NJ CENTER FOR THE HEALING ARTS, INC.

Application for Services for Children

PERSONAL HISTORY-CHILDREN AND ADOLESCENTS (<18)

Client's Name:_____Date _____/_____/_____

Preferred Name: _____ Sex ____ F ____ M ____ Intersex___Other___

Gender : M___F___Non-conforming___ Date of Birth:_____/_____/_____ Age_____

Grade in School: _____ School Name: _____

Form Completed by (if someone other than client): _____

Address:_____City:_____ State:_____ Zip:_____

Phone (home): _____ (work):_____ Ext:_____

Email address: _____

Current Primary Care Provider/Pediatrician:_____Phone: _____

Do you give us permission to contact PCP Y___N___

Primary Reason(s) for seeking services:

____ Anger management ____ Anxiety ____Coping ____Depression ____Fears/Phobias

____Eating Disorder ____Mental confusion ____Sexual concerns ____Sleeping Issues

____Addictive behaviors ____Alcohol/drugs ____Hyperactivity ____Attention/Focus

____Other mental health concerns (specify):_____

FAMILY HISTORY

Parents

With whom does the child live at this time?_____

Are the parent's divorced or separated?_____

If Yes, who has legal custody?_____

Were the child's parents ever married? Yes____ No____

Is there any significant information about the parent's relationship or treatment toward the child which might be beneficial in counseling? Yes____ No____

If Yes, describe: _____

PARENT/GUARDIAN 1

Name: _____Age:_____Occupation: _____FT___PT___

Gender: F____M____ Non-conforming____

Where employed:_____Work phone:_____

Parent/Guardian 1 Education _____

Is the child currently living with parent/guardian 1? _____ Yes _____No

_____ Natural parent _____Stepparent _____Adoptive parent _____Foster home

_____Other (specify)_____

Is there anything notable, unusual, or stressful about the child's relationship with parent/guardian? ____Yes ____No

If Yes, please explain:

_____

_____

How is the child disciplined by parent/guardian 1? _____

For what reasons is the child disciplined by parent/guardian 1?

_____

PARENT/GUARDIAN 2

Name: _____Age:_____Occupation: _____FT___PT___

Gender: F____M____ Non-conforming____

Where employed:_____Work phone:_____

Parent/Guardian 2 Education _____

Is the child currently living with parent/guardian 1? _____ Yes _____No

_____ Natural parent _____Stepparent _____Adoptive parent _____Foster home

_____Other (specify)_____

Is there anything notable, unusual, or stressful about the child's relationship with parent/guardian ?
____Yes ____No

If Yes, please explain:

_____

_____

How is the child disciplined by parent/guardian 2? _____

For what reasons is the child disciplined by parent/guardian 2?

_____

CLIENT'S SIBLINGS AND OTHER WHO LIVE IN THE HOUSEHOLD

Name of Siblings	Age	Gender	Lives	Quality of relationship
_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good

Others living in the household: Relationship (e.g. cousin, foster child)

_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good
_____	___	__F __M __GNC	__home __away	__poor __average __good

FAMILY HEALTH HISTORY

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles, or grandparents) Check those which apply:

____Allergies	____Deafness	____Muscular dystrophy
____Anemia	____Diabetes	____ Nervousness
____Asthma	____Glandular problems	____Perceptual Motor disorder
____ Bleeding tendency	____Heart blood pressure	____Mental retardation
____Blindness	____ High blood pressure	____ Seizures
____Cancer	____ Kidney disease	____ Spina bifida

____Cerebral palsy ____Mental illness ____ Suicide

____Cleft lips ____ Multiple sclerosis

Comments re: Family Health:

_____

_____

CHILDHOOD/ADOLESCENT HISTORY

Pregnancy/Birth

Has the child's biological mother had any occurrences of miscarriages or stillbirths? ___Yes ___No

If Yes, describe: _____

Was the pregnancy with the child planned? _____Yes _____No Length of pregnancy: _____

Biological mother's age at child's birth: _____Biological father's age at child's birth: _____

