The Behavioral Health Institute of Monmouth County
37 Village Court
Hazlet NJ 07730
732-847-9777

Welcome to our practice.

This form requests information about your needs and informs you of our services and policies. Please complete to the best of your ability. The questions on the following pages are designed to help us best meet your treatment needs.

Client's Name:_____
Cell Phone Number:_____ Email address: _____
Permission to leave voice message/text/email: Yes No
Address:_____
Date of Birth:_____ Age:____ Social Security # _____
Relationship Status: Single Married Domestic Partner Widowed Separated Divorced
Occupation: _____ Identified Pronouns:_____
Primary Care Physician and phone number:_____
Permission to contact Physician: □ Yes □ No
If no, please explain why:_____

Please list other members living in your household:
Name: Relationship: Age:
_____
_____
_____
_____

If We Need to Contact Someone about You
If there is an emergency during our work together, or our staff becomes concerned about your personal safety, the law requires that someone close to you is contacted—perhaps a relative, spouse, or close friend. We are also required to contact this person, or the authorities, if we become concerned about you harming someone else. Please write down the name and information of your chosen contact person in the blanks provided:

Name: _____
Address: _____
Phone: _____ Relationship to you:_____
Please explain your reasons for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:_____
_____
_____

Please indicate how /if the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Impact	Mildly Impact	Moderate Impact	Significant Impact
Marriage/Partner/Relationship	1	2	3	4
Family	1	2	3	4
Job/School Performance	1	2	3	4
Friendships	1	2	3	4
Financial Situations	1	2	3	4
Physical Health	1	2	3	4
Anxiety level/Nerves	1	2	3	4
Mood	1	2	3	4
Eating Habits	1	2	3	4
Sleeping Habits	1	2	3	4
Sexual functioning	1	2	3	4
Alcohol/Drug usage	1	2	3	4
Ability to concentrate	1	2	3	4
Ability to control your temper	1	2	3	4

What results do you expect from treatment?

Have you ever sought mental health treatment before? Please list dates, provider names, and the issue for which treatment was sought in the past:

Confidentiality:

All information between provider and client is confidential unless:

1. The client authorizes release of information with their signature.
2. The client presents a danger to self.
3. The client presents a danger to others.
4. The welfare of a child or an elder is endangered, which includes alcohol and drug dependency in the presence of children.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Agreement to Pay for Professional Services

Fees, Payments, and Billing: Payment is based on clients' income and family size. Please refer the attached sliding fee schedule to assess qualification. Please contact the program director regarding any questions or concerns. A rate will be agreed upon prior to the intake assessment and will be reevaluated at each admission. Please pay for each session at the beginning of the session in the form of cash, check or credit card prior to

each session begins, so that the therapy time will be used best. Other payment or fee arrangements must be worked out before the end of the first meeting. Returned checks occasion a $25.00 fee.

Cancellation Policy: A scheduled appointment means that time is reserved for only you. If an appointment is missed or cancelled with less than 24 hours' notice, you will be directly billed $30.00. Please make arrangements for payment prior to scheduling your next appointment. If you cancel three or more consecutive sessions, have not attended a session over a three week period without prior discussion, and do not respond to outreach, your case will be closed.

Telehealth Services: There is always a risk electronic communications can become compromised and both the office and clients will take steps to ensure the security of our communications by using the secure platform of Theranest for telehealth sessions. If the session is interrupted for any reason, and you are having an emergency, do not call BHI or your therapist back; instead, call 911, or go to your nearest emergency room. Call your therapist back after you have called or obtained emergency services. If you do not receive a call back within two (2) minutes, please text your assigned therapist. If there is a technological failure and it is not possible to resume the connection, you will only be charged the prorated amount of actual session time.

Telephone Consultations/Letters and Supportive Documents*:* Telephone consultations that are not related to scheduling appointments are charged at the regular fee, prorated over the time needed. I understand that one clinical hour of therapy is approximately 45 minutes. I understand that letters and supportive documents written on my behalf will be billed to me prorated to the same rate as a clinical hour of therapy.

Emergency Procedures: If you need to contact us, leave a message according to the instructions on the voicemail and your call will be returned. If you have a behavioral or emotional crisis, please text the cell phone number (732) 581-4657. In case of a psychiatric emergency, you or your family members should call 911, and/or go to the closest hospital emergency room. Please tell the emergency worker to contact your treating therapist. Please be advised that phone calls are not answered during therapy sessions. You can always leave a message and calls will be returned as soon as possible.

Evaluations (Forensic/Disability/Work): I understand that BHI does not participate in forensic, disability or work evaluations.

Release of information: I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan. I reviewed HIPPA rules and regulations.

BHI is a Training Institute: I understand that the treating therapists are graduate students in psychology, may not be licensed in the state of New Jersey, and receive 2.5 hours of weekly supervision from licensed psychologists regarding your treatment. I

provide consent for redacted information regarding my treatment to be used in future research studies and that no identifying information will be revealed.

My Rights as a Client:

1. I have the right to decide not to begin therapy at the Behavioral Health Institute of Monmouth County. I can ask for the names of referrals for other therapists.
2. I have the right to end therapy at any time. The only thing I will have to do is to pay for any treatments I have already had.
3. I have the right to ask any questions, at any time, about the therapeutic process and to decline the use of any therapy technique.
5. I have the right to confidentiality.
6. I have the right to review my records at any time, to add to or correct them, and to get copies for other professionals to use.

_____

Client Name- Printed Date

_____

Client Name- Signature Date