|  |  |
| --- | --- |
|  | Client Face Sheet  |
| Client’s Name:  |  |
| Date of Birth  |  | Age  |  |
| Street Address  |  |
| City  |  | State | **NJ** | Zip |  |
| Phone Number  |  |
| Email Address  |  |
| Race/Ethnicity  |   | Religion |  |
| Marital Status  | [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widowed  |
| Children  | [ ]  No children [ ]  Yes, age(s):  |
| Education Level  | [ ]  Elementary [ ]  Middle School [ ]  High School  [ ]  Some College [ ]  Undergraduate [ ]  Higher Education  |
| Employment Status  | [ ]  Employed, Occupation: [ ]  Not in the workforce |
| Veteran  |  [ ]  Veteran [ ]  Non-Veteran  |
|  |  Insurance InformationPlease note Arrow Counseling is an In-Network with Horizon Blue Cross / Blue Shield |
| Insurance Name |  |
| Policy Holder’s Name |  | Policy Holder’s Date of Birth |  |
| Policy Holder’s Address |  |
| Policy Number  |  |
| Group Number  |  |
| Deductible (if any) |  | Copay (if any) |  |
|  |  Emergency Contact Information  |
| Name  |  | Relationship  |  |
| Address  |  |
| Phone Number  |   |

|  |  |
| --- | --- |
| How did you hear of Arrow Counseling, LLC?  |   |

Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

 **INFORMED CONSENT**

This form describes the confidentiality of your medical records, how the information is used, your rights and how you may obtain this information.

 **Our Legal Duties**

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our private of information policies, your right and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes takes place. The contents of material disclosed to us in an evaluation, intake or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

 **Use of Information**

Information about you may be used by the personnel of Arrow Counseling, LLC for diagnosis, treatment planning, treatment and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals and mental health students and business associated affiliated with Arrow Counseling, LLC such as for bill, quality enhancement, training, audits and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of both the client or the client's legal guardian or personal representative. It is the policy of Arrow Counseling, LLC not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below and there may be other provisions provided by legal requirements.

 **Duty to Warn and Protect**When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report his information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

 **Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial ad administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military and when complying with worker's compensations laws.

 **Abuse**

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

 **Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

 **Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed. Insurance companies, managed care and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within Arrow Counseling, LLC or by outside sources specializing in (and held accountable for) such services.

I understand the limits of confidentiality, privacy policies, my rights and their meanings and ramifications.

Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

The staff at Arrow Counseling, LLC, are committed to providing caring and professional mental health care to all our clients. As part of the delivery of mental health services, Arrow Counseling, LLC has established a financial policy which provides payment policies and options to consumers. The financial policy is designed to clarify the payment policies as determined by management of Arrow Counseling, LLC.

The Person Responsible for Payment of Account is required to sign the form, “*Payment Contract for Services,”*which explains the fees and collection policies of Arrow Counseling, LLC. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, Arrow Counseling, LLC will bill insurance companies and other third-party payers, but cannot guarantee such benefits of amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not responsible or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Client are responsible for payments regardless of any insurance company’s arbitrary determination of usual and customary rates.

Clients are responsible for the full payment as agreed upon in the “*Payment Contract.”* The Person responsible for payment (as noted in the “Payment Contract for Services”) will be financially responsible for such services. The Person for Payment of Account is financially responsible for paying funds in full at the time of service. Payments not received after 120 days are subject to collections.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amount may have been met elsewhere (e.g. if there were previous visits to another mental health provider since January of the current year that were prior to the first session at this location), this amount will be collected by Arrow Counseling, LLC until the deductible payment is verified to the clinic by the insurance company of third-party provider. All insurance benefits will be assigned to Arrow Counseling, LLC (by insurance provider or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card or payment at the time of service.

I (we) have read, understand and agree with the provisions of the Financial Policy.

