Ocean Point
Counseling, LLC
1228 Asbury Avenue
Ocean City, NJ 08226

Client Information Form

***Note**: If you have been a patient here before, please fill in only the information that has changed. Of course, your name may not have changed, but we still need it.*

Today's date: _____

Identification:

Name: _____ _____ _____ _____
first name middle initial last name suffix

Nickname or preferred name: _____

Phone #: _____ email address: _____

Home street address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Date of birth: _____ Age: _____ Gender: _____

Please identify any restrictions regarding calling you, leaving messages, texting or emailing you:

_____

_____

_____

Referral:

How did you find Ocean Point Counseling?

Saw sign ☐ On the internet ☐ Referred by someone ☐

Referred by your Insurance Company ☐ Other ☐

If you were referred by someone or "Other", please fill in the following information:

Referred by: _____ phone #: _____

Insurance Information

We may not accept your insurance, but we can submit a claim on your behalf as an out-of-network provider. Do you want us to submit claims for you?

Yes ☐ No ☐

If you answered Yes, please provide us with your insurance card(s) so that we can make a copy.

If you are not the primary insured, we will need the following information about the primary insured person:

What is your relationship to the primary insured person?

Self ☐ Spouse ☐ Child ☐ Other ☐

If you checked "Self" skip to the next page.

Please provide us the following information regarding the primary insured person:

Name of Primary Insured: _____ _____ _____
first name middle initial last name

Primary Insured's Date of Birth: _____

Gender of Primary Insured: _____

Primary Insured's Home Address (just write "same" if it is the same as the address you provided above):

Street: _____

Apt #: _____

City: _____

State: _____

Zip code: _____

Primary Insured's Phone #: _____

Emergency Contact:

Please identify someone as your emergency contact.

Name: _____ phone #: _____

Relationship: _____

Address: _____

Note: an emergency contact is NOT someone that you have agreed to share treatment information with (although it may be). An emergency contact is someone that we will contact in a dire situation such as you having a medical emergency in our office and needing to be rushed to a hospital.

I do not wish to identify an emergency contact: ☐

Signature: _____ date: _____

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Consent to Treatment

I acknowledge that I have discussed my situation with the below named therapist. Furthermore, the therapist has informed me of the clinical approach and goals of my therapy. Any questions that I had rewarding the therapy have been answered and I have understood this discussion regarding the planned therapy. I am also aware that I can and am encouraged to ask more questions as therapy proceeds.

I do hereby seek and consent to take part in the treatment by Ocean Point Counseling, LLC. I understand that developing a treatment plan with an Ocean Point Counseling therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Ocean Point Counseling, LLC.

I am aware that I may stop my treatment with Ocean Point Counseling, LLC at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), diagnosis(es), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Ocean Point Counseling may stop my treatment.

My signature below shows that I understand and agree with all the above statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the Ocean Point Counseling, LLC therapist, have discussed the matters noted above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Ocean Point Counseling, LLC therapist Date

___ Copy accepted by client ___ Copy kept by therapist

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist for time to be scheduled in advance.

A $20.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face- to-face sessions are highly preferable to phone sessions. However, if you are out of town, sick or need additional support, phone sessions are available but currently not covered by insurance companies. If a true emergency arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you

do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

Print Name

_____ _____

Signature Date

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices and that we may discuss medical/therapy matters with the person named on this sheet (if you name a contact).

Please identify anyone with whom we may discuss your medical records with (a close family member or friend). ***Note: this is optional.***

- ☐ Check here if you do not wish non-emergency information to be discussed with anyone. Note: if you have identified an emergency contact, that person will only be contacted in the event of an emergency.
- ☐ Check here if same as the Emergency Contact. If so, you do not need to re-enter the contact's information.

_____ _____
Contact's Name Relationship

_____
Contact's Address

_____
Contact's Phone Number

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THE NOTICE OF PRIVACY PRACTICES (with a release date of March 12, 2019).

_____
Print Name

_____ _____
Signature date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.