Integrated Treatment for Body, Mind and Soul

Dear client,

You have just taken a very positive step in deciding to seek counseling. We are happy that you have chosen Connect Counseling & Wellness, LLC and want to take a moment to tell you a little bit about our practice.

We started in 2012 with the premise that true wellness takes into account both physical and psychological health. To this end, our therapists create treatment plans that incorporate not only counseling but, health and wellness services offered by trusted community partners with the goal of your optimal functioning in mind.

We have three convenient locations in Cresskill, Lyndhurst and Monmouth Beach, New Jersey. More than 100 clients are seen each week in individual, couples, family or group therapy. We offer classes and support groups for divorce, seniors, women, men, adolescents, kids and more.

Our intern training program is highly sought-after and attracts top candidates seeking licensure as clinical social workers and marriage, family and child counselors. Our practice has an excellent reputation for its supervision and training curriculum.

We invite you to learn more about Connect Counseling & Wellness, LLC. For more information, please visit us online at ConnectCounselingAndWellness.com and follow us on Facebook at facebook.com/ConnectCounselingandWellness.

Welcome to our practice—we hope it will be a positive experience for you.

Warmly,

Donna Strauss-Russo

Donna Strauss-Russo, LCSW
Clinical Director, Connect Counseling & Wellness, LLC

Connect Counseling & Wellness, LLC
Cresskill, NJ | Lyndhurst, NJ | Monmouth Beach, NJ | 201-399-7225
ConnectCounselingAndWellness.com | ConnectCounselingAndWellness@gmail.com

CONNECT
COUNSELING & WELLNESS

Counseling I am seeking: Individual Couple Group Therapy

CLIENT INFO	STATUS & EMPLOYER
Name: ______________________	**I am:**
Preferred Name: ______________________	Single Divorced Other
Date of Birth:_____/______/_______	Married Widowed
Gender: M F Other:______________________	
Preferred Gender Pronouns:______________________	**I am:**
Address:______________________	Employed Full-time Self-employed Retired
City:______________________ Zip:__________	Employed Part-time Unemployed A student
Email:______________________	
I would like to receive email updates from	Company: ______________________
Connect Counseling & Wellness: Yes No	Address: ______________________
Home #:______________ Cell #:______________	City: ______________ Zip: __________
Work #:______________ Other #:______________	
On what number may we leave a confidential message:	
Home Cell Work Other	

How did you hear about Connect Counseling & Wellness?

Another counseling or mental health treatment center

Therapist, Psychiatrist, Physician or Hospital Staff

Referral from relative, friend or Connect Counseling & Wellness Client

Internet Search

Other

EMERGENCY CONTACT INFO

Notify: ______________________________ Phone: ______________________________

Relationship to client: ____

HEALTH AND MEDICAL

Primary Care Physician: ______________________________ Phone: ____________________

Psychiatrist: ______________________________ Phone: ____________________

Please list any medical conditions: ____

Please list any current medications: ____

____

ADDITIONAL INFORMATION

Are you required by a court of law to receive counseling as part of a legal proceeding? **Yes** **No**

Have you obtained services from Connect Counseling & Wellness before? **Yes** **No**

If yes, when?____

Are you interested in group therapy? **Yes** **No** If yes, what kind? ____

PERSONAL AND FAMILY HISTORY

Have you or a close relative ever been hospitalized for a psychiatric illness? **Yes** **No**

Does anyone in your family have a mental illness? **Yes** **No**

Have you or anyone in your family ever attempted or committed suicide? **Yes** **No**

Do you or does anyone in your family have a substance abuse problem? **Yes** **No**

Have you ever been arrested? **Yes** **No**

If "yes" to any of the above, please briefly explain: ____

____

____

____

HISTORY OF CONCERN

Please describe what concerns brought you in today: ____

____

How long have you had these concerns? ____

____

Have you ever been to therapy before? **Yes** **No**

If so, please list previous diagnoses: ____

Have you experienced any significant stressors (i.e. losses, births, deaths, moves, hospitalizations, financial problems, etc.) in the past several years? ____

____

Please describe any significant trauma you have experienced: ____

____

____

____

Please describe your personal strengths: ____

____

Please describe what you feel are your limitations: ____

____

DASS 21 NAME ______________________________ DATE _______________

Please read each statement and **circle** a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time – SOMETIMES

2 Applied to me to a considerable degree, or a good part of time – OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		Select 0 1 2 3	FOR OFFICE USE D	A	S
1.	I found it hard to wind down				
2.	I was aware of dryness of my mouth				
3.	I couldn't seem to experience any positive feeling at all				
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5.	I found it difficult to work up the initiative to do things				
6.	I tended to over-react to situations				
7.	I experienced trembling (eg, in the hands)				
8.	I felt that I was using a lot of nervous energy				
9.	I was worried about situations in which I might panic and make a fool of myself				
10.	I felt that I had nothing to look forward to				
11.	I found myself getting agitated				
12.	I found it difficult to relax				
13.	I felt down-hearted and blue				
14.	I was intolerant of anything that kept me from getting on with what I was doing				
15.	I felt I was close to panic				
16.	I was unable to become enthusiastic about anything				
17.	I felt I wasn't worth much as a person				
18.	I felt that I was rather touchy				
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20.	I felt scared without any good reason				
21.	I felt that life was meaningless				
		TOTALS	0	0	0

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Consent for Treatment

Please read carefully

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I. Fees and Appointments

1. Appointments are typically 53 minutes in length and take place on a weekly basis. Your counselor holds your specific timeslot for you each week. If you are unable to keep an appointment, please cancel at least 24 hours before your scheduled time so that we can try to fill your time slot. You will be allowed to cancel two sessions within a one-year period with no charge. The year begins on the date of your Intake Appointment. After two canceled appointments with insufficient notice, you will be responsible for the full payment of missed sessions.
2. **You must pay any co-pays at the time of your session each week.** We reserve the right to suspend therapy if services are rendered and not paid for after two sessions.
3. It is your responsibility to contact your insurance company to verify your coverage for Behavioral Health. We will also verify your coverage given the complexity of coverage. If your insurance provider requires a referral, it is your responsibility to acquire said referral from your primary care doctor before your first session.
4. There is a $25.00 service fee for any returned checks. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed-upon fee.

