Wellness Counseling

70 W Allendale Avenue, Suite D Second Floor, Allendale NJ, 07401
258 Newark Street, Suite 208 Hoboken, NJ 07030

Office: 201-661-8070
Email: info@wellnesscounselingbc.com | www.wellnesscounselingbc.com

Intake Form for New Patients

*For Parent of Child

Your Name: **DOB:**

***Name of Patient:** **DOB:**

Address:

City: **State:** **Zip:**

Home #: **Cell #:**

Work #: **E-Mail:**

Presenting Problem:

Medical Conditions:

Current Medications:

Psychiatric History:

Other Important Information to Note:

Indicate which stressors you are experiencing currently (within last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
		Death of a family member			Illness of family member			Illness of friend
		Personal injury illness			Parents separated			Parents divorced
		Conflicts with family			Conflicts with friends			Conflicts at school
		Academic difficulties			Change in residence			Legal problems
		Sexual assault abuse			Physcial abuse			Verbal/emotional abuse
		Other problems						

Previous Counseling Experience: Yes ☐ No ☐ With Whom:

Insurance: (New patient must take responsibility for obtaining initial authorization)

Insurance Company: Policy #:

Name of Insured: DOB:

Employer: Group #:

Social Security #: Occupation:

Complete: ☐ Privacy Notice; ☐ Insurance Forms; ☐ Release of Information Forms

*Need Copy of Insurance Card and Authorization # If Required Before Initial Treatment

Office Information Only

First Date of Consultation: Diagnostic Code(s):

Date Data Entered in Computer: Account #:

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Family History

Have any of your blood relatives (biological parents, grandparents, siblings, aunts, uncles, or close cousins) experienced the following? Please specify which relative.

- ☐ **Reading problems:**
- ☐ **Attention problems:**
- ☐ **Hyperactivity:**
- ☐ **Developmental disorders/mental retardation:**
- ☐ **Addiction to alcohol or other drugs:**
- ☐ **Severe depression:**
- ☐ **Other significant mental illness or disorder:**
- ☐ **Genetic syndromes:**
- ☐ **Other:**

By completing this form, my signature indicates that the information provided is true and accurate. If the client is a minor, I certify that I have legal authority to authorize treatment.

Form completed by: **Date:**

Signature:

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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in the process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged a $40 cancellation charge.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements and the Bill of Rights (reverse side).

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Date

I, _____, (Therapist), have discussed the issues above with the client (and/or his or her parent, guardian, or representative). My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed and willing consent.

_____ _____
Therapist at Wellness Counseling Date

Copy accepted by client_____ Copy kept by therapist_____ See reverse side

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and _____. When the words "you" and "your" are used below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We use this information to decide what treatment is best for you and to provide the actual treatment. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment for you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, you cannot be treated. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by requesting this in writing.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

_____
Signature of authorized representative of this office or practice

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Credit Card Form

Name on Card:

Credit Card #:

Expiration Date:

Security Code (3 or 4 digit pin on back of card):

Zip Code:

Please circle:

Visa Mastercard Discover American Express

Please sign that you authorize payment:

_____ _____

Name Date