Lakeside Counseling Associates, LLC

350 Sparta Avenue, Suite C-2A
Sparta, NJ 07871
Phone: 973-726-4533
Fax: 973-726-0617
lakesidecounselingassociates.com

30 Moran Street
Newton, NJ 07860
Phone: 973-862-6066
Fax: 973-862-6048

Patient Information:

Last Name: _____ First Name: _____Middle Initial:_____

Address: _____City:_____State: _____Zip:_____

Home Phone: _____Work:_____Cell:_____

SSN: _____Sex:_____Birthdate:_____Marital Status:_____

EMAIL: _____

Responsible Party Information: (If different from above)

Last Name:_____First Name:_____Middle Initial:_____

Address: _____City:_____State:_____Zip:_____|

Home Phone:_____Work:_____Cell:_____

Insurance Information: Birthdate and SSN# are required for Insurance Purposes

Primary Insurance Company:_____

Subscriber Name: _____Birthdate:_____SSN#:_____

Relationship to patient: _____ID#:_____Group Number#: _____

Secondary Insurance Company:_____

Subscriber Name:_____Birthdate:_____SSN#:_____

Relationship to patient: _____ID#:_____GroupNumber#:_____

****You are responsible for providing correct and complete INSURANCE Information****

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Lakeside Counseling Associates, LLC to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _____hereby authorize _____to pay and hereby assign directly to
(Name of Insured) (Name of Insurance Company)

Lakeside Counseling Associates, LLC all benefits, if any otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Lakeside Counseling Associates, LLC will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

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Welcome to our office. We are committed to providing you with the best possible care. In order to achieve that goal, your understanding of our office policies is essential. Please read this carefully and sign at the bottom of the page.

Your signature indicates that you have read and understood the following:

1. **Co-payment** – It must be paid before you see your provider. If you arrive for your visit without your co-payment, you will be asked to reschedule.

2. **Referrals** – If your insurance company requires that you have a current referral to see us, you must obtain one prior to your visit.

3. **Patient Balances** – These must be paid before or at the time of your next appointment unless otherwise arranged in advance.

4. **Returned Checks** – You will be responsible for the original amount of your check plus an additional charge of $25.00 and a $15.00 bank fee.

5. **Missed Appointments** – We require a 48-hour notice if you are unable to keep your appointment. There is a $50.00 fee for missed appointments and late cancellations.

6. **Coverage** – Your insurance is a contract between you and your insurance company. We are not a party to that contract. You must familiarize yourself with the details of your coverage as we cannot research your policy at the time of your visit.

7. **Non-Covered Services** – Not all services are covered benefits in all contracts. In such cases, you will be required to pay the full amount at the time of your visit.

8. **Lateness** – If you arrive after your scheduled appointment time, you may be asked to reschedule. This is at the discretion of your provider. A late cancellation fee of $50.00 will apply.

I have read this information sheet and agree to abide by the policies of this practice.

Signature **Date**

Print Name **Witness**

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FINANCIAL POLICY

I understand that my insurance carrier may require an authorization number, precertification or referral. Without this documentation, I understand that they may deny benefits. Covered medical services which I receive will be submitted to my insurance company based on the information that I have provided. Services considered non-covered in nature will be my responsibility and must be paid for at the time of service.

If my insurance carrier denies payment for services rendered, I agree to be financially responsible.

I request that payment of authorization health insurance benefits or Medicare benefits be made to Lakeside Counseling Associates, LLC for any services provided to me. Medical services that I receive will be sent to my insurance company based on the information that I have provided. If payment has not been received within 60 days from the date of service, or due to incorrect insurance information, the charges become my responsibility and will be due in full at that time. I realize that I am responsible for unpaid services. I also understand that any insurance payments that are made directly to me will be remitted to Lakeside Counseling Associates, LLC upon receipt. Failure to do so will result in an immediate billing for the full amount of the services provided subject to the same financial policy outlined herein.

In the event this account becomes delinquent you agree to pay for all cost of collection, including, but not limited to, attorney fees, court costs and collection agency charges.

WE MUST EMPHASIZE THAT AS MEDICAL CARE PROVIDERS, OUR RELATIONSHIPS WITH YOU, NOT YOUR INSURANCE COMPANY.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms.

Patient/Responsible Party:

Signature Date

Print Name Witness

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Dear Client,

This letter is to reiterate to you the office's policy regarding last minute cancellation (LMC) and no-show (NS) fees. The fee for this policy is $50.00 for each LMC and NS. Any appointment cancelled less than 48 hours from your appointment time is considered a LMC. If you know in advance that you will not be able to attend your appointment, please call the office at least 48 hours before your appointment time. If no one is here to answer your call, you may leave a message on the answering machine. If when calling, the answering machine does not come on, this means all of the lines are busy, and you should hang up and try to call back after a few minutes have passed.

