STRESS CARE OF NEW JERSEY, LLC
500 Park Avenue
Manalapan, NJ 07726
Tele #: 732-679-4500 Fax #:732-679-4549
www.stresscareclinic.com

CLIENT COMPLAINT / GRIEVANCE PROCEDURE

If you have a grievance or complaint against any clinician or staff member, you may use either of the suggested processes listed below at any time.

Complaint Process

1. Stress Care of New Jersey encourages you to first speak with your clinician. Staff is aware that quality services are part of Stress Care of New Jersey mission and will attempt to solve problem(s) directly with you. The clinician will attempt to resolve the problem within 7 to 10 working days and will provide a written response.
2. If the problem cannot be solved with your clinician, please ask to speak with the Director of Quality Assurance. The Director of Quality Assurance will investigate and attempt to resolve the problem within 7 to 10 working days and will provide a response in writing.
3. If the problem cannot be solved with the Director of Quality Assurance, please ask to speak with the Program Director. The Program Director will investigate and attempt to resolve the problem within 7 to 10 working days and will provide a response in writing.
4. If the problem cannot be solved with the Program Director, please ask to speak with the Executive Director. The Executive Director will investigate and attempt to resolve the problem within 7 to 10 working days and will provide a response in writing.

At any time during the complaint procedure, you may utilize any of the external advocacy agencies. You may also request review by The County Mental Health Board at any time by calling 732-745-3280 or any of the following phone numbers found on the other side of this form.

I certify by checking the box and printing my name below that I understand the above information.

Click here ☐ *to Acknowledge*

Client Printed Name: _____ Date: _____

Witness Signature: _____

2 copies required: One (1) for Client
One (1) for Client Chart

a. **Police, Fire, Ambulance, State Poison Control Center**
   i. 911 or Manalapan Police: 732-446-4300 ; Manalapan Fire: 732-462-1112
   Manalapan First Aid Ambulance: 732-446-4300 ; Poison Control: 800-222-1222

b. **COMMUNITY MENTAL HEALTH LAW PROJECT**
   i. New Jersey State Office Telephone Number: 732-380-1012
   1 Main Street ; Eatontown, NJ; 07724
   ADA Coordinator, Office of Human Resources, Division of Family Development P.O. Box 716 Trenton, NJ 08625 OR
   Division on Civil Rights, N.J., Department of Law & Public Safety,
   140 E. Front St., P.O. Box 090 Trenton, NJ 08625-0090

c. **COUNTY MENTAL HEALTH ADMINISTRATOR**
   i. Monmouth County: Steve Horvath 1-732-431-7200
   3000 Kozloski Road ; Freehold, NJ ; 07728

d. **DIVISION OF MENTAL HEALTH SERVICES & GUARDIANSHIP**
Advocacy Ombudsperson Suzanne Mills Telephone Number: 609-438-4321
5 Commerce Way ; P.O. Box 362 ; Hamilton, NJ 08625

e. **DIVISION OF MENTAL HEALTH ADVOCACY**
   i. State of NJ, Division of Mental Health Advocacy, Justice Hughes Complex
   25 Market Street, Trenton, NJ 08625 1-877-285-2844
   New Jersey Legal Services, Inc. Advocacy/Legal Services
   Monmouth Division Mental Health Advocacy Unit
   MHA: 1-877-285-2844 ; Monmouth Regional Office: 1-732-305-4320

f. **Department of Children and Families (DCF)** 1-855-INFO-DCF (1-855-463-6323)
20 West State Street, 4th Floor ; PO Box 729 ; Trenton, NJ ; 08625

To Report Child Abuse, Neglect, Exploitation 1-877-652-2873 (1-877-NJ-ABUSE)
Monmouth North: 1-732-571-2190 ; Monmouth South: 1-732-897-6300

To Report Child Abuse, Neglect, Exploitation 732-531-9191 or (911 after hours)
NJ Adult Protective Services (APS) Monmouth County Provider:
Family and Children Services 191 Bath Avenue Long Branch, NJ 07740

g. **COUNTY WELFARE AGENCY (for Adult abuse)**
   i. Monmouth County Board of Social Services: 1-732-431-6000; after hours call Local Police or dial 911
   PO Box 3000 ; 3000 Kozloski Road ; Freehold, NJ ; 07728
   Public Awareness, Information, Assistance and Outreach Unit,
   1-800-792-8820

h. **New Jersey Department of Health & Senior Services**
Department of Aging Telephone Number: 609-826-5090
240 West State Street ; Trenton, NJ ; 08625

i. **DOMESTIC VIOLENCE 1-888-843-9262**

j. **MEDICAID MANAGED CARE HOTLINE: 1-800-356-1561**
   i. Department of Medicaid Telephone Number: 732-761-3600
   3499 Route 9 ; Freehold, NJ ; 07728

k. The Joint Commission 1-800-994-6610 www.jointcommission.org
One Renaissance Bldv, Oakbrook Terrace, IL 60181

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Stress Care of New Jersey - Informed Consent for Services

General Information

I understand that I am voluntarily agreeing to services at Stress Care of New Jersey. If I refuse services, I will not be compelled to accept services except in an emergency. I also understand that once I consent to services, I can revoke consent at any time.

