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Intake Paperwork

***FOR COUPLES* Please fill out and sign separate sets of paperwork for each partner.**

Client Name: _____ Date: _____

Date of Birth: _____ Age: _____ Preferred Pronoun: _____

Phone Number:_____ Email: _____

May we leave you a voicemail? Y N Text? Y N Contact you via email? Y N

Address: _____ City: _____ State: ____ Zip: _____

Occupation/ School/ Employer: _____

Relationship Status: _____ # of years: _____

Partner/ Spouse Name: _____ Age: _____

Do you have children? Y N

If yes, names & ages: _____

_____

Who lives in your home? _____

Have you ever seen a mental health professional (psychiatrist, psychologist, or therapist)? Y N

If yes, please list when and who treated you: _____

_____

Are you currently under the care of a medical doctor, including primary care doctor? Y N

If yes, please list the doctor names and reasons for care: _____

_____

Do you suffer from any chronic medical issues? If so, please list below and age of onset:

_____

_____

Are you currently taking any medications (including birth control)? Y N

If yes, please list prescriber, medication, dosage, and date started medication:

_____

_____

What brings you to therapy? _____

_____

How did you hear about your therapist? _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Client Printed Name: _____

Client Signature: _____Date: _____

Parent/Guardian Printed Name: _____

Parent/Guardian signature: _____Date: _____

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Policies, Procedures, & Informed Consent

Statement Regarding Your Personal Health Information:

I understand that Aspera Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Your signature indicates you understand and agree to the Statement Regarding Your Personal Health Information above. Client Signature: _____

Confidentiality

The therapist-client relationship is confidential, and that confidentiality is legally protected. Everything discussed throughout the course of therapy will be confidential unless you provide written permission to release information about your treatment. In circumstances when more than one person in a family is receiving therapy services, each family member who is at least 18 years of age must agree to the waiver of confidentiality. Exceptions for which the law requires breaking confidentiality: disclosure is required by Federal or State law, regulation, or the Board or Office of the Attorney General during the course of an investigation, or a court order; your therapist has information that you present a clear and present danger to the health or safety of yourself and/or others (duty to warn). Psychotherapists reserve the right to release financial information to a collections agency, attorney, or small claims court for delinquent client accounts. With the goal of giving you the best clinical care, your therapist will regularly engage in peer consultation during which pertinent and relevant information about you may be disclosed. Additionally, your therapist may be an associate level clinician/intern, in which case they will be engaging in regular supervision and disclosing pertinent and relevant information.

Social Media and Confidentiality

If you choose to engage on our social media platforms, please remember that this is a form of self-disclosure. Social media is not an acceptable form of communication with your therapist. No therapeutic advice, referrals or recommendations will be given via social media.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. The confidentiality of minors includes information about sexually transmitted diseases, abortion, and substance abuse. This information cannot be disclosed to parents or guardians without the consent of the patient.

Your signature indicates you understand and agree to the terms of Confidentiality above.
Client SIgnature: _____

Cancelation Policy

Please provide as much notice as possible when canceling sessions. 24 hr. notice is the minimum expected when canceling an appointment or you will be charged your full fee. The fee for a missed session is not reimbursable by insurance. Emergencies and extreme circumstances are taken into consideration.

Cancelation due to Illness or Inclimate Weather

In an effort to provide continuity of care, telehealth will be the default option in the event of illness or inclimate weather. 24 hr. notice remains the minimum expectation for canceling or rescheduling. Emergencies and extreme circumstances are taken into consideration.

Your signature indicates you understand and agree to the Cancelation policy above.
Client signature: _____

Communication

You may leave messages at any time on the 24 hr voicemail system. If you have a life threatening or urgent situation please call 911, or the Monmouth County Crisis Hotline at 732-923-6999. Phone consultations more than 10 minutes will incur a prorated charge. Email communication is also appropriate for brief questions or communications to your therapist and will be discussed at your next session. Please note texting is used ONLY for discussing session times. All forms of communication are generally replied to as soon as possible during business hours.

