PLEASE COMPLETE ENTIRE FORM

CENTER FOR PSYCHOLOGICAL SERVICES OF SOMERSET COUNTY, LLC.

Today's Date:_____

Referred By:_____ ___ Phone:_____ GENDER: _____

LAST NAME	FIRST NAME	BIRTHDATE	AGE

SOCIAL SECURITY	CELL PHONE	HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

YOUR EMPLOYER	OCCUPATION	EMAIL

Please check one: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐_____

RESPONSIBLE PARTY (If Patient is a Minor)

LAST NAME	FIRST NAME	BIRTHDATE	AGE

SOCIAL SECURITY	CELL PHONE	HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

YOUR EMPLOYER	OCCUPATION	EMAIL

1) PRIMARY INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS

INSURANCE POLICY ID#	INSURANCE GROUP #	IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? Yes ☐ No ☐

NAME OF SUBSCRIBER	SUBSCRIBER SS#	SUBSCRIBER DOB	RELATIONSHIP TO PATIENT Self Spouse Parent Other

SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS

2) SECONDARY INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS

INSURANCE POLICY ID#	INSURANCE GROUP #	IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? Yes ☐ No ☐

NAME OF SUBSCRIBER	SUBSCRIBER SS#	SUBSCRIBER DOB	RELATIONSHIP TO SUBSCRIBER Self Spouse Child Other

SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS

ARE WE ABLE TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? Yes ☐ No ☐

ARE YOU ABLE TO RECEIVE CALLS AT YOUR PLACE OF BUSINESS? Yes ☐ No ☐

IF YES, CAN WE STATE WHO AND FROM WHERE WE ARE CALLING? Yes ☐ No ☐

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Children (Names and Ages):_____

_____

Emergency Contact Person(s) Name_____ Phone_____

Name_____ Phone_____

What is happening in your life that resulted in this appointment? _____

_____

What do you want to accomplish in therapy?_____

_____

Prior Outpatient Therapy (Include Dates)_____

_____

Are you currently receiving treatment from another therapist? If Yes, please state Name and Phone #:_____

_____

Is there a history of psychiatric problems in the family? If Yes, please explain_____

_____

Do you have a drug or alcohol history?_____

Are there any present/past alcohol or drug problems in your extended family?_____

Any relevant medical conditions?_____

Are you on any medications? If so, what?

Medications	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy and Phone Number:_____

Does anyone in your family have chronic medical problems?_____

Self Assessment Checklist

Name: _____ Date: _____

Please read this checklist. For each item circle the rating of how much it has been of concern to you in the last month.

1=does not apply; 2=little concern; 3=moderate concern; 4=significant concern

1. Not being the kind of person I want to be	1	2	3	4
2. Too tired to do anything	1	2	3	4
3. Unhappy with my physical appearance/weight	1	2	3	4
4. Discouraged about the future	1	2	3	4
5. Financial problems	1	2	3	4
6. Dissatisfied or bored with everything	1	2	3	4
7. Concerned about physical health	1	2	3	4
8. Feel guilty all the time	1	2	3	4
9. Concerned over living situation	1	2	3	4
10. Lost my interest in other people	1	2	3	4
11. Came from alcoholic family	1	2	3	4
12. Can't make decisions anymore	1	2	3	4
13. too little or too much social life	1	2	3	4
14. Appetite disturbance (more/less)	1	2	3	4
15. Feeling too easily hurt	1	2	3	4
16. Sleep problems	1	2	3	4
17. Feel that others do not like me	1	2	3	4
18. Thought of hurting myself	1	2	3	4
19. Thoughts of hurting someone	1	2	3	4
20. Can't seem to do my work effectively	1	2	3	4
21. Absent from work/school too often	1	2	3	4
22. Worrying about my work performance	1	2	3	4
23. Unable to concentrate very well	1	2	3	4
24. Conflict with co-workers, family members	1	2	3	4
25. Indecision about future career plans	1	2	3	4
26. Being talked about or made fun of	1	2	3	4
27. Feeling that nobody understands me	1	2	3	4
28. Nervousness	1	2	3	4
29. Unhappy too much of the time	1	2	3	4
30. Worrying about unimportant things	1	2	3	4
31. Unsure about current career choices	1	2	3	4
32. Afraid of making mistakes	1	2	3	4
33. No mixing well with others	1	2	3	4
34. Concerned about sexual matters	1	2	3	4

