NEW CLIENT
INTAKE PACKET

Date: _____
Time: _____

Name: _____ **DOB:** _____

Address:_____
_____
_____

Home # (_____) _____ _____
Work # (_____) _____ _____
Cell # (_____) _____ _____

Phone Availability: _____

Treatment Availability: _____

Treatment Here Before: YES___ Date:_____ NO___

Method of Payment (s): _____

How did you find out about **Therapy Resources of Morris County, LLC**?
Referred By:

_____
_____
_____

What prompted you to seek **Mental Health/Behavioral Health Services**?

_____
_____
_____
_____

EMERGENCY CONTACT INFORMATION AND RELEASE

PLEASE PRINT

Client Name _____

Phone # _____

Address _____

EMERGENCY CONTACT

Name _____ Relationship to client _____

Address _____

_____

Home Phone _____

Work Phone _____

Other phone #'s (pager, cell, etc.)_____

Please indicate if there are any other emergency contact people that you want us to have:

In the event of an emergency, I give Therapy Resources of Morris County, LLC permission to contact the above person/persons, and release any information that may be required to handle the emergency. I understand that this consent can be revoked at any time by letter, except to the extent that action has already been taken, and that this consent will remain in effect for one year from the date of the signature. Any variations or additions to the above information must be provided in writing.

_____ _____

Client Signature Date

_____ _____

Witness Date

CONSENT FOR TREATMENT AT THERAPY RESOURCES OF MORRIS COUNTY, LLC

I hereby give permission to the Therapy Resources of Morris County, LLC to provide treatment for me (or my minor child) on an outpatient basis. By signing this form, I am acknowledging the following:

1. I have the right to an explanation of the benefits and risks of each proposed treatment, other treatment within the practice and of no treatment or incomplete treatment.

2. I have the right to refuse treatment except as provided under Emergency Screening Law.

3. Therapy Resources of Morris County, LLC is responsible for making efforts to explore other approaches where clinically appropriate and to discuss them with me.

4. Therapy Resources of Morris County, LLC is responsible for explaining the implications and potential consequences of refusing or withdrawing consent for treatment.

5. Therapy Resources of Morris County, LLC is responsible to discuss with me instances when information from my records is being shared.

6. I understand that I have the right to withdraw this consent at any point in my treatment and that in doing so my case may be closed.

7. I have received information at the start of treatment to include information regarding confidentiality and individual client rights.

_____ _____

Client Name (Print) Date

_____ _____

Signature of Client, Parent or Guardian Date

ELECTRONIC COMMUNICATIONS POLICY

Therapy Resources of Morris County, LLC providers make use of text messaging, electronic mail, Doxy.me, Skype and Face Time interactions with clients to have more accessibility with providers. In order to manage potential risk associated with electronic communication, there are protective measures that are important to reinforce in these areas of communication that are similar in other areas including privacy, confidentiality, and informed consent.

Email Communications: TRMC providers use an independent Google email system through therapyresourcesmc.com, which is password protected to communicate with clients. Only the providers business computer and business smart cell phone will be used to retrieve email sent to this address. Emails are retained for 7 years as per medical record requirements. In addition, clients may request encrypted emails.

Cell Phones/Texting: Providers at TRMC use business only cell phones with protected passwords and address books along with calendar schedules that list clients by first name and last initial only. Providers can be available to clients at their discretion related to appointment scheduling, changes, or clarification/follow up. Any discussion regarding counseling services is highly encouraged to be conducted face to face.

Friending/Following: All Providers at TRMC do not accept friend requests from current or former clients served. This pertains to all sites including but not limited to; Facebook, Twitter, Instagram, Google+, Snap Chat, Pinterest, Linked in, Foursquare, or Myspace.

Business Review Sites: TRMC may be visible on sites such as Yelp, Health Grades, Yahoo, Bing and other places which list businesses. The ACA Code of Ethics outlines "accurate advertising" and "testimonials" as two areas where information listed could be potentially problematic. The internet does not allow for a business owner to protect the name of the business from being added to sites that are not authorized by the business owner. Under testimonials, "Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence."