Total number of children_____

How many pounds did the biological mother gain during the pregnancy?_____

Did the child experience smoke in utero? ____Yes ____No If Yes what amount: _____

Did the child experience drugs/alcohol in utero? ____Yes ____No If Yes what amount: _____

While pregnant, did the biological mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ____Yes ____No

If Yes, describe: _____

Length of labor: _____ Induced: ____Yes _____No Caesarean? ____Yes _____No

Baby's birth weight: _____ Baby's birth length:_____

Describe any physical or emotional complications with the delivery:

_____

_____

Describe any complications of the biological mother or the baby after the birth:

_____

_____

Length of hospitalization: Biological Mother: _____ Baby:_____

Infancy/Toddlerhood Check all which apply:

____Breast fed	____Milk allergies	_____ Vomiting	_____ Diarrhea
____Bottle fed	____ Rashes	____Colic	____Constipation
____ Not cuddly	____ Cried often	_____ Rarely cried	_____ Overactive
____Resisted solid food	____Trouble sleeping	_____ Irritable when awakened	
____Lethargic	____ Unknown		

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps:_____ Tied shoelaces:_____

Spoke words: _____ Rode two-wheel bike:_____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night:_____

Compared with others in the family, child's development was:

_____ slow _____average_____fast _____unknown

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

EDUCATION

Current school: _____ School phone number: _____

Type of school: _____Public _____ Private _____Home schooled _____Other (specify)_____

Grade: _____ Teacher: _____ School Counselor: _____

In special education: _____Yes _____No

If Yes, describe: _____

In gifted program: _____ Yes _____No

If Yes, describe: _____

Has child ever been held back in school? ____ Yes _____No

If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _____Yes _____No

If Yes, describe: _____

Has the child been tested psychologically? _____Yes _____No

If Yes, describe: _____

Check the descriptions that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

____Anxious ____Passive ____Enthusiastic ____Fearful

____Eager ____No expression ____Bored ____Rebellious

____Other (describe): _____

APPROACH TO SCHOOLWORK

____Organized _____Industrious _____Responsible _____Interested

____Self-directed _____No initiative _____Refuses ____Does only what is expected

____Sloppy _____Disorganized _____Cooperative____Doesn't complete assignments ____Other (describe): _____

PERFORMANCE IN SCHOOL (PARENT/GUARDIAN'S OPINION)

____Satisfactory ____Underachiever _____Overachiever

____Other (describe): _____

CHILD'S PEER RELATIONSHIPS:

____Spontaneous ____Follower ____Leader ____Difficulty making friends

____Makes friends easily _____Longtime friends _____Shares easily

____Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____Parent/Guardian 1____Parent/Guardian 2 ____Shared

_____Other (specify) _____

Health: ____Parent/Guardian 1 ____Parent/Guardian 2 ____Shared

_____Other (specify) _____

Problem behavior: ____Parent/Guardian 1 ____Parent/Guardian 2 ____Shared

_____Other (specify) _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ____Poor ___Average ___Good ____Excellent

Current Employer: _____ Position: _____

Hours per week: _____

How have the child's grades in school been affected since working? ____Lower ____Same___Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving:_____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/PHYSICAL HEALTH

____Abortion	____Hay fever	_____Pneumonia
____Asthma	____Heart trouble	_____Polio
____Blackouts	____Hepatitis	____Pregnancy

____Bronchitis ____Hives ____Rheumatic fever

____Cerebral palsy ____Influenza ____Scarlet fever

____Chicken pox ____Lead poisoning ____Seizure

____Congenital problems ____Measles ____Severe colds

____ Coup ____Meningitis ____Severe head injury

____Diabetes ____Miscarriage ____Diphtheria

____Multiple sclerosis ____Thyroid disorders ____Vision problems

MEDICAL/PHYSICAL (con't)

____Dizziness ____Mumps ____Wearing glasses

____Earaches ____Muscular dystrophy ____Whooping cough

____Ear infections ____Nosebleeds

____Eczema ____Other skin rashes

____Encephalitis ____Paralysis

____Fevers ____Pleurisy

____Other:_____

List any current health concerns:

_____

_____

List any recent health or physical changes:

_____

_____

Nutrition:

Meal	How often	Typical foods	Typical amount eaten(times per week)
Breakfast	__/week	_____	___No ___Low ___Med ___High
Lunch	__/week	_____	___No ___Low ___Med ___High
Dinner	__/week	_____	___No ___Low ___Med ___High
Snacks	__/week	_____	___No ___Low ___Med ___High

Comments: _____

MOST RECENT EXAMINATIONS

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications

Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter meds

Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio	
2 months	____	____	15 months____MMR (Measles, Mumps, Rubella)
4 months	____	____	24 months____HBPV (Hib)
6 months	____	____	prior to school____HepB
18 months	____	____	
4-5 years	____	____	

CHEMICAL USE HISTORY

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes ____No

If Yes, describe:

_____

_____

COUNSELING/PRIOR TREATMENT HISTORY

Information about child/adolescent (past and present): Yes___ No___

	When	Where	Reaction or Overall Experience
Counseling/Psychiatric	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____
Hospitalizations	_____	_____	_____

BEHAVIORAL/EMOTIONAL

Please check any of the following that are typical for your child:

____Affectionate	_____Frustrated easily	____Sad
____Aggressive	____Gambling	____Selfish
____Alcohol problems	____Generous	____Separation anxiety
____Angry	____Hallucinations	____Sets fires
____Anxiety	____Head banging	____Sexual addiction
____Attachment to dolls	____Heart problems	____Sexual acting out
____Avoids adults	____Hopelessness	____Shares
____Bedwetting	____Hurts animals	____Sick often

BEHAVIORAL/EMOTIONAL (CONT'D)

Please check any of the following that are typical for your child:

____Blinking/jerking	____Imaginary friends	____Short attention span
____Bizarre behavior	____Impulsive	____Shy, timid
____Bullies/threatens	____Irritable	____Sleeping problems

____Careless/reckless
____Chest pains
____Clumsy
____Confident
____Cooperative
____Cyber addiction
____Defiant
____Depression
____Destructive
____Difficulty speaking
____Dizziness
____Drug dependence
____Eating disorder
____Enthusiastic
____Excessive masturbation
____Expects failure
____Fatigue
____Fearful
____Frequent injuries
____Lazy
____Learning problems
____Lies frequently
____Listens to reason
____Loner
____Low-self esteem
____Messy
____Moody
____Nightmares
____Obedient
____Often sick
____Oppositional
____Overactive
____Overweight
____Panic attacks
____Phobias
____Poor appetite
____Psychiatric problems
____Quarrels
____Slow moving
____Soiling
____Speech problems
____Steals
____Stomachaches
____Suicidal threats
____Suicidal attempts
____Talks back
____Teeth grinding
____Thumb sucking
____Tics or twitching
____Unsafe behaviors
____Unusual thinking
____Weight loss
____Withdrawn
____Worries excessively
____Other:_____

What are the family's favorite activities?

_____

_____

What does the child/adolescent do with unstructured time?

_____

_____

Has the child/adolescent experienced death? (friends, family, pets, other) __Yes ___No

At what age(s)? _____

If Yes, describe the child's adolescent's reaction:

_____

Have there been any other significant changes or events in your child's life (family, moving, fire, etc.

___Yes ____No

If Yes, describe: _____

Any additional information that would assist us in understanding current concerns/problems?

_____

_____

What are your goals for the child's therapy?

_____

_____

What family involvement would you like to see in the therapy?

_____

_____

Do you believe the child is suicidal at this time? _____Yes ____No

If Yes, explain:

_____

_____

FOR STAFF USE

Therapist's comments:

_____

_____

_____

Therapist's signature/credentials:_____Date: ____/____/_____

Supervisor's comments:

_____

_____

_____

Supervisor's signature/credentials: _____Date: ____/____/_____

(Certifies case assignment, level of care and need for exam)

INSURANCE AUTHORIZATION

NJ Center for the Healing Arts
248 Broad St. First Floor
Red Bank, NJ 07701

Tel (732) 747-2944
Fax (732) 747 2979

Please check all items that apply

___ I authorize use of this form on all my insurance submissions.

___ I authorize release of information to all my insurance companies.

___ I authorize The NJ Center for the Healing Arts, to act as my agent in helping me to obtain payment from my insurance companies.