1=does not apply; 2=little concern; 3=moderate concern; 4=significant concern

35. Relationship problems	1	2	3	4
36. Headaches	1	2	3	4
37. Lacking love and affection	1	2	3	4
38. Pressure or conflict with employer	1	2	3	4
39. Family problems	1	2	3	4
40. Belonging to a minority group	1	2	3	4
41. Confused about my religious beliefs	1	2	3	4
42. Fearing failure or rejection	1	2	3	4
43. Having difficulty trusting other people	1	2	3	4
44. Feeling blank; don't know what to do	1	2	3	4
45. Feeling inferior	1	2	3	4
46. Getting into arguments	1	2	3	4
47. Too easily influenced by others	1	2	3	4
48. Concerned about my use of drugs/alcohol	1	2	3	4
49. Feel a great sense of loss or grief	1	2	3	4
50. Wonder whether to get/stay married	1	2	3	4
51. Excessive behaviors (spending, gambling)	1	2	3	4
52. Concerned about my thoughts racing	1	2	3	4
53. Physical and/or sexual abuse	1	2	3	4
54. Feel that I or things around me are not real	1	2	3	4
55. Concerned about blackouts	1	2	3	4
56. Feel I might be going crazy	1	2	3	4
57. Wonder if what I do is obsessive/compulsive	1	2	3	4
58. Concerned about legal issues	1	2	3	4
59. Excessive use of prescription medication	1	2	3	4
60. other problems/symptoms listed below				
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4

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CENTER FOR PSYCHOLOGICAL SERVICES OF SOMERSET COUNTY, LLC.

NAME: _____

We are committed to providing you with the best possible care. If you have medical insurance, my staff is willing to help you receive our maximum allowable benefits. In order to achieve these goals we need your assistance, and your understanding of our payment policy.

Your insurance is a contract between you, your employer and the insurance company. Our primary relationship is with you, the patient. And while we will do our best to assist you in receiving your insurance benefits, all charges remain your responsibility. In certain special circumstances, we may accept assignment of insurance benefits, such as from a certain "managed care plan" in which we participate. In these cases, you will initially be responsible only for your "co-payment and deductible". However, if the insurance company does not pay, you are responsible for the balance.

Limits Confidentiality

Confidentiality will be maintained in all cases except if there is a reason to believe there is danger to yourself or others, or reason to believe abuse of a child has occurred.

Cancellation Policy

Full payment or co-payment is due at the time of service, unless special arrangements have been approved in advance. **There is a $150.00 charge for all missed appointments unless cancelled within 24 hours notice.**

Authorization / Payment / Release of Information

I hereby authorize Center for Psychological Services to furnish information to any and all insurance carriers concerning my medical records and treatments. I hereby assign all payments for medical services rendered to me and all the charges incurred from those services.

Although I have requested that Center for Psychological Services bill my insurance company on my behalf, I clearly understand that I am responsible for any amount not covered by my insurance company for any reason. I will also be responsible for any co-pays, co-insurance amounts and deductibles. Any payments made directly to the patient and owing to Center for Psychological Services will be remitted immediately, payable to Center for Psychological Services.

If I am in a "Managed Care" insurance plan, my treatment may be influenced by parties other than my doctor and I will not hold Center for Psychological Services of Somerset County responsible for these decisions.

If I agree to accept assignment, I hereby instruct and direct my insurance company to make payment to the Center for Psychological Services of Somerset County for services rendered. This is a direct assignment of my benefits under my insurance policy.

I certify that I have read and completed all the information on this form. I am responsible in notifying the Center for Psychological Services of Somerset County of any change of information on this form. My signature below means that I understand and agree with all information stated on this form.

Patient Signature: _____ **Date:** _____ or...if patient is a minor

Guardian/Parent Signature: _____ **Date:** _____

HEALTH/TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology and may not involve direct, face-to-face communication. There are benefits and limitations to this service. I will need access to, and familiarity with the appropriate technology to participate in the service provided. Exchange of information will not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. I may decline any telepsychology services at any time without jeopardizing my access to future care, services and benefits.

3. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, by are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

4. My therapist may utilize alternative means of communication in the following circumstances:

    a. In emergency situations

    b. Should services by disrupted

    c. Routine administrative reasons

5. My therapist will respond to communications and routine messages within 48 hours.

6. It is my responsibility to maintain privacy on the client end of communications. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communication.

7. I will take the following precautions to ensure that my communications are directed only to my therapist or other individuals:

    a. My communications exchanged with my therapist will occur in a private location where confidentiality of the communication exchange is of utmost importance.

    b. I will disclose to the therapist my location.

8. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

9. Insurance coverage for a telepsychology service is not guaranteed. Some insurance companies approve this method on a case-by-case basis. It is the responsibility if the client/guardian to confirm coverage and be financially responsible for all costs involved with the service.

10. Access into telepsychology session will be provided by the therapist you see at CPS. To access, copy the link provided by therapist directly into URL. Prompts and directions are easily available. If questions arise, please know you can reach the therapist on their cell numbers, or call our main number, 908-431-9200.

_____ Client Printed Name

_____ Signature of Client or Legal Guardian Date_____

_____ Printed Name of Therapist

_____ Signature of Therapist Date_____

Credit Card Authorization Form

Name on Card:_____

Card Type ____ Visa ____ Mastercard ____ Discover

Card Number _____

Expiration Date _____ Security Code (3 digits) _____

Billing Address _____ City: _____

State _____ Zip Code _____ email address: _____
(email address of card holder)

I authorize charges for any session fee, copayment, account balances, and/or session cancellation fees (less than 24 hour notice). $150 for missed appointments

Fee is $_____ per session. copay _____ coinsurance _____

Signature of Cardholder

_____

Name of Client (if different than cardholder)

_____

Date Signed _____ Name of Therapist _____