Person Responsible for Payment of Account, Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT CONTRACT FOR SERVICES**

|  |  |
| --- | --- |
| Client Name: |  |
| Client Date of Birth: |  |

|  |  |
| --- | --- |
| Person Responsible for Payment of Account |  |
| Street Address |  |
| City |  | State | **NJ** | Zip Code |  |
| Phone Number |  |

Please refer to the Financial Policy for further information about Arrow Counseling, LLC’s policy on rendering payment from individuals, insurance companies as well as third-party providers.

|  |
| --- |
| **Arrow Counseling, LLC’s Rates are as follows:** |
| Individual Initial Session Rate for 60 minutes: **$150.00** |
| Individual Session Rate per 50 minutes: **$125.00** |
| Group/Family Session per 50 minutes: **$150.00** |
| Couples/Marital Counseling per 50 minutes: **$150.00** |
| Missed appointments or cancellations less than 24 hours prior to appointment are charged at **$50.00**  |
| Phone Session or Consultations 15 minutes+ are charged at **$50.00** |

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am the Person Responsible for Account, with whom have read and are agreeable to the Financial Policy set forth by Arrow Counseling, LLC and assume the financial responsibility for therapeutic services for the above mentioned client.*

Payment is requested to be paid at the beginning of each session. Accepted payment options are: Cash, Credit Card/Debit Card, Checks made payable to “Arrow Counseling LLC”

Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMTION CONSENT- INSURANCE**

|  |  |
| --- | --- |
| Client Name |  |
| Address |  |
| City |  | State | **NJ** | Zip Code |  |
| Date of Birth |  |
| Phone |  |

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**authorize **Arrow Counseling, LLC,** Michelle Cox, LCSW, to send and/or receive the following information to the individual/office/facility listed below. This consent is valid for 365 days following today’s date.

|  |  |
| --- | --- |
| Name | **HORIZON BCBS**  |
| Address | 3 Penn Plaza |
| City | Newark | State | NJ | Zip Code | 07101 |
| Phone | (800) 626-2212 |

A separate authorization, as defined by HIPAA, is required for \*Psychotherapy Notes:

[x]  Academic Testing Results

[x]  Behavior programs

[x]  Progress Reports

[x]  Intelligence Testing Reports

[x]  Medical Records

[x]  Personality Profiles

[x]  Psychological Reports

[x]  Psychological Testing results

[x]  Service Plans

[x]  Summary Reports

[x]  Vocational testing results

[x]  Entire record, except progress notes

[x]  Psychotherapy Notes

[ ] Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be used for the following purposes:

[x]  Planning appropriate treatment or program

[x]  Continuing appropriate treatment or program

[x]  Determining eligibility for benefits or program

[x] Case review

[x] Updating files

 [x] Other (specify)\_INSURANCE PURPOSES

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to the client: [x] Self, [ ]  Parent/Legal Guardian, [ ]  Personal Representative, [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION CONSENT**

|  |  |
| --- | --- |
| Client Name |  |
| Address |  |
| City |  | State | **NJ** | Zip Code |  |
| Date of Birth |  |
| Phone |  |

[ ]  I do not wish to have my information disclosed to any individual/office/facility at this time.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize **Arrow Counseling, LLC,** Michelle Cox, LCSW, to send and/or receive the following information to the individual/office/facility listed below. This consent is valid for 365 days following today’s date.

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City |  | State |  | Zip Code |  |
| Phone |  |

A separate authorization, as defined by HIPAA, is required for \*Psychotherapy Notes:

[ ]  Academic Testing Results

[ ]  Behavior programs

[ ]  Progress Reports

[ ]  Intelligence Testing Reports

[ ]  Medical Records

[ ]  Personality Profiles

[ ]  Psychological Reports

[ ]  Psychological Testing results

[ ]  Service Plans

[ ]  Summary Reports

[ ]  Vocational testing results

[ ]  Entire record, except progress notes

[ ]  Psychotherapy Notes

[ ] Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be used for the following purposes:

[ ]  Planning appropriate treatment or program

[ ]  Continuing appropriate treatment or program

[ ]  Determining eligibility for benefits or program

[ ] Case review

[ ] Updating files

 [ ] Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

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Your relationship to the client: [ ] Self, [ ]  Parent/Legal Guardian, [ ]  Personal Representative, [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client’s Printed Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_