New AGE Behavioral PC – New Patient Overview

Intake Packet – Table of Contents

• This practice provides outpatient psychiatric care only and does not offer emergency or crisis services.

• In emergencies or if you feel unsafe, call 911, go to the nearest emergency department, or call/text 988.

• Telepsychiatry requires that you are physically located in a state where your provider is licensed (New Jersey or Pennsylvania).

• Controlled medications require regular follow-up, Prescription Monitoring Program review, and adherence to prescribing rules.

• Missed appointments or late cancellations may result in fees and delayed rescheduling.

• Email and text communication are for non-urgent matters only and are not monitored continuously.

• ***This practice does not provide after-hours crisis coverage***

Estimated completion time: 10–15 minutes.

Thank you for partnering with New AGE Behavioral PC in your care.

New Age Behavioral

A balanced approach to a healthy mind.

Lloyd C. Alcera, MD
Psychiatrist

Edelquinne A. Jacildo, APN
Psychiatric Nurse Practitioner

Natalie C. Eisenhower, APN
Psychiatric Nurse Practitioner

Kristin Lebeau, APN
Psychiatric Nurse Practitioner

Patient Information:

Last Name	First Name	MI	Male/Female	Marital Status	Birth Date

Address	City	State	Zip	Primary Phone #

Employer / Occupation	Highest Education	Ethnicity	Social Security #	Secondary Phone #

Referred to:	Referred by:	Preferred Method of Contact	Email address

Responsible Party *(if patient is a minor or not financial guarantor):* ☐ *Same As Above*

Last Name	First Name	MI	Male/Female	Marital Status	Birth Date

Address	City	State	Zip	Primary Phone #

Employer / Occupation	Preferred Contact	SS #	Email address	Secondary Phone#

Emergency Contact:

Last Name	First Name	MI	Male/Female	Marital Status	Relationship

Address	City	State	Zip	Primary Phone#

Primary Method of Contact	Email Address	Secondary Phone #

Insurance Information:

Primary Insurance Company	Group #	Policy #	Phone #

Prescription Insurance Company	Group #	Policy #	Phone #

I hereby acknowledge and accept financial responsibility for charges incurred by the above named patient while under the care of New Age Behavioral.

Signature: _____ Date: _____

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize the New Age Behavioral to provide information gained through history, physical exam, progress notes, EKG, and labs to aid in processing any future insurance claims if necessary.

Signature_____ Date: _____

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Patient Background Information

Patient Name: _____ Date of Birth: _____ Marital Status_____

Sex _____ Ethnicity: _____ Religion: _____ Employed: _____ FT/PT_____

Enrolled in school? _____ Highest Education: _____ Profession: _____

Children: _____ Reside with you? _____Living Environment: _____

Is the intention of this psychiatric evaluation for workers compensation, medical leave, etc.? _____

Legal/Criminal history (arrested, probation, parole, incarceration, etc.): _____

Is the intention of this psychiatric evaluation for legal purposes? If yes, please explain. _____

Seeking a psychiatric evaluation for treatment of my _____

Any previous psychiatric inpatient hospitalizations? _____

Any previous emergency room/crisis assessments for psychiatric symptoms? _____

Any current/previous residential or Intensive Outpatient (IOP) treatment? _____

Any current/previous substance abuse treatment? _____

Any current/previous psychiatric outpatient (OP) treatment? _____

Any current/previous psychiatric diagnosis(es)? _____

Any current/previous prescribed psychiatric medications? _____

Any chronic medical conditions? _____

Any other medication(s) prescribed to you? _____

Any personal history of developmental delays? (Infancy, Childhood, Adolescent): _____

Any personal history of physical, sexual, or emotional trauma? _____

Any family history of psychiatric or substance abuse disorders? _____

Any additional information:

10000 Lincoln Drive East, Suite 101A, Marlton, NJ. 08053
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New AGE Behavioral Office Policy

(Please initial after reading each paragraph)

OFFICE HOURS & APPOINTMENTS

Each practitioner has varied hours, and we will try, whenever possible, to fit appointments to your schedule. A 24 hour cancellation policy is in effect. Appointments cancelled without the required notice will be billed to the "Responsible Party." ***Missed appointments are not covered by your insurance and will be subject to a $40 fee. Please call as soon as possible to cancel your appointment so we may give that time to someone else. All appointments not cancelled within 24 hours before your scheduled appointment time will be subject to a $40 fee***. Initials_____

