CLIENT INTAKE FORM INSTRUCTIONS

1) **DOWNLOAD** the Client Intake Form & **SAVE** within your computer
2) **LOCATE THE FORM** you downloaded. **OPEN** & **COMPLETE THE FORM**
3) **SAVE THE FORM** (This will be attached to email)
4) **EMAIL & ATTACH YOUR FORM** to: **counselingcenterathamilton@gmail.com**

Counseling Center at Hamilton, LLC.

2667 Nottingham Way
Suite #3, Hamilton, NJ. 08619
Office/fax: 609-890-9998
www.counselingcenterathamilton.com

Client Intake Form

Date: _____ Therapist: _____

Referred by: _____Reason for referral: _____

Client information

Client name: _____ DOB:_____

Age:_____ Sex: _____Ethnicity: _____

Cell #: _____Work #:_____

Street Address: _____

Town/City:_____State:_____Zip Code:_____

E-mail: _____

Parent Name (if client is minor): _____

Address: _____

Home #: _____Cell #: _____Work #:_____

Medical Health Insurance Information

Primary Insurance: _____

Address: _____

Insurance phone#: _____Mental Health #: _____

Insured Name: _____Insured DOB: _____

Insured SS #:_____Employer:_____

Policy #: _____Group #: _____

Client's relationship to Insured: self:_____ spouse:_____ dependent:_____

Insured Address (if different):_____

Insured home #:_____Work #:_____Cell #:_____

Secondary Insurance: _____

Address:_____

Insurance phone#:_____MH phone#:_____

Insured name:_____ Employer:_____

Client relationship to Insured: self:_____ spouse:_____ dependent:_____

Insured address (if different):_____

Insured home#:_____Cell#:_____Work#_____

Medical information

Primary Physician: _____

Phone: _____

Significant health problems: _____

Medications you are presently taking and dosage:

_____

_____

Have you been in therapy before? _____

If yes, give date(s) and name(s) of therapist:

_____

_____

Give brief description of issues worked on:

_____

_____

Emergency contact person & number: _____

Reasons for Counseling

1. What is your present concern?

_____

_____

_____

_____

_____

2. How will you know you have achieved your goals?

_____

_____

_____

_____

Confidentiality Statement

All information in session is confidential except in circumstances governed by the laws of New Jersey including the mandatory duty to warn in cases of alleged harm to self or others, and in cases of abuse, particularly in the case of a child, handicapped person, or elder abuse. I acknowledge use of and give my consent to the use of security cameras at the Counseling Center at Hamilton, LLC.

Notice of Privacy Practices

I acknowledge by signing below that I have received notice of privacy practices in keeping with HIPA laws.

Financial Agreement and Client Consent

I voluntarily agree to receive counseling treatment for myself and/or my minor child(ren) with Joanna O'Neill, MA. LPC. NCC or her designee.

I permit Joanna O'Neill, MA. LPC. NCC. to provide information for treatment and medical billing to my insurance company. Any request for information beyond that which is/has been ordinarily used for billing purposes requires that I give additional permission by signing an additional release of information form.

I am responsible for payment of my fee to the Counseling Center at Hamilton. In many cases my health insurance company determines the payment for the provider and the payment (co-pay) which is my responsibility. I am responsible for the portion of my fee that has been designated my responsibility (co-pay) by my insurance company. When the insurance company fails to pay I agree to pay my bill in full. I acknowledge that sessions are 45 minutes and I understand this time has been reserved for me. **I agree to 48 hour notice that is required for cancellation of appointment or I will be charged a $50.00 fee for a missed office visit.** It is understood that charges will be added to my account for professional services rendered by my therapist (i.e., emergency phone contacts/sessions over 10 minutes, preparation of special forms, reports, etc.) The fee for these

services is $125.00 per hour or $62.50 per half hour. Reports/Letters are $125.00 for each request. Court appearances, Child Study IEP Meetings, CART Meetings, Team Meetings, Home Base Family Therapy Sessions and Lectures are services available upon request. The fee for these off site services is $175.00 per hour. I am aware that a $25.00 fee will be charged for a bounced check. If I am billed for services rendered, and that bill is unpaid, I understand I will also be charged 1.5% interest on the balance due each month. If my balance is left unpaid and sent to collections, I understand that I am responsible and will also be billed for any attorney fees and collection costs incurred by the Counseling Center at Hamilton, LLC. I understand that I have the right to terminate treatment at any time up to 48 hours before my next scheduled appointment.

