Inner Clarity, LLC
Robyn DeRespinis, LCSW
9 Village Court
Hazlet, NJ 07730

APPLICATION FOR SERVICES

Please Note: The following information is requested so that we may best understand both you and your needs. Please complete as thoroughly as possible. Thank you.

General Information:

Today's Date: ____________________________

Name of client: ____

Address: ____

____

Date of Birth: __________________ Social Security Number: __________________________

Age: __________________ Sex: __________________ Marital Status: _______________________

Ethnic Background: __________________________

Name to contact in an emergency: _____________________ Phone # ____________________

Work Phone: (_______)__________________ Home Phone:(_______)______________________

Cell Phone: (_______)___________________ Can we send text messages to this #?________

Is it okay to call you at work? ____Y/N____ at home? ____Y/N____ cell? ____Y/N____

What is your preferred method of verbal contact? (circle one) Work Home Cell

What is your email address? ____

Who referred you? ____

Employment Information:

Employer: ____ Job Title: _________________________

Address: _______________________________________ Yearly Income: _____________________

Work Phone: (_______)__________________ Is it okay to call you at work? ____Y/N____

Is it okay to leave you messages at work? ____Y/N____

Insurance Information:

Do you have health insurance? ____Y/N____

If yes, company name: ____

Do you have out-of-network benefits? If so, what are they? (eg. ____?____Percentage

reimbursed after ____?____ deductible is met.)

____

Policy/ID#: ______________________________ Name of Insured: _________________________

Social Security # of insured: _____________________ D.O.B. of Insured __________________

Insurance phone #: (may specify "Behavioral Health") _______________________________

An invoice will be provided for you to be reimbursed directly by your insurance company if you have out-of-network benefits.

Inner Clarity, LLC
Robyn DeRespinis, LCSW
9 Village Court
Hazlet, NJ 07730

Name: ______________________________________

Today's Date: ______________________________

What is the presenting concern, or reason treatment is being recommended at this time? ____

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations etc.)? If so please indicate treatment provider and dates attended:

From ________ To ________ Provider: ________________ Reason: ________________

From ________ To ________ Provider: ________________ Reason: ________________

From ________ To ________ Provider: ________________ Reason: ________________

Are you currently taking any prescription medication?

- ☐ Yes
- ☐ No

If Yes, Please list:

____

____

Are you currently receiving treatment by a Psychiatrist, or APN for medications?

- ☐ Yes
- ☐ No

If Yes, Please Provide Contact Information:

____________________________________ ____________________________________

Psychiatrist/APN Name Address

(____)______________________________ ____________________________________

Phone

Have you ever been prescribed psychiatric medication?
- ☐ Yes
- ☐ No

If Yes, Please list and provide dates:

____

____

Marital Status: (circle one) Never Married Domestic Partnership Married

Separated Divorced Widowed

Please list household members/age: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? ____________________

What type of exercise do you participate in ____

4. Please list any difficulties you experience with your appetite or eating patterns

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

- ☐ No
- ☐ Yes

If yes, for how long? Please describe: ______________________________

____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- ☐ No
- ☐ Yes

If yes, for how long? Please describe: ______________________________

____

7. Are you currently experiencing any chronic pain?

- ☐ No
- ☐ Yes

If yes, please describe: ______________________________________

8. Do you drink alcohol more than once a week?

- ☐ No
- ☐ Yes

If yes, please indicate amount and frequency: ________________________

Have you ever needed substance abuse treatment? If yes, when/where was

treatment obtained? ____

9. How often do you engage in recreational drug use?

- ☐ Daily Type: ____________________
- ☐ Weekly Type: ____________________
- ☐ Monthly Type: ____________________
- ☐ Infrequently Type: ____________________
- ☐ Never

10. Are you currently in a romantic relationship?
- ☐ No
- ☐ Yes

If yes, for how long? ___________________________

On a scale from 1-10, how would you rate your relationship? _______________

11. What significant life changes or stressful events have you experienced recently:

____

____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, paternal grandmother, maternal uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Bipolar Disorder	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed?

- ☐ No
- ☐ Yes

If yes, what is your current employment situation: (job title/employer)

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

If you are not currently working, do you have any work history?