FINANCIAL RESPONSIBILITY

When completing our Patient Information form, the person listed as "Responsible Party" will be legally financially responsible for the account. This person is required to sign at the bottom of our form accepting financial responsibility. Unfortunately, we will not be able to divide financial responsibility between parties. Initials_____

PAYMENT / RATES

Payment is **due in full** at the time of your appointment. We gladly accept cash, check or credit card. Initials_____

- Statement Fee – A $1 statement fee for unpaid accounts requiring a mailed billing statement. Initials_____
- NSF Fee – There will be a $20 fee for all returned checks. Initials_____
- Unpaid Accounts – Accounts left unpaid may be given to an outside collection agency. Initials_____
- Dictated letter less than 2 pages will be charged $20. Initials_____
- ***Social Security and disability forms will be charged $20.*** Initials_____

INSURANCE

OUR DOCTORS PARTICIPATE WITH AETNA, HORIZON BCBS OF NJ, MAGELLAN, IBC, COMPSYCH and MEDICARE.

Please contact your insurance company to verify your mental health benefits. It is your responsibility to meet your deductible; please contact your insurance company if you are not sure of your deductible amount. Co-payments are due at time of service. ***If you are a FEE FOR SERVICE PATIENT it is YOUR RESPONSIBILITY to seek payment from your insurance company. All payments are due at time of service unless otherwise specified.*** Initials_____

PHONE CALLS

As a courtesy to our patients, there is no charge for brief, routine phone calls and medication refills. If more time is required, please arrange an appointment. ***Medication refills may be subject to a $40 charge if appointments are cancelled regularly. An appointment MUST be made prior to receiving medication refills.*** Initials_____

PATIENT FORMS

A fee will be charged for any form requiring completion by your physician. The fee will be determined by your physician according to the intensity of the form. Initials_____

ACKNOWLEDGMENT

Office fees, no-show fees, billing policies, NSF fees, Notice of Privacy Practice are all subject to change at the discretion of the PROVIDER. By signing this agreement, it is understood that you, or as the guardian of a minor, understand and agree to abide by our office policy and will accept the conditions thereof. Initials_____.

PSYCHIATRIC EMERGENCIES

I understand that New AGE Behavioral provides outpatient services only and does not offer emergency or crisis care. In a psychiatric emergency, I agree to call 911, go to the nearest emergency department, or contact 988. _____

_____	_____	_____
SIGNATURE	PRINT NAME	DATE

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in secure electronic health records and will not contain any coding which identifies a patient'scondition or information which is not already a matter of public record. The normal course of providing care meansthat such records may be left, at least temporarily, in administrative areas such as the front office,examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, USPS, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing, advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward per my signature below:

_____ _____

(Signature) (Date)

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Telepsychiatry Informed Consent

Purpose of Telepsychiatry
Telepsychiatry involves the delivery of psychiatric evaluation, diagnosis, and treatment using secure, real-time audio-visual communication technology.

Patient Location Requirement
I understand that telepsychiatry services may only be provided when I am physically located in a state where my clinician is licensed. I agree to accurately disclose my physical location at the start of every telepsychiatry visit.

Licensure Disclosure
My clinician is licensed to practice medicine in the following states:

New Jersey – Alcera, Eisenhower, Jacildo, LeBeau

Pennsylvania – Alcera, Jacildo

Telepsychiatry services may only be provided when I am physically located in one of these states at the time of the session.

Risks and Limitations
I understand that:

- Technical failures may disrupt services
- Telepsychiatry may not be appropriate for all clinical situations
- Emergency situations may require in-person or local emergency services

Emergency Procedures
In the event of an emergency, I agree to seek immediate assistance by calling 911 or local emergency services. I understand that my clinician may contact emergency services if there is concern for my safety or the safety of others.

Confidentiality
All telepsychiatry sessions are conducted using HIPAA-compliant platforms. However, no technology is entirely risk-free, and confidentiality cannot be guaranteed.

Controlled Substances
I understand that additional restrictions apply to the prescribing of controlled substances via telepsychiatry and that my clinician may require in-person visits or additional safeguards.

Consent
By signing below, I acknowledge that I understand the above information and consent to receive telepsychiatry services.

_____	_____	_____
Patient Signature	Print Name	Date

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Patient Email and Text Messaging Informed Consent

You may give permission to New AGE Behavioral to communicate with you by email and text message. This form provides information about the risks of these forms of communication, guidelines for email/text communication and how we use email/text communication. It will also be used to document your consent for communication with you by email and text message.

1. **How will we use email and text messaging?:** We use these methods to communicate non-sensitive and non-urgent issues. All communications may be made part of your medical records. You have the same right of access to such communications as you do to the remainder of your medical record. We will not disclose your emails or text messages to any third party.

