NJ CENTER FOR THE HEALING ARTS, INC.

Application for Services

Date:_____/______/________

Note: The following information is requested so that we may best understand you and your needs.

Please complete as thoroughly as possible. Thank you. All information will remain strictly confidential.

Please Print

I. GENERAL INFORMATION

Name of Client: ____
Last First Middle

Address:
____
____
____

Phone (Home):______________________________
(Work):______________________________

Date of Birth:_____/_____/_______
Age:_______ Sex:______________
Marital Status: (check one)
Single___ Married___
Separated___ Divorced___

Is it alright for us to call you at home?________________Is it alright for us to call you at work?_________________

E-mail:____

Would you like to receive e-mail promotions about events happening at the Center? Yes____No____

Ethnic Background:____

Name of guardian or nearest relative:____

Emergency Contact:

Name:_______________________________________ Phone:_______________________________

Address:____

II. EMPLOYMENT INFORMATION

Employer:____ Occupation:____________________________

Employer Address:
____Work Hours:____________________________
____Yearly Income:__________________________

Primary Insurance Company:____

Policy No.________________________Group No.________________________Effective Date:_____/_____/_______

Policy Holder:____Relationship to Patient:_____________________

Date of Birth:_____/_____/_________ Social Security No.________________________________Sex:___________

Secondary Insurance Company:____

Policy No.________________________Group No.________________________Effective Date:_____/_____/_______

Policy Holder:____Relationship to Patient:_____________________

Date of Birth:_____/_____/_________ Social Security No.________________________________Sex:___________

III. DESCRIPTION OF PRESENTING PROBLEMS

Please tell us why you are here. How would you best describe your problem and why you are seeking counseling?

____

____

How and when did your problem begin?

____

____

Do you consider this problem to be (check one) Mild____ Moderate____ Severe____

Please check all that apply:

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Pain Killers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc.)				
Diarrhea				
Constipation				
Allergies				
High Blood Pressure				
Heart Problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backache				
Early Morning Awakening				
Overeat				
Poor Appetite				
Eat “junk foods”				

IV. FAMILY HISTORY

Relationship to you	Name	Age	Living (L) Deceased (D)	Date of Death	Alcohol and/or Drug Abuse (Y/N)
Mother					
Father					
Siblings					

(Please use this area if additional space is needed)

____

____

____

List all member currently residing in your household:

Name	Relationship to you	Age	Alcohol and/or Drug Abuse (Y/N)

Do you live in a house___, hotel room___, apartment___ (check one)

Is there any alcohol or drug abuse with current family members? Yes___ No___

If yes, name of person(s) ____

Has anyone in your family ever received counseling? Yes___ No___

If yes, name of person(s)____

Please explain:____

Indicate counselor or agency:______________________________Dates:____________

Has anyone in your family ever been hospitalized due to emotional reasons? Yes___ No___

If yes, name of person(s)____

Hospital:____Dates:____________

V. YOUR HISTORY

Have you ever been abused emotionally, physically, or sexually? Yes___ No___

If yes, how and when were you abused?____________________________________

Have you ever been violent toward anyone else? Yes___ No___

Do you have a legal history? (arrests, charges, convictions, etc.) Yes___ No___

If yes, please explain:____

Sexual orientation or preference (optional):______________________________

What is the highest grade you completed in school? (degree)____

Military service? Yes____ No____ Dates:____

Religion: Present________________________________ Previous (if different)_______________________________

Past serious illness?____

Are you currently taking any medications for any physical or psychological conditions? Yes___ No___

If yes, please explain:____

Family Physicians Name:____

Address:____Phone:______________________

Check each of the following words that you might use to describe yourself:

Intelligent___ Confident___Worthwhile___Ambitious___Sensitive___Loyal___Trustworthy___Full of Regrets___Worthless___Useless___Considerate___Unattractive___Unlovable___Inadequate___ Confused___Naìve___Honest___Incompetent___Horrible thoughts___Conflicted___Concentration difficulties___Memory problems___Attractive___Can't make decisions___Suicidal ideas___ Perservering___Good sense of humor___Hard-working___

Others:____

Have you ever thought about hurting yourself or contemplated suicide? Yes___ No___

If yes, dates:_____________________________________Under what circumstances:__________________________

Have you ever been hospitalized due to an emotional condition? Yes___ No___

If yes, please explain:____

Hospital:____Dates:_____________________________

Have you ever received counseling before? Yes___ No___

If yes, where? ____Dates:____________________________

May we have permission to open your file? Yes___ No___ Please Initial Here:____________________________

Have you ever used drugs? Yes___ No___ Are you currently using drugs? Yes___ No___

If yes, what kind and how often?____

Do you ever drink just to feel better or more comfortable? Yes___ No___

Do you currently feel you may have an alcohol problem? Yes___ No___

If no, have you ever felt that you had an alcohol problem? Yes___ No___

If yes to either of the above, please explain:

____

____

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.)