Last worked: ____________________ Job Title: ___________________________

Employer: ________________________ Reason employment ended: __________________________

2. Do you consider yourself to be spiritual or religious?

- ☐ No
- ☐ Yes

If yes, describe your faith, or belief:

____

3. Have you ever experienced any type of trauma? (eg. Physical, Sexual Abuse, Domestic Violence, Loss, Natural Disaster, Witness Crime, Victim of Crime, Rape, etc.) If so, please indicate date and type of trauma:

____

____

____

4. What do you consider to be some of your strengths?

____

____

5. What do you consider to be some of your weaknesses?

6. What would you like to accomplish during your time in therapy?

7. On a scale of 1 to 10 how motivated are you to work on these goals?

1 2 3 4 5 6 7 8 9 10

Inner Clarity, LLC
Robyn DeRespinis, LCSW
9 Village Court
Hazlet, NJ 07730

Notice of Policies and Practices to Protect the Privacy of Your Health Information

Experience has taught me that it is easier for you to focus on your process of therapy when all expectations and ground rules are clearly understood. Therefore, please read through the following policies and procedures. If you have any questions or concerns, please discuss them with your therapist before signing this agreement. Your signature indicates your agreement with all aspects of the following:

1. **Confidentiality**: I will not release or transfer any information pertaining to you without your express written consent. The only exceptions are required by law (Duty to Protect Bill, signed 8/27/91) as follows:

a) **Serious Threat to Health or Safety:** When an individual's thoughts or actions pose a threat to her/himself, I must report this suicidal intent to the immediate family, the police, or arrange for you to be admitted to a psychiatric unit of a hospital or other healthcare facility. When an individual's thoughts or actions pose a threat to another, I must report this homicidal intent to the target or to the police.

b) **Child Abuse:** When I have reasonable cause to believe that child abuse or neglect has occurred, or is occurring, I must make a report to DCP&P (formerly known as DYFS).

c) **Adult or Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

d) **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

e) **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

f) **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant I the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in communication with the case, the Division of Worker's Compensation or the Compensation Rating and Inspection Bureau.

2. **Cancellation Policy:** Appointments must be cancelled or rescheduled by phone at least 24 hours in advance, unless there is a serious emergency, or you will be responsible to pay your full fee.

3. **Length of Session:** Individual sessions are approximately 45 minutes in length. There are times when a longer session is needed. Extended session length and fees need to be discussed prior to lengthening session.

4. **Payment Policy:** Payment is due in the form of *cash, check, or credit card* at the *beginning* of each session. There is a $3 fee for all credit card payments. I do not accept insurance and it is the responsibility of the client to determine what out-of-network benefits your insurance company offers. It is also the responsibility of the client to submit all necessary documentation to the insurance company in order to obtain reimbursement. A receipt will be provided for proof of payment. An invoice will be provided if needed for the purpose of submission to the insurance company for reimbursement.

5. **Billing:** If you need a bill for your records or insurance company, one will be prepared for you.

6. **Uses and Disclosures Requiring Authorization**: I may use or disclose your protected health information (PHI) for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization from you before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

6. **Lateness**: If you are late, your session may be cut short. This may occur because there is a client scheduled directly after you. If we can make up the time, we will; however, if we cannot you will be charged your full fee. Please notify your therapist by calling or sending a text message if you anticipate that you will be late. If you are more than 15 minutes late, it may not be clinically appropriate to hold the session and you may be asked to reschedule.

7. **Phone Contacts:** In emergency situations and times of need, I want you to call for support. If this becomes a regular need, or if phone calls extend longer than 30 minutes, then we will arrange for phone sessions at an agreed upon rate.

8. **Respect**: Because you may attend a group or workshop here, you may become privy to personal information about others. Please respect their confidentiality.

Inner Clarity, LLC
Robyn DeRespinis, LCSW
9 Village Court
Hazlet, NJ 07730

I, ____ have received a copy of Inner Clarity, LLC's Notice of Policies and Practices to Protect the Privacy of Your Health Information.

Please sign this form to acknowledge receipt of the Notice of Policies and Practices to Protect the Privacy of Your Health Information. You may refuse to sign this acknowledgement, if you wish.

____
Signature

____
Date

IF THE ABOVE IS NOT SIGNED, THE LOWER SECTION SHOULD BE COMPLETED BY A REPRESENTATIVE FROM INNER CLARITY, LLC.