___ I authorize payment directly to NJ Center for the Healing Arts.

___ I understand that I am responsible for my bill.

I understand that if I receive payment from an insurance provider for services rendered by NJCHA and there is a balance due on my account, I will remit payment to the NJCHA within ONE WEEK, of receiving the insurance check. If I fail to submit a payment, I will be committing insurance fraud and NJCHA will report it as such.

_____
Please initial here that you understand the above statement

Client Name_____
(Please Print)

Signature_____Date_____/_____/_____
(Signature of Client of Guardian if Client is a Minor)

Statement of Understanding
NJ Center for the Healing Arts

Experience has taught us that it is easier for you to focus on your process of therapy when all expectation and "ground rules" are clearly understood. Therefore, please review the following policies and procedures with your therapist. If you have any questions or concerns, please address them immediately. If your therapist cannot help you, he/she will direct you to the person who will be able to assist you.

1) Confidentiality: NJCHA will not release or transfer any information pertaining to you without your permission. However, the following exceptions are required by law (under the "Duty to Protect Bill", signed 8/27/91).
    a) When an individual's thoughts or actions pose an immediate threat to her/himself, we must report this to the immediate family and/or the police. This would include any disclosures the person makes about committing suicide.
    b) When an individual's thought or actions pose an immediate threat to others, we must report it to the police and warm the named targets of any homicidal intent.
    c) When we have reasonable cause to believe that child abuse (including incest) is occurring (or has occurred), we must report it to the DYFUS (Division of Youth and Family Services).
    d) When the court issues a subpoena and it is then determined then we must respond.
2) Emergency/Crisis Situations: If an emotional crisis does arise, you can call NJCHA's main line at 732-747-2944 during regular business hours. If your therapist is not immediately available, efforts will then be made to alert him/her to contact you as soon as possible. In the event that an emergency occurs at a time when your therapist cannot be reached, we strongly advise you to call any of the following crisis hotline:

Riverview Hospital (Red Bank)	- - - - - - - - - - - 732-219-5235
Non-emergency	- - - - - - - - - - - 732-530-2451
Pollock Mental Health-Monmouth Medical Center	- - - - - - - - - - - 732-923-6500
(Long Branch)	- - - - - - - - - - - 732-222-3030
Jersey Shore Medical (Neptune)	- - - - - - - - - - - 732-776-2325
Crisis	- - - - - - - - - - - 800-822-8905

3) Cancellation Policy: Appointments must be canceled at least 24 hours in advance, or you will be responsible for paying our full fee. Missed appointments cannot be billed to insurance. This may be avoided if the therapist can reschedule you during the same week. Groups have their own cancellation policies; however, in most cases you will be responsible for payment of all group sessions.
4) Session Time: Individual therapy sessions at NJCHA range from 45-50 minutes in length. If a decision has been made mutually between you and your therapist to extend a session, you will be charged an hourly prorated fee based on your current session fee.
5) Payment Policy: Payment is due at the time of your session

_____
Client/Guardian Initials

6) Insurance: Generally, we do not accept insurance as direct payment. You are entirely responsible for payment of services rendered. We will be happy to issue you a statement or receipt so that you will be able to submit it to your insurance provider. Any exceptions to full payment at the time of your session must be approved through the business office when you sign your initial contract, or, prior to any session which you are unable to pay your full fee.
7) Returned Checks: You will be charged a $20 fee per returned check.
8) Phone Contacts: If a situation occurs that does not require immediate psychiatric intervention and you need to call your therapist for support, you can call NJCHA's main line 732-747-2944. Every effort

will be made to contact your therapist. If extended phone communication is necessary, a fee will be charged at a rate equivalent to your regular therapy fee. In the event that your therapist is out of NJCHA's offices and needs to call you back long distance, the cost of the call will be added to the therapy fee. If you only need to leave your therapist a brief message. You can call the main line or use the voicemail network at 732-747-0722.