The intention of this policy is to ensure that we have ample time to schedule other clients in your appointment time, if you are unable to attend. Often, there is a waiting list of clients that need an appointment, and it is difficult to schedule someone else in your time slot without sufficient notice. If you are not able to give 48 hours' notice under any circumstances, including emergencies, please be aware that this fee will still apply. This fee is not intended to be a consequence to you. The intention of this fee is to ensure that our providers will be compensated for the time spent in the office while not seeing a client.

You are required to pay the full fee prior to your next appointment. If you are unable to pay your fee in full, you may set up a payment plan with your provider. Please note that a payment towards your balance is expected within a month of receiving your bill.

Thank you for your cooperation.

Regards,

Lakeside Counseling Associates, LLC

Signature of Client Date

Signature of Witness Date

Lakeside Counseling Associates, LLC

New Client Information Form

Today's Date: _____

Client Name _____Date of Birth_____ Sex: M F

BASIC INFORMATION

Briefly describe the most important problem in your life that you want our help with:

_____

How long has this been a problem? _____

How do you think our services can be most helpful to you?_____

_____

FAMILY INFORMATION

Ethnic/cultural group with which you identify: _____

Father's name:_____age:_____living_____deceased_____

Mother's name: _____age:_____living_____deceased_____

Please list brothers and sisters _____

_____

MARITAL AND CHILD INFORMATION

Current marital status: __single __married/together __separated__intimate partnership

__divorced __widowed

Who lives in your home with you?_____

_____

SEXUAL ORIENTATION INFORMATION

How would you describe your sexual orientation?

____Heterosexual _____Bisexual _____Homosexual _____Would rather not say

Do you have any concerns about your sexual orientation or about sexual matters?

_____No _____Yes

Describe: _____

EDUCATIONAL INFORMATION

Are you in school now? _____No _____Yes Where? _____

Grade:_____

If not in school now:

Highest grade completed: _____ Last school attended:_____

_____Regular classes _____Special education classes _____Advanced or gifted classes

_____Child study team/Classification

Academically, how did you do in school? _____

ABUSE HISTORY

Have you ever been abused? ____No ____Yes In the ____past ____present ____both

Was the abuse: _____physical abuse _____emotional abuse _____sexual abuse

What information can you tell us about the abuse? _____

Would you like to address the abuse with us _____No _____Yes

WORK INFORMATION

Are you working now? _____No _____Yes Where? _____

How long?_____ What do you do?_____

If not working, please describe the reasons: _____

SPIRITUAL INFORMATION

Do you have a spiritual affiliation? _____No _____Yes Describe _____

Would you like to address any spiritual or religious matters? _____No _____Yes Describe_____

LEGAL INFORMATION

Are you currently or have been in the past involved in any legal matters; such as lawsuits, civil actions, arrests, DWI's, had any charges or have a restraining order against you?

_____

_____

AGRESSION/VIOLENCE HISTORY

Have you ever been aggressive or violent with someone _____No _____Yes

Describe _____

_____

MENTAL HEALTH INFORMATION

Have you ever been involved in treatment for an emotional, alcohol, drug or behavioral problem? ____No ____Yes

Explain _____

What psychiatric medications are you currently taking? Who is prescribing your medications?

_____

_____

Do you have any medical issues? _____No _____Yes

Describe _____

SUBSTANCE ABUSE DATA

Do you drink alcohol? _____No _____Yes

Do you use illegal drugs? _____No _____Yes

Do you abuse legal drugs? ____No _____Yes

Have you ever had a problem with drugs and alcohol? _____No _____Yes

Reviewing Psychotherapist:

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Consent Form

I, _____, consent to receive
(Client name)
treatment from Lakeside Counseling Associates, LLC. I understand that my records are held in confidence and will not be released to any party unless Lakeside Counseling Associates, LLC first receives my written permission.

I have read this form in its entirety, and I certify that I understand and consent to its contents.

Signature **Date**

Signature of Witness **Date**

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Client Email/Texting Informed Consent Form

Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and tests can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered forwarded or used without authorization or detection.
6. Email and text can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
4. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
7. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.
8. It is the policy of this practice to not accept requests for contact (friending etc.) from current or former patients on LinkedIn, Facebook, Instagram, Snapchat or other social media.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name:_____
Client Signature:_____Date:_____
Parent/Legal Guardian name:_____
Parent/Legal Guardian signature:_____Date:_____
Provider name:_____
Provider signature:_____Date:_____

CONFIRMATION OF RECEIPT OF HIPPA
NOTICE OF PRIVACY PRACTICES

Your signature below confirms that you have been offered (and given a copy unless chosen not receive) a copy of the Notice of Privacy Practices, explaining your rights regarding your medical records under HIPPA (Health Information Portability Act). Please feel free to inquire of us any questions you may have regarding these rights.

_____ _____

Patient Signature Date

_____

Print Patient Name