Perspectives Counseling Group

Individual/Family Information

Personal Information

Name:_____ Date of birth:_____

Age:_____ Gender:_____ Email:_____

Home Phone:_____ Cell Phone:_____

May we leave a message at these numbers? ☐ Yes ☐ No ☐ Cell ☐ Home

Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____ Place of Employment:_____

Education (optional):_____

Referral Source (agency and/or individuals):_____

Are there other agencies involved (i.e. county services, corrections, medical clinics, etc.)?_____

If yes, please list them:_____

Presenting problem (reason you are seeking therapy):_____

_____

_____

_____

_____

How long has the issue been presenting?_____

Family Information

Please list important family relationships that would be helpful for the therapist to know (i.e. significant other, children, siblings, parents, etc.)

Name	Relationship	Age	Live together? (Y/N)	Other Information

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Medical Information

Primary Physician:_____ Phone Number:_____

Clinic Name:_____ City:_____

If you are being treated for psychological issues, may your therapist notify your doctor in order to coordinate treatment options, if needed? ☐ Yes ☐ No

Medications (Current and Previous):_____

_____

_____

_____

_____

Emergency Contact and Relationship:_____

Phone Number:_____ Alternate Number:_____

Additional Information (optional)

Religion/Spiritual Affiliation:_____

Is there a history of abuse (sexual, physical, verbal, emotional, etc)? ☐ Yes ☐ No

Is there a history of substance abuse/addiction? ☐ Yes ☐ No

Have you been or are you currently involved in any legal issues? ☐ Yes ☐ No

Please describe any additional information and/or concerns you would like your therapist to know prior to the first session:_____

_____

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Therapy Agreement

Please read the below notice carefully to understand the policies and procedures of Perspectives Counseling Group, LLC (Perspectives Counseling Group). Questions are welcome and may be addressed at the start of the initial session.

Client Rights

* Services are rendered with the clients' well-being as the first and foremost priority and with respect to their autonomy.
* Clients have the right to services free of discrimination based on race, religion, gender, or other unlawful categories.
* Clients are welcome to, and often benefit from taking an active role in the development of a treatment plan and goals.
* Clients have the right to an explanation of their bill.
* Clients have the right to end services at any time and to be informed if there are any potential psychological consequences. Court-ordered clients will have the responsibility of answering to the courts regarding their termination. Clients are responsible for payment of any services already rendered.

Provider Policies

* All providers maintain current licensure in the state of NJ as mental health professionals (i.e. Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT)).
* Sessions are defined as 50 minutes in length; frequency may vary depending on circumstances.
* No promises have been made as to the results of any services provided at Perspectives Counseling Group.
* Client video or audio recording on any device is not permitted and may result in termination of services.
* Perspectives Counseling Group is not an emergency service. Clients may call 9-1-1 or Somerset County 24-hour primary screening services at 908-526-4100. For suicide prevention, contact the NJ Hope Line at 1- (855)-654-6735.
* Perspectives Counseling Group does not provide psychiatric assessments nor prescribe medication; referrals for such services are given if needed or requested.
* Therapists will discuss ending services with clients so that the completion of therapy will be a collaborative process to promote emotional and mental wellbeing.

Payment and Cancellation Policy

* The cost of therapeutic services will be discussed before the first appointment and confirmed at the start of the initial session.
* To avoid a fee, please call at least 24 business hours in advance to cancel/reschedule an appointment (i.e. Monday appointments would need to be cancelled no later than Friday at 5 PM).
* Failure to cancel an appointment or cancelling in less than 24 hours will result in a $50 fee to be paid on or before the next scheduled appointment.
* Perspectives Counseling Group may refuse to continue therapy services should debt become greater than $250 and a payment plan has not been discussed with the therapist.
* All payments, copayments, and deductibles are due at the time of service. Any payments made with a credit card will be subject to a $2.00 surcharge.

Client Name (Printed)	Date	Second Client/Parent Name (Printed)	Date
Client Signature	Date	Second Client/Parent Signature	Date
Therapist Signature	Date		

Perspectives Counseling Group

Notice of Privacy (HIPAA)

Perspectives Counseling Group, LLC (Perspectives Counseling Group) is committed to protecting personal client information. This notice describes how medical information may be used/disclosed by Perspectives Counseling Group and how to access this information. Please read the below notice carefully and feel free to address any questions during the initial session.

Understanding Client Protected Health Information

When receiving services at Perspectives Counseling Group, a record is made of each client's: diagnosis, treatment plan, and other pertinent personal, mental health, and/or medical information. This record is the physical property of Perspectives Counseling Group; the information within it, belongs to the client. Being aware of what is in this record will help clients make informed decisions when authorizing disclosure to others. In using and disclosing protected health information, Perspectives Counseling Group follows the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of NJ law.

- Clients' protected health information will be kept confidential unless written permission is given by the client, with the following exceptions:
  - When the therapist must, by law, report to the appropriate state agency the abuse or neglect of: children, elderly, or disabled.
  - If there is a threat to harm oneself, others, or property, potential victims and police will be informed.
  - If a client sues for malpractice or involves information about their mental health or therapy services while involved in litigation.
  - When a judge orders a therapist to share therapy records or to testify. A subpoena for records or testimony does not release confidential information. The order to break confidentiality must be given by a judge.
  - If you are a minor, parents and/or guardians will be given general information regarding progress; details will only be given if the therapist determines there is a risk to one's safety.
- If using insurance to pay for services, the client authorizes the release of medical or other information to process claims.

Obtaining a Copy of Protected Health Information held by Perspectives Counseling Group

- Perspectives Counseling Group will provide summary letters, not full therapy/mental health records, unless the therapist feels the details of that letter cannot encompass relevant matter, including: diagnosis, treatment, and prognosis.
- To receive a summary of the therapy/mental health records, a written request must be submitted in person or by mail.
- Perspectives Counseling Group will respond to all written requests within 10 days of receiving the request.
- Only the client may receive a summary of therapy records unless the client signs a waiver authorizing another personal representative or provider to receive the information.

Client Name (Printed)	Date	Second Client/Parent Name (Printed)	Date
Client Signature	Date	Second Client/Parent Signature	Date