These practices have been put in place to provide clients with more confidence in the protection of privacy rights. I have read the above policy and procedures, understand and accept them unless otherwise discussed and documented in my medical record.

_____	_____
Client Signature	Date
_____	_____
Other (Parent, Legal Guardian, Authorized Person)	Date
_____	_____
Witness	Date

COUNSELOR/CREDENTIALED INTERN DISCLOSURE FORM

Therapy Resources of Morris County, LLC
AGREEMENT OF TREATMENT
N.J.A.C. 13:34C-6.2(c) AND 6.3 (c)

Client Name:_____Date:_____

I have been informed that the following staff are either Counselor/Credentialed Interns, certified as an Alcohol and Drug Counselor or an Associate Counselor and require supervision to provide counseling.

Staff that is Master's Level, Counselor/Credentialed Interns, CADC, or Associate Counselors in training providing treatment at this practice includes:

1. Blake Sloven	Licensed Associate Counselor
2. Susan Wolf	Licensed Associate Counselor
3. Arlene Phillips	Licensed Associate Counselor
4. Adam Siegel	Licensed Associate Counselor
5. Sara Melberger	Licensed Associate Counselor
6. Anna Kronfeld	Licensed Associate Counselor
7. Patricia Betz	Licensed Associate Counselor
8. Maria Palamara	Licensed Associate Counselor
9. Tedisha Murray	Licensed Associate Counselor
1. Kathryn Mullett	MA Intern, New York University
2. Danielle DePrimio	MA Intern, Northwestern University
3. Dalia Mourad	MA Intern, Northwestern University
4. Brian Carreira	MA Intern, Fairleigh Dickinson University
5. Malika Leary	MA Intern, Fairleigh Dickinson University
6. Kristin Pizzanok	MA Intern, William Paterson University

I also understand that:
~Cheryl Garodnick LPC, LCADC, ACS, CCS
~Kathleen Dennis LPC, LCADC, ACS, CCS
~Dorian Head LPC, ACS
are Clinical Supervisors for my treatment and have access to my treatment record. I understand that the supervisor is ultimately responsible for all aspects of my treatment.

A copy of this disclosure shall be kept in my client record.

Client Signature:_____Date:_____

Witness:_____ Date:_____

Revised: 5/19

CLIENT/FAMILY MEMBER FINANCIAL AGREEMENT

I, _____, request services at Therapy Resources of Morris County, LLC for _____ (DOB: ____/____/_____).

(Self, Partner, Family Member, Guardian)

"I hereby agree that Therapy Resources of Morris County, LLC is authorized to bill my insurance company for services rendered to me and/or my family members and that Therapy Resources of Morris County, LLC may release any and all appropriate information required by said companies for the payment of any claims submitted by the group practice." If you have appropriate health insurance coverage, we will bill your insurance carrier for sessions at Therapy Resources of Morris County, LLC. If your insurance company remits payment directly to you, you are obligated to endorse the check to Therapy Resources of Morris County, LLC in order to cover the balance of charges in your account. We require that you assign benefits to Therapy Resources of Morris County, LLC where applicable.

I also herby assign Therapy Resources of Morris County, LLC all my rights and interest to any insurance proceeds to which I am entitled for such services. I further agree that any such insurance proceeds shall be paid to the practice in addition to my agreed upon fee and that I shall not be entitled to a refund unless the combination of my insurance proceeds and my agreed upon fee exceed 100% of the standard fee set forth in the Schedule of Fees. If the insurance reimbursement exceeds the cost of service, Therapy Resources of Morris County, LLC will refund the excess amount to you.

IF A THIRD-PARTY CLAIM (SUCH AS INSURANCE) IS NOT SUBMITTED OR IS DENIED DUE TO YOUR FAILURE TO COOPERATE IN FILING OR COLLECTING, YOU WILL BE RESPONSIBLE FOR THE FULL COST.