II. Confidentiality

1. Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on “Training and Clinical Supervision”).
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
    a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
    b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
    c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
    d. If you introduce your emotional condition into a legal proceeding.
    e. If there is a court order for release of your records.

III. Training and Clinical Supervision

1. Connect Counseling & Wellness, LLC is a training center for Master’s level counseling and psychology interns. All counselors at Connect Counseling & Wellness, LLC are under the supervision of licensed mental health professionals.

2. In order to ensure that counselors receive the best possible training and that clients are well served, sessions will be reviewed in supervision with a licensed supervisor and/ or the Clinical Director.
3. Counselors are generally on a time-limited contract with Connect Counseling & Wellness, LLC. Therefore, it is possible that your counselor may leave Connect Counseling & Wellness, LLC prior to the end of your therapy. If this occurs, we will take reasonable steps to ensure a smooth transition.

IV. Counselor Availability and After Hours Emergencies

Counselors check for voice mail and email messages during normal business hours. Messages left outside of normal Connect Counseling & Wellness, LLC hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you should call 911 or seek assistance at the nearest emergency services department.

V. Child Care Release

Connect Counseling & Wellness, LLC does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

VI. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

Connect Counseling & Wellness, LLC reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by Connect Counseling & Wellness, LLC of your therapeutic needs, Connect Counseling & Wellness, LLC's ability to address those needs, or other circumstances that lead Connect Counseling & Wellness, LLC to conclude in its sole and absolute discretion that your counseling needs would be better served at another counseling facility. Under such circumstances, Connect Counseling & Wellness, LLC will suggest an appropriate counselor(s) or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to Connect Counseling & Wellness, LLC to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

Print Name:____ Date:__________________

Signature of Client #1:____

Print Name:____ Date:__________________

Signature of Client #2:____

Signature of Parent or Legal Guardian:___________________________ Date:__________________

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name:____

Patient Phone Number:____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional or school counselor/ psychologist. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate Connect Counseling & Wellness, LLC. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature:____ Date:______________________

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient:_______________________________________

Print Name:____ Date:______________________

Cresskill, NJ I Lyndhurst, NJ I Monmouth Beach, NJ
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For more information connectcounselingandwellness.com

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Insurance Information Form

Patient Information

First Name___________________________ Last Name______________________ Date____/_____/______

Birthdate____/____/_____ Social Security #_____-_____-_______ Employer___________________________

Insurance & Policy Holder Information

Primary Insurance_________________________________ Member ID _______________________________

Policy Group _____________________________ Relationship to Policy Holder ________________________

Policy Holder Name (If not yourself) ____

Employer ____ Date of Birth____/____/_____

Street Address_______________________________ City_______________ State_______ Zip___________

Home Phone _________________________________ Cell phone __________________________________

Payment/copay is required at the time of service by credit card, cash, or check. A billing charge will be added to any unpaid accounts to defray the cost of sending statements. In the event any balance due hereunder is not paid as agreed, the undersigned jointly agree to pay all costs incurred in said unpaid balance, including a reasonable attorney fee. If my check is returned unpaid, my signature authorizes that a fee, as allowable by state law, be charged to my account in addition to the check's full value.

Authorization: I hereby authorize the release of any medical information necessary to process any insurance claims. Payment of insurance benefits may be made directly to Connect Counseling & Wellness, LLC. I understand that I am responsible to Connect Counseling & Wellness, LLC for charges not covered by this authorization. Copays are due at the time of service. **I understand that I am responsible for checking my own benefits including copayments/ coinsurance, deductibles and coverage rates. I am also responsible for reporting any changes in my insurance coverage to Connect Counseling & Wellness, LLC within five business days of the change.**

____ __________________________

Signature of patient (OR legal guardian if patient is under 18) Date

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201-399-7225 l connectcounselingandwellness@gmail.com
For more information connectcounselingandwellness.com

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Credit Card Authorization Form

Print Name of Card Holder:____

Phone # of Card Holder:_____________________ Email of Card Holder:__________________________

Credit Card Holder's Name (exactly as it appears on the card) __________________________________

Type of Card: Debit☐ Credit☐ HSA ☐ Card Number________-_________-__________-__________

Expiration Date_________ 3-digit Security Code____________

Billing Address ____

*We currently accept Visa and Mastercard

I authorize Connect Counseling & Wellness, LLC to charge the credit, debit or HSA card provided for copays after each visit and for any additional charge, including non-payment from existing insurance providers.

I understand that I may cancel this authorization upon written notice to Connect Counseling & Wellness, LLC.

*Connect Counseling & Wellness, LLC will keep all card and personal information secure and will notify you before charging your card.

Card Holder Signature____ Date_______________