ESSENTIAL COUNSELING SERVICES
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Client Information

Name (Legal & Preferred): _____

Gender: _____ Date of Birth: _____ Age: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____Cell: _____ (Permission to text __Y __N)

Email: _____

Please circle the preferred method of contact above

Are we able to leave detailed messages? _____ Y _____N

Emergency Contact: _____

Emergency Contact Address: _____

Emergency Contact City: _____ State: _____ Zip: _____

Emergency Contact Phone (home): _____ Cell: _____

Insurance Plan: _____

Insurance ID Number: _____

Insurance Group Number (if applicable): _____

Insurance Policy Holder: _____

Insurance Policy Holder's D.O.B. _____

Briefly describe the reason(s) for seeking services: _____

_____

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_____

_____

_____

How long has this been a concern? _____

How much does this problem impact your life? (circle one):

1	2	3	4	5
Not at all	A little bit	Somewhat	A Lot	Extremely

Have you ever been prescribed medication for this issue? YES NO

If yes, please list the physician/prescriber: _____

Please list any current medications:

_____

_____

_____

_____

_____

_____

_____

Is there anything else you would like us to know at this time?

_____

_____

_____

_____

105 Grove Street Ste. 5A Montclair, NJ 07042
286 5th Avenue 10th Floor New York, NY 10001

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HIPAA

Essential Counseling Services adheres to the legal standards set forth by HIPAA and is as follows: "The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that **required the creation of national standards to protect sensitive patient health information** from being disclosed without the patient's consent or knowledge." For further information on HIPAA please visit the website https://www.hipaa.com

ECS Privacy Notice

Essential Counseling Services is committed to maintaining client confidentiality. You will be advised if there is an inquiry into your health record (i.e. from an insurance company) and will be a part of the discussion regarding release of records. We must adhere to federal and state laws in accordance to the release of protected health information. Due to New Jersey & New York State Laws, there are some exceptions to confidentiality. Here are some of those instances:

- When there is a report made of harm towards a minor or a vulnerable adult related to abuse. We are obligated to make a report to Protective Services and/or law enforcement.
- When there is a disclosure of potential harm to self or others.

Treatment: We may need to use or disclose health information to provide, manage, or coordinate your care. This may include consulting with other healthcare professionals and referral sources. Treatment coordination will be explored with your written consent.

Payment: We need to use or disclose information related to your healthcare coverage to our billing company in order to process your payments including the submission of health insurance claims.

Please feel free to ask any further questions related to confidentiality with your treatment provider.

Notice of HIPAA information and Privacy Notice: I/We have read and are able to access the HIPAA website for further information. A copy of the "Notice of HIPAA information and Privacy Notice" will be provided upon request.

_____ _____

Client Signature Date

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Informed Consent

Coordination of Treatment: To ensure continuity of care, we would like your voluntary permission to communicate with your healthcare providers. You have the right to revoke this written authorization at any time.

Please initial below your intention.

____ I decline authorization for ECS to contact other treatment providers for collaboration

____I authorize ECS to contact other treatment providers for collaboration

Provider/Office Name: _____

Address: _____

Phone: _____

Email: _____

Provider/Office Name: _____

Address: _____

Phone: _____

Email: _____

Client Name: _____

Client Signature: _____

Date: _____

Client Guardian (if under 18) Name: _____

Guardian Signature: _____

Date: _____

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Informed Consent

(Continued)

Consent for the Treatment of Minors (*Must be completed for clients under 18 years of age*)

I/We consent that _____may be treated as a client by Essential Counseling Services. It is understood that children who are at least 16 years-old have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

By signing below, you indicate that you have read and understood the informed consent document.

_____ _____

Client Signature: Date:

_____ _____

Parent/Guardian Signature (if applicable) Date:

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Financial Policy

As part of the delivery of mental-health services, we have established a financial policy that provides payment policies and options to all of our clients. This financial policy is designed to clarify the payment policies so that you, the "person responsible for payment of account," can be informed of your financial responsibility.

Prior to a scheduled appointment, our billing company will verify your insurance benefits with you. This will include, co-pay amounts/deductibles, and/or any other financial responsibilities for mental-health services. We will bill insurance companies and other third party payers on your behalf. In some cases, insurance companies or other third party payers, may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, you are responsible for payment of these services. We charge our clients the usual and customary rates for this area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

By signing below, as the person responsible for payment, you are agreeing to be financially responsible for payment of the services we provide to you and, as such, responsible for paying funds not paid by insurance companies or third party payers after 60-days.

Your insurance deductibles and co-payments will be billed once services are rendered. A credit, debit, HSA card is kept on file with our agency biller to submit payments such as co-pays, deductibles, and balances. In the event that neither of the above options are available, cash payments would need to be further discussed with management.

Cancellations: If you late cancel or 'No Show' a scheduled appointment with less than 24 hour-notice, a late cancellation fee of $50 will be charged. This cannot be billed to your insurance.

I/We have read, understand, and agree with the provisions of the financial policy.

Person responsible for account: _____ Date: _____/_____/_____

Co-responsible for account: _____ Date: _____/____/_____