NJ CENTER FOR THE HEALING ARTS, INC.

Application for Services for Couples

Date: _____

I. GENERAL INFORMATION

Referred by (if internet, which site): _____

If a personal/professional referral, may I thank the person? Yes ◯ No ◯

Client 1

_____

Last name First name Middle Initial

Birth Date: Age: _____

Street Address: _____

Street City State & Zip

Cell phone: _____ okay to leave message? Yes ◯ No ◯

Home Phone: _____ okay to leave message? Yes ◯ No ◯

Work phone: _____ okay to leave message? Yes ◯ No ◯

Place of Employment:

Length of Employment: Occupation

Highest level of education completed (check one):

☐ *High School* ☐ College Degree ☐ *Graduate Degree*

☐ *Professional Training* ☐ *Other:*

In case of emergency, contact _____

Relationship: _____ Emergency Phone: _____

Client 2

_____

Last name First name Middle Initial

Birth Date: Age:

Street Address: _____

Street City State & Zip

Cell phone: _____ okay to leave message? Yes No

Home Phone: _____ okay to leave message? Yes No

Work phone: _____ okay to leave message? Yes No

Place of Employment: _____

Length of Employment: _____ Occupation _____

Highest level of education completed (circle one):

☐ High School ☐ College Degree ☐ Graduate Degree

☐ Professional Training ☐ Other: _____

In case of emergency, contact _____

Relationship: _____ Emergency Phone: _____

Relationship Status (circle one):

☐ Engaged ☐ Married Partnered ☐ Living Together ☐ Separated

Length of time marries/partnered (or length of relationship): _____ _____

Others living in your home:

Name	Relationship	Age

Children not living in your home:

Name	Age

II. COUNSELING CONCERNS

What is the major problem?

Client 1: _____

Client 2: _____ _____ _____ _____

How long have you had this problem?

Client 1: _____ _____

Client 2: _____ _____ _____

When else have you had similar problems?

Client 1: _____ _____ _____

Client 2: _____ _____ _____

Why are you seeking help now?

Client 1: _____ _____ _____ _____ _____ _____

Client 2: _____ _____

_____

What would you like to see happen as a result of therapy?

Client 1:

Client 2:

III. MEDICAL AND PSYCHOLOGICAL HISTORY

Have you received psychotherapy or counseling in the past? Yes ◯ No ◯

If yes, when and with whom? _____ _____

Client 1:

List physical illnesses or symptoms: _____ _____ _____

Physician/Psychiatrist's name(s) and phone number(s): _____

List current medications:

_____

Client 2:

List physical illnesses or symptoms:

_____

Physician/Psychiatrist's name(s) and phone number(s): _____

_____

List current medications:

_____

Have either of you received help for drug or alcohol dependency? Yes ◯ No ◯

Who? _____ When? _____ For what? _____

Where? _____

Have either of you been hospitalized for mental/emotional/psychiatric reasons? Yes No

Who? _____ When? _____ For what? _____

Where? _____

IV. OTHER

Please provide any other information you think will be necessary or helpful:

_____

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 withut 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 thoughts or actions pose an immediate threat to others, we must report it to the police and warn 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 732-747-9244 during regular business hours. If you therapist is not immediately available, efforts will then be made to alert him/her to contact you as soon as is possible. In the event that an emergency occurs at a time when your therapist cannot be reached, we strongly advise you tyo 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 pro-rated 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 Other 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 uis 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. Pleas respect the confidentiality of others.

I have read the above and agree to the policies of NJ CHA 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 office 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 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 co-insurance 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 (co-insurance, 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 if you have any difficulties resolving your bill. Payment arrangements can be made on a case to case basis. We accept cash, check or credit card. An 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 ($125.00) for the session. Missed appointments cannot be billed to insurance companies.

I have read the above policy regarding to 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 adjustments have been credited OR the full amount of all bills incurred by me or the below named if there is 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: _____

INSURANCE AUTHORIZATION

NJ Center for the Healing Arts
248 Broad Str. First Floor
Red Bank, NJ 077 01

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 direct to NJ Center for the Healing Arts.
- ☐ I understand that I am responsible for my bill.

I understand that if I receive payment from 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 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 or Guardian if Client is a Minor)

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)