Mt. OLIVE Counseling & Clinic
1278 Route 46, Ledgewood, NJ 07852
Ph. 973-584-6700, Fax 972-584-4991

CLIENT CONFIDENTIAL PERSONAL INFORMATION

DATE _____ REFERRAL SOURCE_____

CLIENT NAME _____GENDER ____M___F

RESIDENTIAL ADDRESS only_____

CITY_____STATE_____ ZIP_____

SOCIAL SECURITY #_ _____DRIVERS LICENSE #_____

Contact Information		Permission to Contact or Leave Discreet Message?
Home:	- -	Yes ___No ___ initials
Work:	- -	Yes ___No___ initials
Cell:	- -	Yes ___No___ initials
Email:		Yes ___No___ initials

PROFESSION _____EMPLOYER_____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS___S___M __D__W

CULTURAL BACKGROUND _____ RELIGION_____
Are spiritual or religious resources important for you to cope with your treatment? (Please Circle) Yes **No**
Are you open to sharing this part of your life as appropriate in your treatment? (Please Circle) Yes **No**

LANGUAGES SPOKEN_____ LEVEL OF EDUCATION _____

EMERGENCY CONTACT: _____PHONE_____

RELATIONSHIP_____DATE OF BIRTH_____

SPECIFIC REASON/S FOR COUNSELING:

_____
_____
_____

SPECIFIC GOALS FOR COUNSELING: (Specific changes you are determined to make in your life)

_____
_____
_____

PAST/CURRENT PSYCHOLOGISTS, COUNSELORS, OR HOSPITALIZATIONS: (Please list)

_____
_____Was your counseling experience **positive** or **negative**? (Please Circle)
PRIMARY CARE PHYSICIAN_____PERMISSION TO CONTACT? **YES NO**
PHYSICIAN PHONE #_____
PRESCRIPTION USAGE (Please list)

_____
_____

LIFE CONTRACT (Please check)
____ I have never considered suicide and rarely have suicidal thoughts entered my mind.
____ I have considered suicide and battle suicidal thoughts.
____ (Please initial) I promise that I will speak with the therapist / counselor(s) about any serious thoughts or consideration I may have regarding suicide, harm to self or others.

SIGNATURE _____ DATE _____

MT. OLIVE COUNSELING & CLINIC

CONSENT FORM

I_____ , HEREBY AGREE TO HAVE THE STAFF of Mt. Olive Counseling & Clinic to provide substance abuse/mental health treatment services to me, which may include ***psychiatric evaluation, individual, family and group sessions, as well as supervised urine screenings, specimen being witnessed orifice to cup.***

I have read the Informed Consent Form and I understand, consent to, and have provided honest answers to the attached information and questions. I understand that counselor/therapist will attempt to help me by using various counseling principles, and that he/she does not make any representations or warranties with respect to the results of the services and/or referrals or his/her ability to help me (us) with my (our) credit/ financial/ emotional /mental /relational and spiritual management.

I the undersigned in consideration thereof agree to indemnify, hold harmless, release and forever discharge MTOCC and anybody associated with MTOCC from all actions, causes of actions, claims, injuries, damages, costs, expenses, or damages of any kind growing out of or related to any activity in which the undersigned participates. The undersigned further acknowledges that this is full and complete release.

I understand that MTOCC is required to disclose information in the event that- I threaten to harm myself or others- I am under the age of 18 years and release of information is authorized by my parents (1037 regulations). Any kind of adult abuse must be reported: people residing at nursing homes, boarding and /or roaming houses.

I consent to be open, honest, be on time, serious, prompt with fees, hardworking and cooperative in this healing process of change for my own well-being.

I acknowledge that I, the undersigned will not be allowed to participate in this treatment process without releasing and holding harmless MTOCC and all persons associated with the counseling process.

I am clearly informed that any evaluation session facilitated by an intern would be concluded by a licensed counselor.

I further understand that the counseling service rendered by any credentialed counselor/s or intern/s are under the supervision of the following licensed counselors:

Julia Akpan, MBA, MA, LCADC, CCS, LCCS
Emmanuel Akpan, PhD, LPC, MFT, DADP, SAP, LCADC, ICADC

- □ **I agree to be seen by any available counselor including an intern.**
- □ **I disagree to be seen by an intern.**
- □ **I do understand that random Drug Screen (UDS) will be required from all DUI, and/or Substance abuse clients: All positive results will be discussed per incident. However, MTOCC is not responsible for any positive/dilute results. All UDS are tested by an independent laboratory.**
- □ **I understand that my case will be immediately DISCHARGED if I exhibit hostile behavior towards other clients and/or staff members or refuse to comply with necessary recommendations.**

Please present your Insurance Card(s) for photocopying at the initial visit.

Depending on the payment arrangement, Initial assessment fee is $280.00 for M/H & S/A, $450.00 for initial psychiatric evaluation.

