist's or Practice Name)

confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by **alternative** means will be granted. Please describe the **alternative** means (e.g. telephone call, US mail, etc.) by which you prefer to receive your health information.

Telephone number: **(If different from phone # you have already supplied on our blue information sheet)**

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_____

B. All reasonable requests to receive communication of your health information at **alternative** locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

Mailing address: **(If different from address you have already supplied on our blue information sheet)**

*

_____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

X_____ _____
(Signature) **(Date)**

Form1HIPAA