CALM & SENSE THERAPY

INTAKE AND INSURANCE FORM

Date: _____
Client Name: _____ Client Date of Birth: _____
Gender: _____ Pronoun:_____ Sexual Orientation:_____ Race or Ethnicity:_____ Primary Language:_____

Street Address: _____
City/State/Zip: _____

Home Phone: _____ Leave Message: Yes or No Work Phone: _____ Leave Message: Yes or No

Mobile Phone: _____ Leave Message: Yes or No

Email: _____

Relationship / Marital Status: _____

Would you like to receive our monthly newsletter? Yes or No
How did you hear about Calm and Sense Therapy?_____

Insurance Company:_____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Plan/Group #: _____
Member ID#: _____
Relationship of Policyholder to Client: _____
Policyholder Address (if different than client): _____

Name, Phone & Relationship of a close relative/friend to alert in an emergency:

_____

ONLY FOR MINORS (15 and under) OF DIVORCED PARENTS

(If not applicable, please continue on to Consent for Additional Participants in Treatment and Client Information)

Must Be Completed by Divorced Parent / Guardian Consent Form

Child's Full Legal Name: _____

Child's Date of Birth: _____

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child and be authorized to grant permission for medical treatment.

To proceed with mental health services, please provide your child's therapist with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

In cases of separated or divorced parents, it is typical for your minor child's therapist to notify the other parent that he or she is meeting with your child. If there is a joint custody agreement, the signature of both parents will be required. Also please be aware that clinical notes throughout your child's treatment will be available to any person or entity that has legal access to your child's treatment record.

Please note: In the state of New Jersey, a minor over the age of 16 can consent to behavioral health services on a temporary outpatient basis without parental consent.

I certify that I am the parent of, _____, and as such, I hereby provide consent for my minor child named above to seek psychotherapy services from Calm and Sense Therapy

By signing below, you agree that you have read and understood the policies described above.

Print Name of Parent/Guardian _____

Date:_____

Signature of Parent/Guardian _____ Date: _____ Therapist

Signature _____ Date: _____

<u>Consent for additional participants in Treatment</u>

If you anticipate that any additional family members and/or identified support systems will be joining sessions at any point in your treatment with us, we ask that you identify these parties in advance, in order to give us permission to involve them in treatment as needed.

Please note that you have the right to cancel this consent at any time except when your therapist has already taken action on it. If you wish to cancel this consent, you need to ask your therapist for instructions. Otherwise, this consent will be valid from the date of the authorization until termination of treatment with Calm and Sense Therapy.

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1. Name, Phone & Relationship of a close relative/friend:

_____

2. Name, Phone & Relationship of a close relative/friend

_____

3. Name, Phone & Relationship of a close relative/friend

_____

In addition, please note that if you have additional family members in treatment with Calm and Sense, it is common practice that the involved clinicians may collaborate as needed to ensure high quality care. If you are uncomfortable with this, please advise your clinician.

CLIENT INFORMATION

Please describe what brings you to treatment today?_____

_____

Medical Information:
Do you have a primary care physician? Yes or No
Date of last physical? _____
Please list any medical concerns: _____
Please list any medications you have been regularly prescribed for a medical reason and specify if past or current: _____
_____
Do you have any known allergies? Yes or No
If yes, please list here: _____

Do you have a history of head trauma or concussions? Yes or No
If yes, when was the most recent concussion? _____

Psychiatric Information:
Have you had any previous mental health treatment, including treatment programs and hospitalizations? If yes, when and for how long? _____

_____
Reason for previous mental health treatment: _____
Have you considered any previous treatment to be helpful? If yes, why? _____
_____
Please list any medications you have been regularly prescribed for a mental health reason and specify if past or current: _____
_____

I understand that if I have recently been psychiatrically hospitalized or in detox in the last 30 days, I am required to provide documentation related to completion of a step down in care, ie. Partial or Intensive Outpatient hospitalization. This will be a requirement in the event that any type of higher level of care takes place during the course of treatment at Calm and Sense Therapy.

Family History of mental health issues:
Paternal Family: _____
_____
Maternal Family: _____
_____

Everyone encounters difficulties from time to time. Please check all that you believe pose a particular challenge for you at this time:

Anxious/Excessive Worry[ ] Binge/Purging[ ] Chest Pain[ ] Chronic Pain[ ] Decreased Appetite[ ] Decreased Energy[ ] Depressed Mood[ ] Dependence/Increase in Alcohol/Drug Use[ ] Disorganized Thoughts] Disorientation[ ] Distractibility[ ] Dizziness[ ] Elevated mood[ ] Fatigue[ ] Food Restriction[ ] Frequent Stomach Aches[ ] Grief [ ] Headaches[ ] Homicidal Thoughts[ ] Hopelessness[ ] Impulsivity[ ] Increased Appetite[ ] Irritability[ ] Isolation[ ] Loneliness[ ] Loss of Interest[ ] Low Self-Esteem[ ] Memory Impairment[ ] Mood Shifts[ ] Nausea[ ] Obsessions/Compulsions[ ] Panic Attacks[ ] Paranoia[ ] Phobias/Fears[ ] Racing Thoughts[ ] Recurring Thoughts[ ] Sleep Disturbances[ ] Social Withdrawal[ ] Speech Problems[ ] Suicidal Thoughts[ ] Trembling[ ] Unable to Enjoy Activities[ ] Weight Gain[ ] Weight Loss[ ]