Release

I acknowledge that I have voluntarily entered into treatment with the Counseling Center at Hamilton's Therapist Joanna O'Neill, MA. LPC. NCC. or her designee. I due hereby release the Counseling Center at Hamilton's Therapist Joanna O'Neill, MA. LPC. NCC. or her designee of any and all claims, known or unknown, without reservation that I may have against the Counseling Center at Hamilton, its representatives, agents, and employees.

Statement of Understanding

My therapist has reviewed this 5 page client-therapist agreement (Confidentiality Statement, Financial Agreement, HIPA Privacy Policy, Client Consent, and Release) and I hereby acknowledge that I agree and understand its contents and enter into this agreement voluntarily and without duress.

Client: _____ Date: _____

Therapist: _____ Date:_____

Parent or Guardian if minor: _____

THE COUNSELING CENTER AT HAMILTON, LLC.

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 6/10/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, psychiatrist, psychotherapist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment of upon request.

2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. However, we reserve the right not to agree to the requested restriction.

3. **Request to received communications of protected health information in confidence.**

4. **Inspect and obtain a copy of the protected health information** contained in your medical and billling records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply. Under federal law, however, you may not inspect or copy psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to have a decision to deny access reviewed.

5. **Request an amendment to your protected heatlh information.** However, we may deny your request for an amendment, if we determine that the protected heatlh information or record that is the subject of the request:
   * was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   * is not part of your medical or billing records;
   * is not available for inspection as set forth above; or
   * is accuate and complete

   In any event, any agreed upon amendment will be included as an addtion to, and not a replacement of, already existing records.

6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   * to carry out treatment, payment and health care operations as provided above;
   * to persons involved in your care of for other notifications purposes as provided by law;
   * to correctional institutions or law enforcement officials as provided by law;
   * for national security or intelligence purposes;
   * that occured prior to the date of compliance with privacy standards (April 14, 2003)
   * incidental to other permissible uses or disclosures;
   * that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   * made to patient or their personal representatives;
   * for which a written authorization form from the patient has been received.

7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

SPECIAL PROVISIONS FOR ALCOHOL AND DRUG ABUSE

If you are also being treated for alcohol and or drug abuse, THE COUNSELING CENTER AT HAMILTON, LLC. will not tell any unauthorized person outside ot THE COUNSELING CENTER OF HAMILTON, LLC. that you have been admitted to a facility or that you are being treated for alcohol or drug abuse, without your written permission. We will not disclose any information identifying you as an alcohol, drug, or substance user, except as allowed by law. THE COUNSELING CENTER AT HAMILTON, LLC. may only disclose information about your treatment for alcohol or drug abuse without your permission in the following circumstances:

* Pursuant to a special court order that complies with 43 CFR Part 2 Subpart E
* To medical personnel in a medical emergency
* To qualfied personnel for research, audit or program evaluation
* To report suspected child abuse or neglect
* As allowed by law, to investigate a report that you have been abused or have been denied your rights

Federal and State laws prohibit re-disclosure of information about alcohol or drug abuse treatment without your permission. Federal rules restrict any use of information about alcohol or drug treatment to criminally investigate or prosecute any alcohol or drug abuse patient.

OUR RESPONSIBILITES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Joanna O'Neill, MA. LPC. at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at THE COUNSELING CENTER AT HAMILTON, LLC. or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below:

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619- 0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

THE COUNSELING CENTER AT HAMILTON, LLC
Joanna O'Neill, MA. LPC. NCC.
2667 Nottingham Way, Suite #3
Hamilton, New Jersey 08619
Tel: (609) - 890-9998

NOTICE OF PRIVACY PRACTICES AVAILIBILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain on the organization's Web site (if applicable Web site exists) for downloading.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information without your permission for the following purposes (excluding cases involving alcohol and/lor drug abuse):

Treatment: We may use and disclose protected health information in the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health inforamtion to obtain reimbursement for the health care provided to you, inlluding determinations of eligibility and coverage and other utilization revidew activites.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administratice activites.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other heatlh related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associates so that they can perform the job we have asked them to do.To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activites: We may disclose protected health information to federal or state agencies that oversee our activites.

Law Enforcement: We may disclose protected health inforamtion as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number of the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directosrs as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health inforatmion for public health activites and purposes to a public health authority thta is npermitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminet threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an insitutional review board that has reviewed the research proposal and established protocols to unsure the privacy of your health information has approved their research.