Well Being

THERAPY CENTER

YOUR INFORMATION – INTAKE FORM

Today's Date: _____

Client Name: _____ **Age:** _____ **DOB:** _____

Parent/Guardian (if applicable): _____ **Relationship to child:** _____

Phone (home): _____ **Phone (cell):** _____

Address: _____

City, State, Zip: _____

Email: _____

Single _____ **Married** _____ **Separated/Divorced** _____ **Minor** _____

Occupation _____ **School (if applicable)** _____

***Emergency Contact*:** _____ **Phone:** _____

- **Please briefly describe why you have come to Well Being Therapy Center:**

_____

_____

_____

- **How long has this been a concern? (e.g., days, weeks, months, etc.)**

_____

- **How much does this problem impact you and your family? (Circle One)**

1	2	3	4	5
Not At All	A little bit	Moderately	A lot	Extremely

- **Have you (client) ever been prescribed medication for this problem? YES NO**

  If yes, by which doctor? Name: _____

- **Have you (client) ever been treated by a psychiatrist? YES NO**

  If yes, by which doctor? Name: _____

Continue on back →

- **Have you been in therapy before?** _____ **For how long?** _____

- **Please list any current medications:** _____

_____

- **Immediate Family Members:**

Name	Relationship	Age

- **How Did You Hear of Us?** _____

Thank you!

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INFORMED CONSENT

Thank you for choosing **Well Being Therapy Center**.

Confidentiality: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by New Jersey State Law, we are obligated to report this to the Division of Youth and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law.*
The confidentiality of alcohol and drug abuse records are protected by federal law and regulations. We will not disclose any information identifying a client as an alcohol or drug abuser unless the client consents in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. These federal laws do not protect any information about suspected child abuse or neglect from being reported under NJ State Law to appropriate state or local authorities.

Emergency Situations: *If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the emergency services in the community (911). Your therapist at Well Being Therapy Center will follow up those emergency services with standard counseling and support to the client or the client's family.*

Consent for Assessment and Treatment
I hereby agree to have the staff of Well Being Therapy Center provide mental health treatment and/or substance abuse treatment services, which may include individual, family, and group sessions, as well as urine screenings (for substance abuse treatment only).

Parent/Guardian Complete for Minors: Consent for the Treatment of Children or Adolescents

I/We consent that _____ may be treated as a client by Well Being Therapy Center. It is understood that children over the age of 12 have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

Payments and Cancellations: *As a courtesy we will provide you with a bill/receipt for your insurance company. Client is responsible for full payment, which is due at the time services are rendered. Please note, in order to provide a convenient schedule for you and all of our clients, if you cancel a booked appointment with less than 24-hours notice, full payment will be due. Thank you for your understanding of this policy.*

Notice of Privacy Practices and Client Rights: *I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document.*

By signing below, you indicate that you have read and understood this document, and that any questions you have about this statement have been answered to your satisfaction.

_____ _____
Client Signature ***Date***

_____ _____
Parent/Guardian Signature ***Date***

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HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about your may be used and disclosed and how you can get access to this information.

Well Being Therapy Center has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling and social work profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

Treatment We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This may include consultants and potential referral sources.

Payment We may need to use or disclose information needed to process your payments as well as information needed for billing and collection purposes.

Healthcare Operations We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by New Jersey State Law, we are obligated to report this to the Department of Youth and Family Services; Information that informs us that you are in danger of harming yourself or others; Information to remind you of or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

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Client Rights & Privacy Policies

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.