Other: _____

Have you ever had feelings or thoughts of wanting to hurt yourself: Yes or No If yes, please explain: _____

Alcohol/Drug Use: Yes or No

If yes, what substance(s) and how often: _____

Do you smoke cigarettes or use tobacco products? Yes or No

If yes, how often and have you ever attempted to quit?_____

Have you had previous substance abuse treatment, including hospitalizations and detox? Yes or No
If yes, when and where? _____

Did you find treatment to be successful? _____

Do you have any family history of substance abuse? Yes or No

Have you ever been a victim/perpetrator of physical, sexual or emotional abuse: Yes or No

Have you experienced trauma? Yes or No

History of legal charges:
Yes or No
If yes, please explain: _____
_____

Employment/School

Current Employment (if applicable): _____
Highest Grade Completed in School/Current grade in school: (ie. High School junior/college first-year) _____

Family History/Social Supports
Who do you currently live with? _____
Please list any identified social supports: _____
_____
Please list any religious, cultural or spiritual practices that you would like to make your clinician aware of: _____
_____

COORDINATION OF CARE CONSENT

In order to coordinate care, do we have your permission to contact your primary care provider? Yes or No

If yes, please fill out the following:
I hereby authorize Calm and Sense Therapy to discuss, release, or receive my health information with my primary care provider whose contact information is as follows:

Doctor's Name: _____
Doctor's Address: _____
Telephone Number: _____

I understand that I have the right to cancel this consent for release of information at any time except when my therapist has already taken action on it. If I wish to cancel this consent, I need to ask my therapist for instructions. Otherwise, this consent will be valid from the date of the authorization until termination of treatment with Calm and Sense Therapy.

Client Signature:_____
Parent/Guardian Signature (if client under 18yo):_____
Date:_____

FINANCIAL POLICY and Billing Information

Below are the terms of agreement regarding payment for sessions at Calm and Sense:

If I, the client, fail to appear for an appointment without a 24 hour notice of cancellation, a missed appointment fee of $75 will be charged and I will be responsible for payment. Additionally, if I miss 3 sessions, I understand that this could lead to the forfeiture of my weekly appointment slot.

I understand that if I'm late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

• I authorize my health insurance to provide payment of benefits to Calm and Sense

• I understand record of my treatment may be shared with my insurance carrier when necessary to process claims.

• I understand I am responsible for payment if my insurance company declines payment.

•I understand that I am required to pay my copay at the time services are rendered

• We ask that all clients add a valid credit card to their files to handle any unpaid balances. If there is a balance on your account that has not been paid within 1 billing cycle, the credit card on file will be used to pay the balance owed.

As a courtesy, we are willing to check with your insurance to see what your benefits are for our services. Please be advised that this is only an estimate. Our information is only that which is offered by your insurance and may not always be accurate or up to date. You as the member, have every right and responsibility to verify your benefits prior to your first session.

I have reviewed this document and understand the contingencies stated above.

Client / Client Guardian Signature: _____

Print name:_____ Date:_____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, the noted exceptions are as follows:

Duty to Warn and Protect

Duty to warn is “a threat of imminent, serious physical violence against a readily identifiable individual or against oneself.”

When a client discloses intentions or a plan to harm another individual, the clinician is required to warn the intended victim- or the police where the intended victim lives. 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 to support with making appropriate arrangements for psychiatric evaluation and/or hospitalization.

Abuse of Children and Vulnerable Adults

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 mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful to the appropriate social service and/or legal authorities.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Clinical Quality Review

We take our commitment to maintaining high quality care for all of our clients very seriously. To this end, please be aware that your case could be confidentially presented to a practice Clinical Supervisor by your clinician, but only on an as- needed basis for the sake of additional oversight.

Inter office clinical collaboration:

In instances where a Calm and Sense client refers a family member to the practice or a Calm and Sense clinician refers a client to another in-house clinician for additional specialized support, the involved clinicians may provide relevant clinical updates and collaborate for the sake of ensuring high quality care. If you are not comfortable with this practice please alert your clinician to discuss alternatives.

