Prepared Approach LLC

Counseling Intake Form

650 E Palisade Ave, Suite 2-130, Englewood Cliffs, NJ 07632

Phone 551-574-1947

Demographic Information

Name _____

DOB_____ **Male**_____ **Female**_____

Adress_____

City/State_____

Phone #_____ **Cell**_____

Email_____ **Race**_____

Marital Status_____ **Spouse** _____

Current Occupation_____**Education**_____

Do you have any religious background_____

What type_____

Described your view of God_____

What are you hoping to get out of counseling _____

Medical Information

Primary Care Physician_____

Phone_____ **Las Physical Exam**_____

Description of medical problem_____

List current Medications/dosage_____

Reason Prescribed_____

Background Information (please check all that apply)

Anger Management | Anxiety| Abuse/Violence | Depression
Inattentiveness |Self Esteem | Hyperactive | Hyperactive

Family Concerns | Withdrawn | Eating Disorder |Financial Stressors |

Grief & Loss | Attachment Issues | Substance Abuse | Divorce Separation | Sexuality/Homosexuality Concerns | Suicidal/Homicidal Work/school-Related | Adoption/Foster-Care | Recent Weight Loss

Weight Gain | Sleep Problems | Masturbation | Pornography

Crisis Intervention | Transition Issues | Sibling Rivalry
Relationship Concerns |Sleeping Problems | Chronic Pain/Illness

Bullied | Rejection | Alcohol | Nicotine | Sexual Issues | Theft/ Stealing|

Work Issues | Co-Dependency | Drugs | TV/Sports/Computer Addiction

Additional Problem_____

HIPAA Notice of Privacy Practices

I have received or been provided the opportunity to review a copy of HIPAA Notice of Privacy Practices. I Understand Prepared Approach Counseling Services may use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations.

This authorization permits Prepared Approach Counseling to use and /or disclose individually identifiable health information about me.

1. Prepared Approach Counseling is authorized to disclose my individually identifiable health Information to partnering counseling therapists/agencies
2. I understand that this authorization is voluntary, and I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, or eligibility for benefits unless allowed by law.
3. I understand that I may inspect or copy the information to be disclosed.
4. I understand that I may revoke this authorization at any time by notifying Prepared Approach Counseling in writing, except to the extent that: a) Prepared Approach has taken action in reliance on his authorization; or (b) If this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy.

Financial Responsibilities

(1) The client (or client's guardian, if a minor) is responsible for the payment for all services rendered. (2) The Client is required to provide us with the most correct and updated information about their insurance, and will be responsible for the payment of co-pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

Child Custody Issues

Prepared Approach Counseling Services does not make recommendations for custody of children in disputed cases. Such recommendations are beyond the scope of our services.

Supervision Disclosure Statement and Recording Consent

I give my consent for Prepared Approach Counseling to record my counseling sessions for educational purposes. I understand counseling sessions may be taped and reviewed by the therapist in effort to provide the most beneficial services.

X_____ _____ Date_____

Signature of client/Legal guardian if client is under 18 Relationship to Client

CONSENT FOR EVALUATION & TREATMENT

1. Consent to Evaluate /Treat: I voluntarily consent that I will participate in a mental health status evaluation and /or treatment by staff from Prepared Approach Counseling. I understand that following the evaluation and /or treatment by staff from Prepared Approach Counseling. I understand that following the evaluation and /or treatment, complete and accurate information will be provided concerning each of the following areas:
   a) The benefits of the proposed treatment
   b) Alternative treatment modes and services
   c) The manner in which treatment will be administered
   d) Probable consequences of not receiving treatment
   e) The evaluation or treatment will be conducted by a licensed professional counseling.

2. **Benefit to evaluation /Treatment**: Evaluation and treatment may be administered with psychological interview, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatment, may be offered. Uses of this education and planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges**: Fees are based on the length or type if evaluation or treatment, which are determined by the nature of the service. I will be responsible for all charges. Payments is due at time services are rendered unless otherwise discussed and agreed upon.
   "No Show"-All appointments that are cancelled within twenty-four (24) hours of the scheduled appointment time will not be eligible for a refund. All appointment cancellations will be credited to a future session. Refunds may be issued on a case by case basis. All sessions are 60 Minutes. _____initial as "I accept"

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and /or treatment is contained in a confidential medical record at Prepared Approached Office and I consent to disclosure for use by Prepared Approach Counseling to use by Prepared Approach Counseling for the purpose of continuity of my care. All invoices are due upon receipt.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and /or treatment at any time by providing a written request to Prepared Approach Clinician**.**

Please Identify the main issues as it pertains to why you're seeking counseling:

_____
_____

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask question of my service provider about the above information at any time.

_____ **Date**_____

Client Name

_____

Signature of client /Legal guardian if client is under 18.