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_____

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 if I have not met my insurance deductible or if I do not have insurance. It is also my responsibility to pay a $30 no-show fee for no-show or cancellations with less than 24 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_____