

# Mindful Solutions NJ, LLC

## General Information

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_

If under 16, please give mother's name \_\_\_\_\_ and father's name \_\_\_\_\_

Marital Status: S M D W Other \_\_\_\_\_

Current status:  Student  Employed  Unemployed  Homemaker  Retired  Other: \_\_\_\_\_

If student, are you Full Time or Part Time? FT PT Please give School attended \_\_\_\_\_

If working, please give Occupation and Place of Employment \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency contact Phone Number \_\_\_\_\_ Alternative Phone number \_\_\_\_\_

If person filling out form is not client, check here:  What is your relationship to client? \_\_\_\_\_

## Address & Contact Information

Home Address \_\_\_\_\_

\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Okay to call? Y N Okay to leave a message? Y N

Email (*used for scheduling issues and payment reminders*) \_\_\_\_\_

Any special instructions when calling, leaving messages or emailing? \_\_\_\_\_

## Insurance Information (complete ONLY if you will be seeking insurance reimbursement for your sessions)

Insurance company (eg. Cigna, Horizon, BCBS, Aetna, etc.): \_\_\_\_\_

Name of employer providing insurance (if any) \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Your name \_\_\_\_\_ Your DOB \_\_\_\_\_

Policy holder name \_\_\_\_\_ Policy holder DOB \_\_\_\_\_

Insurance company address (see back of card) \_\_\_\_\_

\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance company phone \_\_\_\_\_ Insurance company fax \_\_\_\_\_

*Note: we work mostly on an out of network basis. Generally, you will be required to cover the full session fee and receive reimbursement from your insurance company. Please check with your insurer to understand if you have a deductible for out of network coverage. We will complete and submit all the appropriate paperwork for you.*

Would you like to receive copies of invoices for FSA or HSA purposes? Y N

PLEASE TURN SHEET OVER FOR IMPORTANT INFORMATION & SIGNATURES

**Initials and Signatures**

\_\_\_\_\_ I understand it is my responsibility to pay for the session at the time of service. It is also my responsibility to pay the full session fee for no-show or cancellations with less than 48 hours notice.

\_\_\_\_\_ I affirm that I have willingly sought treatment from Mindful Solutions NJ, LLC for issues relating to the field of mental health. I recognize that such treatment may involve exploration of my personal and family experiences and has the potential to be emotionally unsettling. I agree and consent to receive treatment from my therapist at this time. I understand that I have the right to terminate such treatment at any time.

\_\_\_\_\_ I acknowledge that I have received, read, signed and consent to abiding by the Client Rights and Responsibilities document.

\_\_\_\_\_ I acknowledge that I have read and consent to the Notice of Privacy Practices document, which explains in detail my rights to access my Personal Health Information and how, when and with whom that information may be shared.

\_\_\_\_\_ I acknowledge that if my therapist deems the treatment I require to be beyond her level of training or resources as a practitioner that it is her/his ethical duty to provide referrals to other professionals or agencies. In the event that such a referral is, in his/her opinion, necessary for treatment to be effective, I recognize that in order to continue in therapy with them I will need to follow up on such referrals and/or obtain additional licensed clinical responsibility for my care. Such situations may include (but are not limited to): recurrent suicidality, alcohol or chemical dependency, eating disorders, domestic violence, symptoms of bipolar, psychosis or a personality disorder.

\_\_\_\_\_ I agree that my therapist's sole responsibility is in working with me as a therapist and that I will not enlist in any legal proceedings related to my case. I further agree that neither he/she or his/her records nor her testimony will be subpoenaed for deposition or court testimony, and she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

Client Name (please print legibly) \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_