STRESS CARE OF NEW JERSEY, LLC
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)

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CLIENT BILL OF RIGHTS

1. The right to be informed of these rights and exercise his or her rights as a client, as evidenced by the client's written acknowledgment or by documentation by staff in the clinical record that the client was offered a written copy of these rights and given a written or verbal explanation of these rights in terms the client could understand;
    i. The right to have his or her property and person treated with respect.
    ii. The right not to be subjected to discrimination or reprisal for exercising his or her rights.
2. The right to be notified of any rules and policies the program has established governing client conduct in the facility;
3. The right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for the client's care, and fees and related charges, including the payment, fee, deposit, and refund policy of the program and any charges for services not covered by sources of third-party payment or the program's basic rate;
    i. The right to receive information about specific limitations on services that he or she will be furnished.
    ii. The right not to be compelled to perform services for the agency, and to be compensated by the agency for any work performed for the agency at prevailing wages and commensurate with the client's abilities.
4. The right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment; .
5. The right to receive from his or her physicians or clinical practitioner(s) an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s), in terms that he or she understands;
    i. If, in the opinion of the medical director or clinical director, this information would be detrimental to the client's health, or if the client is not capable of understanding the information, the explanation shall be provided to a family member, legal guardian or significant other, as available;
    ii. Release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record; and
    iii. All consents to release information shall be signed by client or their parent, guardian or legally authorized representative; ·
6. The right to participate and be involved in the planning and developing of his or her care, treatment, treatment plan and to refuse medication and treatment;
    i. A client's refusal of medication or treatment shall be documented in the client's clinical record;
    ii. The right to be free from unnecessary or excessive medication. (See N.J.A.C. 10:37-6.54)
7. The right to participate in experimental research only when the client gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent client in accordance with law, rule and regulation;
    i. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, ... or provider demonstration programs, without written informed consent,
    ii. The client has been adjudicated incompetent; authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2(d) 2.
8. The right to voice grievances or recommend changes in policies and services to program staff, the governing authority, and/or outside representatives of his or her choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal;
9. The right to be free from mental and physical abuse, exploitation, and from use of restraints:
    i. The right to treatment in the least restrictive setting, free from physical restraints and isolation.
    ii The right to be free from corporal punishment
    iii. The right to the least restrictive conditions necessary to achieve the goals of treatment/services vi. A client's ordered medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client in accordance with this chapter; medications may only be withheld when the facility medical staff determines that such action is medically indicated;

10. The right to confidential clinical record and confidential treatment of information about the client;

i. Information in the client's clinical record shall not be released to anyone outside the program without the client's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records at 42 U.S.C. §§290dd-2, and 290ee-2, and 42 CFR Part 2 § §2. l et seq., and the provisions of the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts l 60 and 164, unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, or the information is needed by DAS, DHMAS, or other regulatory/accreditation organization for statutorily authorized purposes; and

ii. The program may release data about the client for studies containing aggregated statistics only when the client's identity is protected and masked.

11. The right to be treated with courtesy, consideration, respect, and with recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy;

i. The client's privacy also shall be respected when program staff are discussing the client with others;

ii. The right to privacy and dignity.

I 2. The right to exercise civil and religious liberties, including the right to independent personal decisions;

i. No religious beliefs or practices, or attendance at religious services, shall be imposed upon any client.

I 3. The right to be free from mistreatment, neglect, verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client property and to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights.

i. Programs shall not discriminate against clients taking medications as prescribed.

14. The right to be transferred or discharged only for medical reasons, for the client's welfare, that of other clients or staff upon the written order of a physician or other licensed clinician, or for failure to pay required fees as agreed at time of admission (except as prohibited by sources of third-party payment);

i. Transfers, discharges, and reasons therefore, shall be documented in the client's clinical record; and

ii. If a transfer or discharge on a non-emergency basis is planned by the outpatient treatment program, the client and his or her family shall be given at least 10 days advance notice of such transfer or discharge, except as otherwise provided for in N.J.A.C. 10: 161 B-6.4(c).

15. The right to be notified in writing and to have the opportunity to appeal, an involuntary discharge and;

16. The right to have access to and obtain a copy of his or her clinical record, in accordance with the program's policies and procedures and applicable Federal and State laws and rules.

Client Name: _____ Date: _____

Client Signature: _____

Signature of Client or Guardian (18 years old and over)

Witness Signature: _____

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