Consumer Consent

I have been informed by Stress Care of New Jersey staff of agency and program services that may be beneficial to me and/or my child or for whom I am a legal guardian. I understand that there are advantages (relief of symptoms) and possibly some disadvantages (possible adverse reactions) of these services and this has also been explained to me.

I have been given a copy of the Consumer Bill of Rights and Grievance Procedures and have been given an opportunity to review it and ask questions.

Based on my understanding of these benefits and risks of the services and the choices that are available to me, I consent and authorize Stress Care of New Jersey to provide behavioral health and integrated care service(s)/evaluation(s)/treatment for me and/or my child or for whom I am a legal guardian.

Stress Care of New Jersey - Consent to Use/Disclose PHI and Notice of Privacy Practices

By signing this form, I consent to the use and disclosure of my protected health information (PHI) by Stress Care of New Jersey, and its business associates for the purposes of treatment, payment and health care operations. This is a joint consent form of Stress Care of New Jersey and its clinical staff.

I understand that my signature on this Consent is required in order for me and/or my child or for whom I am a legal guardian to receive care from Stress Care of New Jersey and I have the right to revoke this consent, in writing, at any time, except to the extent that Stress Care of New Jersey has taken action in reliance upon this Consent.

Stress Care of New Jersey agrees to maintain my protected health information in accordance with the practices described in its Notice of Privacy Practices. This notice also describes my rights with respect to the use and disclosure of my protected health information.

I understand I have a right to review the Notice of Privacy Practices prior to signing this Consent. I acknowledge that I have reviewed and understand the Notice of Privacy Practices of Stress Care of New Jersey. I understand that if I choose to request a copy, one will be provided to me. Stress Care of New Jersey reserves the right at any time to change the privacy practice described in the Notice of Privacy Practices. The Notice of Privacy Practices is also posted at the address set forth at the top of this Consent and at a website with the address of www.stresscareclinic.com.

I certify by checking the box and printing my name below that I understand the above information.

Click here ☐ *to Acknowledge*

Client Printed Name: _____ Date:_____

Witness Signature:_____

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Assignment of Benefits

Financial Responsibility

I have requested professional services from Stress Care of New Jersey, LLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services/treatment. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitles to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolute me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

I certify by checking the box and printing my name below that I understand the above information.

Click here ☐ *to Acknowledge*

Client Printed Name: _____ Date: _____

Witness Signature: _____

2 copies required: One (1) for Client
One (1) for Client Char

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Authorization to Disclose Protected Health Information to Primary Care Physician (PCP)

Patient Name: _____ Patient Date of Birth: _____

Primary Care Physician (PCP): _____

Primary Care Physician (PCP) Address: _____

_____

Phone: _____ Fax: _____

☐ I **Refuse** Permission to Contact my Primary Care Physician

Printed Name of Client _____ Date _____
(If 18 years or older)

Printed Name of Guardian _____ Date _____
(If client is under 18, or otherwise permitted to consent by law)

☐ I **Allow** Permission to Contact my Primary Care Physician

I understand that these medical records contain information pertaining to psychiatric counseling or testing; alcohol/drug abuse counseling or testing; and/or HIV/AIDS diagnosis or testing. I do expressly and voluntarily authorize the disclosure of this medical record information to the person and/or entity as stated above.

This authorization /consent will remain in effect for a period of one year from the date stated below, unless revoked in writing to the medical records department by the person to whom it pertains (or his or her parent, legal guardian or legally authorized agent) whom to in any event this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

These medical records are being disclosed under the provisions of applicable New Jersey State and Federal Law (42 CFR). These laws prohibit any further disclosure of these records and require these records may only be used for the purposes stated on this authorization.

I certify by checking the refuse / allow box and printing my name that I have read (or have had read to me) the contents of this form and understand its contents.

Printed Name of Client _____ Date _____
(If 18 years or older)

Printed Name of Guardian _____ Date _____
(If client is under 18, or otherwise permitted to consent by law)