Your signature indicates you understand and agree to the Communication policy above.
Client signature: _____

Financials

Payment is due at the time services are rendered either by cash, check, or credit card. We have agreed that your fee(s) for professional services are; $____ for 80 minute assessment/ couples/ family sessions, $____ per 50 minute individual sessions, and/ or $____ per group session. Consultations with other professionals and reports prepared on your behalf will be charged a prorated fee. A $25 charge will apply for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied. Fees are reviewed each year and may increase periodically.

You will be prompted to create an account with our payment app, Ivy Pay, in order to provide credit card information to be used for session fees, missed/late (within 24hrs notice) canceled appointment fees, returned check fee and amount of returned check, and any 30 days overdue balances unless otherwise arranged with your therapist. Your credit card will only be used if you have not provided an alternative form of payment, i.e. check or cash.

Your signature indicates you understand and agree to the Financial policy above and authorize your therapist to charge your credit card on Ivy Pay.
Client signature: _____

Insurance

Your therapist is an out-of-network provider and is not on any insurance panels. If you have PPO insurance and you would like to receive reimbursement from your insurance company, you will be provided a superbill that will have all of the necessary information for you to submit to your insurance company. Please note your therapist cannot guarantee reimbursement. Please address any questions regarding the specifics of your plan with your insurance provider. You are responsible for all payments.

Your signature indicates you understand and agree to the Insurance policy above.
Client signature: _____

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is advised to plan for your termination in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment

alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates you understand and agree to the Termination of Therapy policy above. Client signature: _____

Litigation and Subpoenas

Your therapist will not testify nor disclose your psychotherapy records for any reason including legal proceedings unless subpoenaed by a court order. In the event of a court ordered subpoena, you will be charged an hourly fee for your therapist's time, inclusive of but not limited to, preparation and review of records, travel, time in court.

Your signature indicates you understand and agree to the Litigation and Subpoenas policy above. Client signature: _____

In the event any provision of this Agreement is determined to be invalid, illegal, or unenforceable, it shall not affect the enforceability of any other provision of this Agreement.

Your signature below indicates that you have read this Agreement carefully and understand and agree to its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Client Printed Name: _____

Client Signature: _____Date: _____

Parent/ Guardian Printed Name: _____

Parent/ Guardian Signature: _____Date: _____

Therapist Sign: _____ Date: _____

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Telemedicine Informed Consent

I, _____ , hereby consent to engaging in telemedicine with _____, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine may also involve the communication of my medical/mental information, both orally and visually, to healthcare practitioners located in New Jersey or outside of New Jersey.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/ or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that telemedicine based services and care may not be as complete as face-to-face services. I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with New Jersey law.

(6) I understand that reimbursement rates may be different for tele- health and it is my responsibility to check with my insurance company to verify my benefits. I understand that the fee for tele- health services does not change and I am responsible for payment at the time of service.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

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COVID19 Informed Consent

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise I understand my therapist may require that we meet via telehealth for everyone's well-being. I will discuss any concerns about us meeting via telehealth with my therapist.

I understand that I have the right to decide at any time that I would feel safer staying with, or returning to, telehealth services and will communicate that desire to my therapist as needed. As long as it is feasible and clinically appropriate telehealth sessions will resume at that time.

Please note reimbursement for telehealth services may differ as determined by the insurance companies and applicable law. I understand it is my responsibility to contact my insurance company for information about my specific plan.

Risks of Opting for In-Person Services

I understand that by coming to the office I am assuming the risk of exposure to the coronavirus (and/or other public health risk). I understand this risk may increase if I travel by public transportation, cab, or ridesharing service.

If You or I Are Sick

I understand that my therapist is committed to keeping all parties safe from the spread of this virus. I understand that if my therapist tests positive for COVID-19 I will be advised and given the option for telehealth. I agree that if I test positive I will advise my therapist so they can take appropriate precautions.

Your Confidentiality in the Case of Infection

I understand if I test positive for the coronavirus, my therapist may be required to notify local health authorities that I have been in the office. If this report is required only the minimum information necessary for their data collection will be provided. By signing this form, I am agreeing that s/he may do so without an additional signed release.

My signature indicates I agree to these terms and conditions and have been given the opportunity to discuss any issues.

Client Name Print: _____

Client Signature: _____ Date: _____

Parent/ Guardian Name Print: _____

Parent/ Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____