Insurance Providers(when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications

Client Signature:_____

(Client's Parent/Guardian if under 18) :_____
Today's Date: _____

Calm and Sense Telehealth Informed Consent

Telehealth is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two dif erent locations. Calm and Sense Therapy uses the Zoom platform to conduct Telehealth sessions; it of ers secure, encrypted audio/video transmission software. To participate in Zoom sessions, the client and clinician will need to utilize the device of their choosing with video and audio capabilities. Audio-only (phone) sessions will ***only*** *be conducted in the event that the staf member and/or client does not have access to the necessary equipment and/or software or for other discussed reasons out of their control.*

I understand the following with respect to telehealth:

1) It is my responsibility to ensure that the session is taking place within the state of my clinician's licensure (NJ) and only in a safe, sufficiently private and therapeutically conducive space- as my clinician will ensure for themselves as well prior to starting the session. In addition, it is my responsibility to alert my clinician if privacy has been disrupted in any way during session (ie. family member has suddenly entered the room) as to pause the conversation until privacy is restored.

2) I understand that I will need to ensure that I am prepared to start my scheduled telehealth session on time and if I will be late, or need to cancel or reschedule, I must provide my clinician with at least 24-hour notice or I will incur a "late cancellation fee" of $75 which will charged to the card on file. Communicated **emergency exceptions** will be honored and not incur a charge.

3) I understand that I have the right to withdraw consent at any time without affecting my right to future services to which I would otherwise be entitled.

4) I understand that there are risks and consequences associated with telehealth, including but not limited to: disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

5) I understand that there will be **no recording** of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without my written authorization, except where the disclosure is permitted and/or required by law.

6) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth **unless an exception to confidentiality applies** (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

7) I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

8) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, my therapist will encourage me to end and restart the session. ***__If we are unable to reconnect within ten minutes, my therapist may call me at (please provide preferred contact number) _____ to resume via phone call__. If for whatever reason the connection cannot be restored promptly, the session will be billed for the time completed and my clinician will contact me with the next available appointment.

Telehealth Emergency Protocols:

9) I understand that as much as my assigned clinician will be a trained professional equipped to support me with my presenting concerns, there are certain situations, including emergencies and crises, which are inappropriate for audio-/video-/computer-based psychotherapy services.

If I am in crisis or in an emergency, I understand that I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. After this point, I can then inform my clinician of the events and seek additional support.

10) I understand that if I have recently been psychiatrically hospitalized or in detox in the last 30 days, I am required to provide documentation related to completion of a step down in care, ie. Partial or Intensive Outpatient hospitalization. This will be a requirement in the event that any type of higher level of care takes place during the course of treatment at Calm and Sense Therapy.

11) I understand that if at any point during my services my clinician believes I would be better served by another form of intervention (e.g., face-to-face services), they will outline a plan for me which may entail office visits or a referral to another mental health professional. Such circumstances include but are not limited to: If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely.

12) I understand that I must provide my clinician with the address of my physical location at the outset of the session in the event of an emergency that requires the dispatch of support.

13) I understand that I must provide the name and contact information of my emergency contact my therapist will reach out to on my behalf in a life-threatening emergency only. This person must

live with me or within 30 minutes of my location. I understand that this person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ My emergency contact is (Name): _____ Address: _____

Phone: _____

SIGNATURES

I have read the information provided above and discussed it with my therapist to ensure my full understanding.

Signature of client/parent/legal guardian: _____ Date: _____ Signature

of Therapist: _____ Date: _____

Calm and Sense Social Media Policy

This document outlines Calm and Sense Therapy's policies related to use of social media and communication beyond the realm of the therapy session. Please discuss any questions or concerns you may have with your therapist.

Email/Phone Calls/Text Messages

Please use either your clinician's work email or if you do not have their email, call our main number 908- 322-9623 to contact your therapist for administrative reasons only (modifying appointments, billing information, etc.).

Calm and Sense staff may opt to utilize text messaging with a phone overlay service for the sole purpose of confirming appointments / noting appointment changes.

Please do not email or text content related to the counseling sessions or assessments, unless otherwise discussed. Email communication is secure and HIPAA compliant, but text communication is not completely secure or confidential. Any emails or texts received from you and any responses sent to you become a part of your legal record. Please note that all emails or voice messages left through the answering service will be responded to within 12-24 hours of receipt, during office hours. If there is a life or death situation please dial 911.

****Please do not use either the work email, text, or the answering service for emergencies but rather call 911 and alert your assigned clinician once safely connected to an appropriate emergency service.**

Social Media- Friending/Following

No Calm and Sense employee will accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and the therapeutic relationship.

No Calm and Sense employee will follow any client on Twitter, Instagram, blogs, or other apps/websites.

If there is content you wish to share from your online life with your clinician, please bring it into the sessions where it can be explored privately.

Signatures

I have read and understand the Calm and Sense Media policy above and will adhere to its specifications.

Client signature (Client age 14 or older)_____

Client Parent/Guardian signature (if client is under 18)_____

Date:_____

Clinician Signature: _____

----------OFFICIAL USE ONLY----------

Therapist Signature: _____ **Date:** _____

Calm & Sense Therapy DX: _____

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