If you wish to make your payments for services via credit card, you hereby agree that Therapy Resources of Morris County, LLC is authorized to charge your credit card on file upon rendering of services at the fee set forth in the Schedule of Fees, or at the appropriate co-payment, co-insurance, or deductible amount defined in your health insurance policy. You are responsible for updating Therapy Resources of Morris County, LLC regarding changes to credit card information required to charge your account.

Cancellation Policy - If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you will be required to pay a cancellation fee of **$80.00**. If you do not show up for a Holiday scheduled appointment you will be charged a **$80.00** cancellation fee regardless of prior notice.

I have read and understand the information regarding fee payment.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

CREDIT CARD PROCESSING FORM

All information released on this form is for payment purposes only and will remain confidential.

Name of Person Completing Form: _____

Circle One: Mastercard Visa Discover American Express

Credit Card Number: _____

First Name on Credit Card: _____

Last Name on Credit Card: _____

Billing Zip Code: _____
(Listed at time card was initiated)

Expiration Date: ___/___

By signing below, you authorize Therapy Resources of Morris County, LLC to process credit card payments for client balances due. Please contact your therapist or the billing department to discuss any questions regarding credit card charges to your account. Charges disputed with a credit card company resulting in chargeback fees to Therapy Resources of Morris County, LLC will ultimately be the client's responsibility.

Signature: _____ Date:_____

Witness: _____ Date:_____

Insurance Information

Date:_____ **Name:_____**

PRIMARY INSURANCE INFORMATION Client Is To Contact Insurance Company For The Following Information	
Primary Insured's Information Insured's Name _____ (If different than client) DOB _____ SS# _____ Employer_____ Client's relationship to insured: ☐Self ☐ Spouse☐ Child ☐ Other _____	**Primary Insurance Company** **Name:_____** **_____** ☐ **In Network** ☐ **Out of Network** Telephone # _____ Contact Name _____ ID/Policy/Member # _____ Group # _____
Behavioral Health Claims Submission EFT Provider: _____ **Behavioral Health Claims Submission Address** _____ _____ Payor ID #: _____	**Behavioral Health Carrier** **Name:_____** **___** ☐ **In Network** ☐ **Out of Network** Telephone # _____ Contact Name _____ ID/Policy/Member # _____ Group # _____
Therapy Resources of **Morris County, LLC Information** **TAX ID (EIN):** **460 594 448** **GROUP NPI:** **188 193 6847**	**Benefits** Effective Date: _____ Deductible $ _____ Copays $ _____ Pays at % _____ Co-insurance % _____ Number of visits available _____ Authorization Needed? YES____ NO____

RECORDS & INFORMATION RELEASE AUTHORIZATION
(Excludes Drug and Alcohol Information)

I, _____ D.O.B: (__/__/__), do hereby give permission to **Therapy Resources of Morris County, LLC - (_____) or Authorized Representative** to release the following information from my records and **(_____)** to release the following information about me:

- ☐ Medication & Psychiatric History
- ☐ Mental Status on Admission or Discharge
- ☐ Physical Exam & Laboratory Test Results
- ☐ Progress Notes
- ☐ Final Summary
- ☐ Other:

Note: The person whose records are being released has the legal right to have specific information withheld.

This information is to be released to **(_____)** and the same information to be released to **Therapy Resources of Morris County, LLC – (_____) or Authorized Representative** to release the following information from my records:

The purpose or need for this reciprocal disclosure is to:
Share Collateral Information to Coordinate Treatment Services

This information may be given: X☐ Verbally, by phone or in person X☐ Fax X☐ In writing
X☐ A reproduction of the authorization shall be as effective and valid as the original.

Frequency: X☐ As needed X☐ Until _____**1 year from signed date**_____

I understand this consent can be revoked at any time in writing except to the extent that action has already been taken in reliance thereon; and this consent will reasonable time needed to accomplish the purpose for which it is given, not to exceed one year.

