info@ecsofnj.com | 973-619-9619

Client Information

Name: _____ Date: _____

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: _____

_____

_____

_____

_____

_____

_____

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 prescribe medication for this issue? YES NO

If yes, who is/was your physician/prescriber? _____

Are you / have you been under the care of a psychiatrist? YES NO

If yes, for how long? _____

Have you been under the care of a mental-health provider? YES NO

If yes, for how long? _____

Please list any current medications:

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____

HIPAA

Essential Counseling Services of NJ 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 of NJ Privacy Notice

- Essential Counseling Services of NJ is totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling and social work profession.

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

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

-Due to New Jersey State Law 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 physical or sexual abuse. We are obligated to make a report to the Department of Child Protection and Permanency.
- You are in danger of harming yourself or others.
- Information shared with law enforcement if a crime is committed on our premises or against our staff or us

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 received a copy of the "Notice of HIPAA information and Privacy Notice"

_____ _____

Client Signature Date

Informed Consent

Confidentiality and Emergency Situations: Your verbal communication and clinical records are strictly confidential except:

a) Information (diagnosis and dates of service) shared with your insurance company to process your claims
b) Reporting thoughts to harm self or others; under NJ state law, the mental health provider is obligated to inform the chief law enforcement officer of the municipality in which you reside or the superintendent of state police if you reside in a municipality that does not have a full time police department
c) Information that a minor or vulnerable adult is being abused; under NJ state law, the mental health provider is obligated to report this to either NJ division of child protection and permanency or adult protective services
d) When required by court order
e) When you sign a consent form to have confidential information shared

Coordination of Treatment: It is important that all health care providers work together. As such, we would like your permission to communicate with your providers. Your consent is valid for 1 year. You have the right to revoke this authorization at any time.

Please initial below your intention.

____ I decline authorization for ECS of NJ to contact other treatment providers

____I authorize ECS of NJ to contact other treatment providers

Name: _____

Address: _____

Phone: _____

Fax: _____

Name: _____

Address: _____

Phone: _____

Fax: _____

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 of NJ. It is understood that children over the age of 14 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, and that any questions you have about aforementioned has been answered to your satisfaction.

_____ _____

Client Signature: Date:

_____ _____

Parent/Guardian Signature (if applicable) Date:

Financial Policy

We are committed to providing caring and professional mental-healthcare to all our clients. 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 and understand your payment options.

As a service to you, we will bill insurance companies and other third party payers if we are an out-of-network provider. We cannot guarantee, your benefits, or the amounts covered, and are not responsible for the collection of your payments. 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 are due at the time of service if we are an in-network provider. Although it is possible that mental-health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to other mental-health providers during the current year that was prior to your first session with ECS of NJ), we will collect this amount until we verify the deductible payment with the insurance company or third party provider.

Payment methods include: credit card or Zelle. A credit card is kept on file with our agency biller to submit payments such as co-pays, deductibles, and balances at the end of each session. In the event that neither of the above options are available, cash payments would need to be further discussed with management.

Payments and Cancellations: Payment is due at the time services are rendered. Please note, if you cancel a scheduled appointment with less than 24 hour-notice, a late cancellation fee of $50 will be charged which 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: _____/____/_____