I have made every effort to obtain written acknowledgement of receipt of our Notice of Policies and Practices to Protect the Privacy of Your Health Information from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain acknowledgement.
- ☐ I was not able to communicate with the patient.
- ☐ Other (*Please provide specific details)*

____
Signature

____
Date

Inner Clarity, LLC
Robyn DeRespinis, LCSW
9 Village Court
Hazlet, NJ 07730

Client Rights and Responsibilities

CLIENT RIGHTS:

1. Understand and use these rights if for any reason you do not understand or need help, your therapist at Inner Clarity, LLC must provide assistance.
2. Receive treatment without discrimination to race, color, sex, nation, origin, disability, or sexual orientation.
3. Receive considerate and respectful care in a clean and safe environment.
4. Be informed of the name and position of the therapist providing your treatment.
5. Know the names of the staff involved in your care
6. Receive complete information about your diagnosis, treatment, and prognosis.
7. Receive all the information needed to give informed consent for any proposed procedure or treatment.
8. Refuse treatment and be told what effects it may have on your health.
9. Participate in decisions about his/her own treatment and discharge and/or transfer from a program
10. Review your clinical record upon written request and obtain a copy of the clinical record – unless the therapist assesses that this disclosure may be harmful.
11. Complain without fear of referrals. If not satisfied with the care you are receiving you may contact: The Community Health Law Project at 721-502-0059, Monmouth County Health Administrator 732-431-7200, Division of Mental Health Advocacy at 1-800-922-7233.
12. Participate in the decisions involving ethical issues.
13. Privacy while in the agency program and confidentiality of all information and records and have received a summary of HIPPA Privacy.

CLIENT RESPONSIBILITIES:

1. Provide to the best of your knowledge, ACCURATE AND COMPLETE INFORMATION about your present complaints, past illness, hospitalizations, medications, and other matters relating to his or her health.
2. Report any unexpected changes in your condition to the responsible practitioner.
3. Report whether a contemplated course of action and what is expected of you is understood or not.
4. Follow the treatment plan formulated by the therapist with your participation.
5. Keep scheduled appointment and make timely notifications if you are unable to do so.
6. Assume responsibility for your actions upon refusing treatment or not following the prescribed treatment plan.
7. Consent for the release of relevant information in an emergency situation including medical emergencies or psychiatric emergency. This includes information being released to Monmouth County's Screening Center, Ocean County's Screening Center, Monmouth Medical Center, Riverview Medical Center, Jersey Shore Medical Center, Centra State Medical Center, Saint Barnabas Behavioral Health, and Community Hospital.

I HAVE RECEIVED A COPY OF MY RIGHTS AND RESPONSIBILITIES, WHICH WERE EXPLAINED TO ME. I CONSENT TO RECEIVE AND PARTICIPATE IN TREATMENT.

____ ________________

Client Signature (14 years old) **Date**

____ ________________

Parent/Guardian Signature **Date**

Inner Clarity, LLC
Robyn DeRespinis, LCSW

9 Village Court, Hazlet, NJ 07730 Phone: (732) 759-0881

Authorization to Release Psychiatric Records

Patient Name	Birthdate

I hereby authorize the following release:

Inner Clarity, LLC, its agents, employees, or servants may disclose my psychiatric and/or psychological records and information obtained in the course of my diagnosis and treatment facility to:

Name	Agent/Facility/School/Physician
Street Address	Phone

Who may, in turn, release psychiatric and/or psychological records and information to Inner Clarity, LLC. Personal contact, including phone calls and face-to-face meetings, may be initiated by either party when deemed necessary, within the time-frame specified.

Purpose (s) of Release

Such disclosures shall be limited to the following specific information.

- ☐ Discharge Summary
- ☐ Psychiatric History & Medical Status
- ☐ Lab Results
- ☐ Progress Notes
- ☐ Result of psychological tests
- ☐ Educational Assessments & Reports

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and, if not earlier revoked, it shall terminate when I stop receiving services from Inner Clarity, LLC.
Law prohibits release or transfer of the disclosed information to any person or entity not specified herein. An additional consent must be obtained for further transfer of information. I understand that I have the right to receive a copy of this authorization if I so request. (A copy is as valid as the original).

I am fully aware that certain state and federal statutes and regulations require that I voluntarily sign this document before Inner Clarity, LLC can release records, and that I may refuse to sign my signature, but in the event the records cannot and will not be released by Inner Clarity, LLC. I free both above named parties of any liabilities if ever I revoke my decision to release the data.

Client Signature	Date	Witness Signature	Date
Parent/Guardian Signature	Date	Therapist Signature	Date