9) Lateness: If you are late, your session will last only up until the time it was scheduled for however, you will be responsible for the full fee.
10) When Older People Come to Your Session: Sometimes it may be mutually decided between you and your therapist that it would benefit your therapy to have your family or friends attend one of your therapy sessions. In this case, as long as it occurs during your regularly scheduled session time, there will be no additional fee. However, if it is mutually decided that additional people are needed to continue in therapy with you, your contract must be renegotiated to change your treatment from individual to couples or family therapy, In this event, a new financial agreement will be necessary and will be arranged through the business office.
11) Work with Children and Adolescents Under Age 18: The primary responsibility of your child's therapist is to safeguard your child's welfare and facilitate honest disclosure so that a healing process may occur. Therefore, confidentiality relating to matters he/she may discuss in treatment is required. It should also be understood that any therapist assigned to work with a child is to remain neutral in the event that parents/guardians are in dispute (including divorce). Any matter that is disclosed by a parent that pertains to the child in treatment may be revealed to the other parent. It is our policy at NJCHA to recommend family therapy in most cases where children are involved in treatment so that the integrity of the family may be preserved and so that the child is not put in the middle of family disputes.
12) Respect: Since NJCHA provides group therapy, as well as support and self-help groups, you may become privy to very personal information about other members of the community. Please respect the confidentiality of others.

I have read the above and agree to the policies of NJCHA as stated.

Client Signature_____Date_____

Parent/Guardian Signature_____Date_____

Therapist Signature_____Date_____

NJ Center for the Healing Arts

FINANCIAL POLICY

Thank you for choosing us. We are committed to serving you with skill and care. The services provided by our offices are services you have elected to receive, which may imply a financial responsibility on your part.

COPAYS

Copays are due at the time of service.

SELF PAY

Payment in full is due at the time of service.

PRIMARY INSURANCE

We may or not be a participating provider for your insurance company. Your primary as well as your secondary insurance (if any) will be billed for you. You are responsible for copayment or deductible amounts as stated by the insurance company.

REFERRALS/AUTHORIZATIONS

You are responsible for obtaining a referral or authorization, if required, by your insurance company. You may be financially responsible for the charges if denied due to absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral/authorization.

DEDUCTIBLES

Before or on your first visit, your insurance deductible and coinsurance amount will be determined. You may be required to pay at the time of service up to your anticipated deductible amount.

PATIENT BILLING

A statement of your financial responsibility (coinsurance, deductible) will be sent to you after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. You will be sent up to three notices. After the third and last notice, your account may be forwarded to collections. Please let the billing office know you have difficulties resolving your bill. Payment arrangements can be made on a case to case basis. We accept cash, check, or credit card. As additional $30.00 will be added to your statement if the check is returned for insufficient funds.

APPOINTMENT CANCELLATIONS

Cancellations must be made 24 hours in advance or you will be responsible for the full fee ($150.00) for the session. Missed appointments cannot be billed to insurance companies.

I have read the above policy regarding my financial responsibility to NJCHA for providing medical services to the below named patient or me. I agree to pay NJCHA any amount due after insurance payment has been made by my carrier and any contractual adjustment has been credited OR the full amount of all bills incurred by me or the below named if no health insurance coverage exists.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM NJCHA IF THERE IS A CHANGE IN MY HEALTH INSURANCE INFORMATION.

PRINT Patient Name_____Signature_____

Date_____/_____/_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name_____Signature_____

Relationship to Patient_____Date_____/_____/_____

NJ Center for the Healing Arts

Medication/Vitamin/Supplement List

Name_____Date_____/_____/_____

Please list ALL prescription and over-the-counter medications, vitamins (including multivitamins), herbal supplements, diet pills, etc., that you are currently taking.

Product Name	Dose	Taken Since	Reason for Use	Prescribed by (if applicable)	Date of Last Check-Up

Please inform your counselor of any changes to the above (i.e. change in dose, stopping use, adding new substance, etc.)