(Without insurance coverage, client will be responsible for the entire cost of service)

Counselor's Name:_____ ⌗ Credentialed Intern ⌗ Counselor Intern

Counselor's Signature_____ Date_____

Patient's Signature_____ Date_____

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AUTHORIZATION FOR PAYMENT TO BE MADE TO PROVIDER INSTEAD OF CLIENT

As Out of Network Provider, sometimes insurance companies release payment to client instead of the provider. Please fill and sign this form authorizing your insurance company to make payment directly to the provider listed below:

I ,_____the undersigned authorize my insurance company to make check payable to Mt. Olive Counseling & Clinic.

Primary Insurance Information

Name on Card _____ Birth Date _____
Insurance Company _____Social Security #_____
ID Card Number _____ Group Number _____
****

Secondary Insurance Information

Name on Card _____ Birth Date _____
Insurance Company _____ Social Security #_____
ID Card Number _____ Group Number _____
****

Name of Policy Holder _____Relationship_____

Date of Birth_____ Social Security Number _____

Driver's License Number _____Employer_____

Home Address_____

Home Phone_____ Cell_____ Work Phone _____

ATTESTATION FOR RELEASE OF PAYMENT TO PROVIDER:

I promise that if insurance company issued me a check mistakenly or based on policy, for a substance abuse or mental health treatments provided by Mt. Olive Counseling & Clinic; I will endorse the check and forward it promptly to the provider Mt. Olive Counseling & Clinic.

Please note that the money does not belong to the client; therefore he/she cannot use it for personal purposes. Failure to comply with this consent will be equivalent to insurance fraud as such reimbursement only goes to the provider and not the client. If payment is not made as promised, the client will be responsible for the total amount due plus any collection and/or legal fees involved in the attempt to collect the debt. Please keep in mind, the patient will be responsible for the total cost of attorney fees should legal services be used to collect the amount due. In the event of litigation, the venue shall be in Morris County, New Jersey, since service was provided in Ledgewood. If this occurs the client will be billed at full rate without insurance adjustment.

A copy of this agreement will be sent to your insurance company and will remain effective for the duration of your treatment.

If claims are denied, I acknowledge that I am financially responsible for all charges incurred.

Client Name(s)_____

Signature(s)_____Date_____

Subscribed and sworn to before me this _____day of _____20_____

Notary Public of New Jersey _____Date_____

Consent for Services

Patient Name _____Please Initial and Sign Below

_____
Initial

Treatment Choice / Involvement

I understand I have made a voluntary choice to be involved in treatment. I understand I will be actively involved in forming treatment goals and can inquire about treatment risks and benefits at any time. I understand I may terminate treatment at any time.

_____
Initial

Release of Medical Information

I authorize Mt. Olive Counseling & Clinic to release necessary medical information to appropriate third parties for reimbursement purposes and/or persons authorized to conduct service utilization reviews.

_____
Initial

Policies and Practices to Protect the Privacy of Your Health Information

I have received a copy of the HIPPA guidelines on *Policies and Practices to Protect the Privacy of Your Health Information* and consent to its provisions.

_____
Initial

Responsibility for Charges

All insurance co-pay, co-insurance, and/or deductible amounts are due at the time of service. I agree I am responsible for any and all allowable charges after final insurance benefits have been posted. I will be billed only when balances are due. If I choose not to use my insurance benefits, or, fail to provide accurate and current insurance documentation, then I will be responsible for the entire cost of services at the time of services. I will be financially responsible to pay any costs incurred in collecting overdue balances, including but not limited to collection fees and/or attorney fees.

_____
Initial

Failed Appointments

I understand ***I will be charged Sixty dollars ($60.00) for each Failed Appointment including initial evaluation session.*** A Failed Appointment is any scheduled appointment *No Show* or *Cancellation* within 48-hours' notice. This charge must be paid before another appointment is made. We set aside the scheduled time just for you and cannot use this time for another client. **(This applies to both insurance & self-pay clients).**

_____
Initial

No Refund or Chargeback

I understand all service transactions are final, and there will be no refund or chargeback on any evaluation, psychotherapy group or individual session.

_____
Initial

Patient Bill of Rights

I have received, read, and understood my bill of rights.

_____
Initial

Grievances / Appeal

I have received information concerning grievances policy procedures.

I agree and consent to participate in the substance abuse /mental health services offered and provided by my counselor, as defined in New Jersey law. I understand I am consenting and agreeing only to those substance abuse/mental health services that my counselor is qualified to provide within: (a) the scope of the provider's license, certification, and training; or (b) the scope of the license, certification, and training of those substance abuse /mental health providers directly supervising the services received by the patient.

