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:_____

Phone: _____Okay to call? Y N Okay to leave a message? Y N

Email: _____

Any special instructions when calling, leaving messages or emailing?

_____

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

Name of Insurance Company and Plan Name:_____

Name of Employer Providing Insurance (if any)_____

Policy Number: _____Group Number: _____

Your Name: _____ DOB: _____

Policy Holder's Name: _____ DOB: _____

Insurance Company Address (see back of card)

_____

State: _____Zip: _____Insurance Phone Number: _____Fax: _____

PLEASE CONTINUE TO PAGE TWO

CLIENT'S RIGHTS & RESPONSIBILITIES

_____ I understand it is **my responsibility** to understand in full my insurance benefits prior to my appointment and that **I am fully responsible for all expenses that my insurance does not cover**. If my insurance has a copay or deductible, I understand that it is my responsibility to pay in full at the time of my service.

_____ I understand that Mindful Solutions' list of participating insurances may change from time to time and that **it is my responsibility to know if Mindful Solutions staff are participating providers** to my plan by contacting my insurance prior to my appointment.

_____ I understand that it is my responsibility to inform Mindful Solutions staff immediately should my **insurance change**. If I fail to do so and my claims are unable to be processed, I understand that I am responsible to pay for uncovered charges related to untimely filing of claims.

_____It is also my responsibility to give 48 hours notice should I need to cancel or postpone my appointment. I understand there is a $50 fee for cancelled therapy appointments and an $80 fee for cancelled doctor appointments if I fail to cancel prior to said 48 hour notice. Notification for cancelled appointments scheduled on Monday will need to be made by the preceding Friday by noon or I could be subject to a $50/$80 cancellation fee.

_____ 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/doctor at this time. I understand that I have the right to terminate such treatment at any time.

_____I acknowledge that if my therapist/doctor deems the treatment I require to be beyond her/his scope of practice as a practitioner that it is their **ethical duty** to provide referrals to other professionals or agencies. In the event that such a referral is necessary for treatment to be effective it is my responsibility to follow up on such referrals to continue working with my therapist/doctor at Mindful Solutions. Such situations may include (but are not limited to): recurrent suicidality, alcohol or chemical dependency/abuse, eating disorders, domestic violence, extreme symptoms of bipolar, psychosis or a personality disorder.

_____ I acknowledge that it is not Mindful Solutions' practice to complete disability paperwork in the short-term. Said documentation is only provided to clients/patients with a minimum of 6 months of service by the clinical staff expected to complete same.

_____ I agree that my therapist's sole responsibility is in working with me as a therapist and that I will not enlist them 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 he/she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

_____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. My initials above acknowledge that I have read and understand my rights and responsibilities as a client/patient of Mindful Solutions.

Client Name (please print legibly _____

Client Signature _____Date_____