2. **Risks of using email and text messaging:** The use of email and text messages have a number of risks that you should consider. These risks include but are not limited to:
    a. Emails and texts can be circulated, forwarded, stored electronically and on paper.
    b. Senders can misaddress an email or text message and send information to undesired recipients.
    c. Backup copies of emails and texts may exist even after the sender and/or recipient has deleted their copy.
    d. Emails and texts could be intercepted, altered, forwarded, or used without authorization or detection.
    e. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. **Conditions of the use of email and text messaging:** New AGE Behavioral cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text message information sent and received. You must acknowledge and consent to the following:
    a. **If you are having a psychiatric emergency, call 911 or go to your nearest crisis center.** Email and text messaging should not be used for urgent matters.
    b. Time sensitive matters should not be communicated through email or text messaging. While we will do our best to respond in a timely manner, we cannot guarantee that any particular email/text message will be read and responded to within any particular period of time. Please contact the main office number for time sensitive matters: 856-797-2810.
    c. You should speak directly to the office to discuss complex or sensitive situations rather than communicate via email/text message.
    d. Email and text messages may be filed electronically into your medical record.
    e. Staff will not forward your email/text messages to outside parties without your written consent.
    f. You should use your best judgement when considering the use of email or text messages for communication regarding your medical information.
    g. New AGE Behavioral is not liable for breaches of confidentiality caused by you or any third party.
    h. You will only be contacted at the email address and cell phone number you list below, if there are changes, please contact the office to update your information.
    i. It is your responsibility to follow up with New AGE Behavioral if warranted, at 856-797- 2810.

4. **Withdrawal of consent:** I understand that I may revoke this consent at any time by so advising New AGE Behavioral in writing. Revocation of consent will not affect your ability to obtain future health care nor will it cause the loss of any benefits to which you are entitled.

5. **Patient acknowledgment and agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between New AGE Behavioral and I. I consent to the outlined conditions and instructions regarding communications via email or text messaging.

Patient Name: _____ Email: _____ Cell #: _____

Signature: _____ Date: _____

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Controlled Substance & Medication Acknowledgement

Certain medications prescribed by this practice are classified as **controlled substances** under federal and state law. These may include stimulants, benzodiazepines, opioids, and other scheduled medications. Because of their potential risks, additional prescribing, monitoring, and legal requirements apply.
By signing below, I acknowledge and agree to the following:

Provider Discretion & Safety

I understand that controlled substance prescribing is based on medical judgment, patient safety, and legal requirements and is not guaranteed. Prescribing decisions may change over time based on my clinical status, response to treatment, safety concerns, or adherence to this agreement.
Failure to comply with this acknowledgment or evidence of misuse, diversion, or unsafe use may result in modification or discontinuation of controlled medication prescribing.

Prescribing & Patient Responsibilities

- I agree to take controlled medications only as prescribed and will not change the dose or frequency without provider approval.
- Early refills are not guaranteed and are generally not provided.
- Refill requests must be made during regular business hours and may require a scheduled appointment.
- Lost, stolen, or damaged medications are not routinely replaced.
- My provider may review the Prescription Monitoring Program (NJ PMP / PA PDMP) as required by law.
- Urine drug screening or other monitoring may be required when clinically indicated.
- I agree to obtain controlled medications only from New AGE Behavioral PC unless otherwise authorized.
- I agree to use one designated pharmacy whenever possible and will notify the office of any changes.
- I will not share, sell, or distribute my medication.

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Telehealth & Schedule II Prescribing Requirements *(UPDATED FEBRUARY 16, 2026)*

Prescribing of controlled substances via telehealth is governed by federal DEA regulations and state law and may require in-person visits.

Schedule II medications include:

- Stimulants: amphetamine products (Adderall, Mydayis, Evekeo), lisdexamfetamine (Vyvanse), methylphenidate (Ritalin, Concerta, Focalin), dexmethylphenidate are most common.
- Opioids (oxycodone, hydrocodone, morphine, fentanyl, hydromorphone, methadone)
- certain barbiturates and anesthetics.

As of **February 16, 2026**, emergency pandemic telehealth waivers have ended. Prescribing of **Schedule II** medications must comply with current federal and state requirements.

In New Jersey, Schedule II prescribing generally requires:

- An **initial in-person medical evaluation**, and
- An **in-person follow-up visit at least every three (3) months** for continued prescribing.