Client / Responsible Party: _____ Date: _____

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CREDIT CARD AUTHORIZATION

Client Full Name _____
Address _____
Phone _____

Transaction Detail (Service/s):

Descriptions	**Quantity**	**Price**
Initial Assessment	_____	_____
subsequent session	_____	_____

Credit Card Total: $_____

I hereby authorize Mt. Olive Counseling & Clinic to charge the credit card indicated below for the above service/treatment. I understand there will be no charge back or refund on this transaction. All sales are final.

Today's day _____/_____/_____
Cardholder's Name _____
Cardholder's Signature _____

Please provide the entire 16 digit if you want the card information on file for future transactions. (Only one card at a time)
MasterCard #_____Exp Date_____
Visa # _____Exp Date_____
Discover # _____Exp Date_____

Date Approved _____/_____/_____ **Amount Approved** $_____
Comments:_____
_____
Name _____Signature_____

I understand that by initialing, I am indicating that I have read and understand my rights as a patient at

MT. OLIVE COUNSELING & CLINIC

Patient's Rights 8: 42 CFR

Each patient receiving service in a NJ licensed facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility (posted in the lobby); ____

2. To be informed of services available in the facility, of the names and professional status of personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facilities basic rate; ____

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient shall also have the right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment; ___

4. To participate in the planning of the patient's care and treatment; _____

5. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices; ____

6. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, force, discrimination, or retaliation; ____

7. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and the right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when the facility personnel are discussing the patient; ____

8. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and ____

9. To not be discriminated against because of age, race, religion, sex, nationality, or to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility; _____

10. The right to be free from unnecessary or excessive medication; _____

11. The right to not be subjected to non-standard treatment or procedures, experimental research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice; ____

i. If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A.

12. The right to treatment in the least restrictive setting, free from physical holds and isolation; ____

13. The right to be free from corporal punishment; ____

14. The right to privacy and dignity; ____

15. The right to the least restrictive conditions necessary to achieve the goals of treatment/services; ____

Addendum

Please initial this section if you are receiving any services other than mental health and medication management.

16. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record; ____

17. To confidential treatment of information about the patient medical record shall not be released to anyone outside the facility without the patient's authorization, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third- party payment contract, or a peer review, or unless the information is needed by the office of licensing or Medicaid for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

_____

18. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules; ____

19. To be free from mental and physical abuse, free from exploitation, and free from use of holds unless they are authorized by a physician for a limited period to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

My signature verifies that I have received and read the above patient rights.

Patient Signature _____ Date _____

Parent/Guardian_____Date_____

Provider Signature_____Date_____

Disclosure of Information

MTOCC is required to disclose confidential information if any of the following conditions exist without written authorization.

1. You threaten to harm yourself or others.
2. There is any suspicion of child abuse or neglect. This MUST be reported to DCP&P.
3. If any federal or state law requires the release of the information and/or a judge orders the release of information to a court
4. Your contact with your therapist is for determining sanity in a criminal proceeding and if a judge orders the information to the court.
5. You are under the age of 18 years and release of information is authorized by your parents (1037 regulations).
6. Any kind of adult abuse must be reported: people residing at nursing home, boarding and/or roaming houses.
7. You die and communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting an interest in property, only to estate administrator or next of kin or executor.
8. When the Office of Licensing or Medicaid conducts a review, a consumer's clinical record may be reviewed.
9. An accreditation reviewer may look at a consumer's record.
10. If officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies request the information.

Client Name _____Client Signature _____ Date _____

MTOCCR Staff _____ Signature _____ Date _____

I understand that by initialing, I am indicating that I have read and understand my rights as a client at MT. OLIVE COUNSELING & CLINIC.

10:37-6.9(l)1

Notice of Privacy Practices

MTOCC is required to disclose confidential information if any of the following conditions exist:

1. You threaten to harm yourself or others.
2. Your relatives or significant others report or indicate child abuse or neglect.
3. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
4. Your therapist was appointed by the courts to evaluate you, and if a judge orders the release of information to a court.
5. Your contact with your therapist is for determining sanity in criminal proceedings.
6. Your contact is for establishing your competence.
7. The contact is one in which your psychotherapist must file a report to a public employer or provide information required to be recorded in a public office, if such report or record is open to public inspection.
8. You are under the age of 18 years and are the victim of a crime.
9. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
10. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical or emotional abuse.
11. You die and communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting an interest in property.
12. You file suit against your therapist for breach of duty or your therapist files suit against you.
13. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
14. You waive your rights to privilege or give consent to limited disclosure by your therapist.
15. Your insurance company paying for services has the right to review all records.
16. When the Office of Licensing or Medicaid conducts a review, a consumer's clinical record may be reviewed
17. An accreditation reviewer may look at a consumer's record.
18. If officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies request the information.

Client Name _____ Client Signature _____ Date _____.

MTOCC Staff _____ Signature _____ Date _____.

I understand that by signing, I am indicating that I have read and understand the privacy practice notice as a client at MT. OLIVE COUNSELING & CLINIC.