Client: _____ Date: _____
(Including minors 14 years or older whose refusal to sign renders this consent void)

Parent 1: _____ Date: _____
(Parent, Legal Guardian, Authorized Representative, Significant Other)

Parent 2: _____ Date: _____
(Parent, Legal Guardian, Authorized Representative, Significant Other)

Witness: _____ Date: _____

CONFIDENTIAL: THE WITHIN INFORMATION IS DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. FEDERAL REGULATIONS (SEC 42CFR-PT2) PROGIBITS YOU FROM MAKING FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR, AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THIS INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE CLIENT.

RECORDS & INFORMATION RELEASE AUTHORIZATION
(Includes Drug and Alcohol Information)

I, _____ D.O.B: (__/__/__), do hereby give permission to **Therapy Resources of Morris County, LLC – (_____) or Authorized Representative** to release the following information from my records and **(_____)** to release the following information from my records:

- ☐ Drug/Alcohol Assessment (CASI) or Initial Comprehensive Assessment (ICA)
- ☐ Drug/Alcohol Recommended Level of Care (LOCI Placement)
- ☐ Drug/Alcohol Continued Service Reviews (CSR's) and/or Continued Treatment Updates
- ☐ Drug/Alcohol Toxicology Test Results
- ☐ Drug/Alcohol Progress Notes
- ☐ Drug/Alcohol Final Summary
- ☐ Other (please specify)

Note: The person whose records are being released has the legal right to have specific information withheld.

This information is to be released to **(_____)** and the same information to be released to **Therapy Resources of Morris County, LLC – (_____) or Authorized Representative** to release the following information from my records:

The purpose or need for this reciprocal disclosure is to:
Share Collateral Information to Coordinate Treatment Services

This information may be given: X☐ Verbally, by phone or in person X☐ Fax X☐ In writing
X☐ A reproduction of the authorization shall be as effective and valid as the original.

Frequency: X☐ As needed X☐ Until _____**1 year from signed date**_____

I understand this consent can be revoked at any time in writing except to the extent that action has already been taken in reliance thereon; and this consent will reasonable time needed to accomplish the purpose for which it is given, not to exceed one year.

Client: _____ Date: _____
(Including minors 14 years or older whose refusal to sign renders this consent void)

Parent 1: _____ Date: _____
(Parent, Legal Guardian, Authorized Representative, Significant Other)

Parent 2: _____ Date: _____
(Parent, Legal Guardian, Authorized Representative, Significant Other)

Witness: _____ Date: _____

CONFIDENTIAL: THE WITHIN INFORMATION IS DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. FEDERAL REGULATIONS (SEC 42CFR-PT2) PROGIBITS YOU FROM MAKING FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR, AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THIS INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE CLIENT.

INSURANCE RELEASE FOR AUTHORIZATION OF MEDICAL INFORMATION AND THIRD-PARTY PAYMENT

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits and/or medical benefits to either myself or to Therapy Resources of Morris County, LLC for services provided.

_____ _____
Client Signature Date

STATEMENT OF UNDERSTANDING

I understand that the benefits as quoted by the representative of Therapy Resources of MC, LLC are for my information only, and that it is ultimately my responsibility to call my insurance company to verify these benefits within one week of my Intake/Assessment visit.

I further understand that I must immediately notify Therapy Resources of MC, LLC of any changes in the benefits quoted to me and any changes in benefit coverage during this treatment episode.

_____ _____
Client Signature Date

STANDARD RATES OF SERVICE

I have read, understand and been given a copy of the information regarding fee for services and payment responsibility related to covered and non-covered charges.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Revised: 08-18

CONFIDENTIALITY AND PRIVACY STATEMENT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Confidentiality and Privacy Statement, Notice of Privacy Practices.

_____ _____
Client Signature Date

SCOPE OF PRACTICE DISCLAIMER

I acknowledge that I received a copy of Scope of Practice Disclaimer.

_____ _____
Client Signature Date

CLIENT RIGHTS AND RESPONSIBILILITES

I acknowledge that I received a copy of Client Rights and Responsibilities.

_____ _____
Client Signature Date

RECORDS AND INFORMATION RELEASE AUTHORIZATION

I acknowledge that I received a copy of the Records and Information Release Authorization.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Revised: 08-18