Inner Clarity, LLC
9 Village Court
Hazlet, NJ 07730
Tax ID # 47-1357819

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: _____

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? _____

May we contact them? __Y/N__ If so, what is their phone #? _____

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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/Member ID#: _____ Group #:_____

Name of Insured: _____ D.O.B. of Insured _____

Address of Insured: _____

_____

Name of Policy Holder: _____ D.O.B. of Policy Holder _____

Address of Policy Holder (if different from patient):
_____

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

*Please note as a courtesy we may confirm your OON benefits on your behalf, but it always important to re-confirm this information with your insurance company directly.

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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.). If you or your child was adopted, please indicate whether the reported history is for the biological or adoptive family member.

	Please Circle	List Family Member (specify adoptive or biological)
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	

If you or your child was adopted, or in foster care, please provide any pertinent details you would like to share with your therapist:

_____

_____

_____

_____

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. Are you currently enrolled in school?

☐ No
☐ Yes

If yes, what school do you attend? _____

What is the highest grade/level of education you have obtained?

_____

Do you (or your child) have any cognitive impairments or learning disabilities impacting your performance at school or work? (If so, please describe and attach additional information that can inform this assessment.)

_____

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

☐ No
☐ Yes

If yes, describe your faith, or belief:

_____

4. 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:

_____

_____

_____

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

_____

_____

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

_____

_____

7. 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

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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 <u>not</u> 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 in 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 **a $100 fee**. Clients will need to have a credit card number on file to be charged in the case of a no show/less than 24 hour cancelled session.

3. **Length of Session:** Individual sessions are approximately 45-60 minutes in length. There are times when a longer session is needed. Please note that your coinsurance amount is based on the session length and may increase with a longer session time.

4. **Payment Policy:** Payment is due in the form of *cash, check, or credit card* at the *beginning* of each session. A receipt will be provided to you if requested, but please note that we may not be able to provide receipts for sessions more than 1 year old. If you have a credit card number on file and have not responded to outreach for repayment of bounced check plus bounced check fee, your credit card will be charged the full session fee plus bounced check fee. Please note if your credit card number is continually declined you may be asked to provide another form of payment.

5. **Billing:** It is the responsibility of the client to verify your out-of-network benefits your insurance company offers. Please note that your insurance company may set a ***maximum reimbursable rate***, which may be less than the billed amount for session. In this case, you will be responsible for paying your coinsurance amount at the time of session, but you may also be billed for any balance that is not covered by your insurance. It is also the responsibility of the client to submit all necessary documentation to Inner Clarity, LLC, so that your insurance company can be billed. Incorrect insurance information may lead to a delay, or denial in claim payment. *Please review information listed in our Financial Agreement

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 may be 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.

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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

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I, _____ understand that my credit card listed below will be charged a non-refundable **$100** fee in the event that I do not show for a scheduled appointment at Inner Clarity, LLC, do not inform my therapist of my need to cancel/reschedule my appointment at least 24 hours before my scheduled appointment time, OR in the case of non-payment due to bounced check. Further, I understand that there is a $30 fee for bounced checks.

I also understand that if I have out-of-network benefits through my insurance company, Inner Clarity, LLC will be billing my insurance on my behalf. In the event that my insurance company issues reimbursement to me instead of my provider, (Inner Clarity, LLC), then I am required to sign the check over to my provider. In the event that the payment is NOT signed over to my provider within 30 days, the credit card I have on file with Inner Clarity, LLC will be charged. I also understand that my coinsurance amount is due at the time services are rendered.

The following signature authorizes Inner Clarity, LLC to charge my credit card in the case of aforementioned circumstances.

_____
Print Name (Cardholder)

_____
Signature (Cardholder)

_____
Date

- ☐ CHECK HERE to give permission for your therapist to charge your card automatically after your completed session.

Credit Card Number: _____

Cardholder Name: _____

Expiration Date: (MM/YY) _____

Email Address for Receipt: _____

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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**