An exception may apply for **Schedule II stimulant treatment in patients under age 18**, where telehealth prescribing may occur without an in-person visit if:

- Real-time interactive audio-video technology is used, and
- Written parental/guardian consent for the telehealth waiver is obtained.

These requirements apply even if federal telehealth rules change or allow broader prescribing.

Failure to meet required in-person visit standards may result in delays, interruption, or discontinuation of controlled medication prescribing.

Acknowledgment

I acknowledge that I have read and understand this agreement and agree to follow these requirements while receiving controlled medications from this practice.

_____	_____	_____
Patient Signature	Print Name	Date

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Cancellation Policy

Due to the high demand for appointments, we have updated our cancellation policy. If you have any questions regarding this, please let us know.

- All patients who wish to cancel or reschedule their appointments must do so 24 hours in advance. We understand that some circumstances may not allow for 24 hours in advance; we will use our discretion with those situations.

- Any patient who does not cancel or reschedule and misses their appointment will be charged a $40 no show fee.

- After your third no show, your case will be closed with a final 30-day prescription issued.
  *** Re-establishment of care is NOT guaranteed and may require a new intake.

- If transportation is an issue, a telehealth appointment may be available. This cancellation policy also applies to scheduled telehealth appointments that are missed.

Please be advised that our scheduling is done on a first come, first served basis. We are currently scheduling 6-8 weeks in advance. Any appointments that are missed may not be rescheduled immediately and there may be a significant wait time.

Printed Name _____ Signature _____ Date _____

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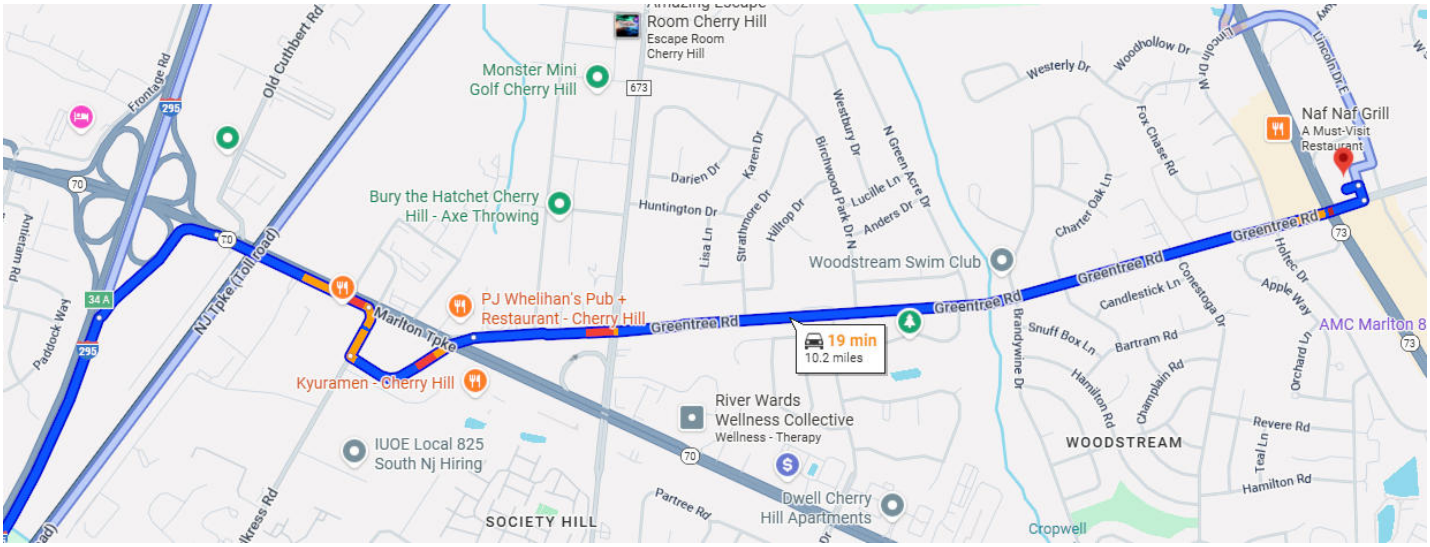
From 1-295 North:
Take exit 34 A to merge onto NJ-70 E/Marlton Pike East/Marlton Tpke toward Marlton
Merge onto NJ-70 E/Marlton Pike East/Marlton Tpke
Continue straight onto Marlton Pike East/Marlton Tpke
Turn right onto Marlkress Rd
Turn left onto Old Cuthbert Rd
Continue onto Greentree Rd
Turn left onto Greentree Center
Turn left. New AGE Behavioral will be on the right.



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