Integrated Care Concepts & Consultation
New Jersey's Premier Mind/Body Service Provider

J. Larry Thompson
LCSW, Founder

Seth A. Arkush
MBA, LCSW, Partner

New Client Intake Form

Just the basics here- your clinician will be providing you a complete orientation to integrated mental health care and work with you to create a biopsychosocial assessment where you will have the opportunity to collaborate in creating a plan of care to support your wellness recovery. So, please take a few moments and provide some basic info to get things started.

Client Information

Today's Date: _____ Date of Birth: _____
Client Name: _____ Sex: M F
Address:_____ City:_____
State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
May we email you? _____ May we text message you? _____

Emergency Name and Contact Number: _____

Referral Information

Whom may we thank for referring you to our office: _____

Are you in our office for: Referral Employee Assistance Program Insurance Website Juvenile Court Referral
Psychiatrist Referral Psychologist Referral School Referral Hospital Referral

Other: _____

Insurance Information

Name of Insured: _____ Relationship to you: _____

Date of Birth of Insured: _____ Insurance Name/Type: _____

Insurance Address: _____ Insurance Phone: _____

Insurance ID Number: _____ Group ID Number: _____

Secondary Insurance- Name of Insured: _____ Relationship to you: _____

Date of Birth of Insured: _____ Insurance Name/ Type: _____

www.integratedcareconcepts.com Phone: 732.389.0697 Fax: 732.389.0611
Main Office: 615 Hope Road | Building 5B; 2nd Floor, Eatontown, NJ 07724

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Insurance Address: _____ Insurance Phone: _____

Insurance ID Number: _____ Group ID Number: _____

Credit Card Information

Please note we keep a credit card on file for no shows or for default in payment.

Credit Card Type: _____ Credit Card Number: _____

Card Security Code: _____ Exp. Date: _____

Credit Card Name as it appears: _____

Client Name/Signature/Date

Client/Guardian Name:	Signature:
Date:	

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Client Rights Form

1. I understand that I have the right to decide not to enter therapy (although depending on my situation there may be legal or other consequences for not entering therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue. Initials: _____

2. I understand that I have the right to a safe environment during therapy, free from physical, sexual, and emotional abuse. Initials: _____

3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits and progress. Initials: _____

4. I understand that I have the right to information about the professional capabilities and limitations of any clinician(s) involved in my therapy, including their certification/licensure, education and training, experience, specialization and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. Initials: _____

5. I understand that I have the right to written information about fees, payment methods, copayments, length and duration of sessions and treatment. Initials: _____

6. I understand that my confidentiality will be protected, and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which must be disclosed. Initials: _____

7. I understand that I have the right to know if my therapist will discuss my case with supervisors or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. Initials: _____

8. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. Initials: _____

9. I understand that I have the right to request the release of my clinical information to any agency or person I choose. Initials: _____

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Date:	

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Consent for Treatment

1. I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with this therapy. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency. Initials: _____

2. I understand that the staff of this agency may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or a disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. Initials: _____

3. I understand that my therapist may work with me at this agency, in my home, or in other settings based on his/her professional judgment. I further understand that my therapy may involve my participation in individual, couple, family and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy. Initials: _____

4. I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group. Initials: _____

5. I understand that my therapy may include my attendance at meetings of independent self-help support groups including Alcoholics Anonymous, Narcotics Anonymous, and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants. Initials: _____

Client/Guardian Name:	Signature:
Date:	

Therapist Name:	Signature
Date:	

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Payment Agreement for Services

I understand and agree that Integrated Care Concepts and Consultation LLC will be providing professional services and I agree to pay fee(s) of:

$200.00 _____ Per session for the Initial Evaluation Session
$150.00 _____ Per session for individual therapy in office
$250.00 _____ Per session for individual therapy in home/other location
$175.00 _____ Per session for family/marital therapy
$300.00 _____ Per session for family/marital therapy in home/other location
$50.00 _____ Per session for group therapy
$350.00 _____ Per session for Psychiatry Evaluation Session
$150.00 _____ Per session for Psychiatry Follow-up
10% of Session Fee _____ to process out of network claims on behalf of client
$30.00 returned check fee
Appointments cancelled with less than 24 hours notice will be charged at session rate

I agree that I am responsible for the charges for services provided by Integrated Care Concepts and Consultation LLC therapists to me. Although other insurance carriers may make payments on my account, I understand insurance deductibles, co-payments, or full fee for services are due at day and time of services.

I further guarantee that charges for services provided will be paid upon receipt of billing statements from (this therapy/agency) and that the balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, I guarantee that payment will be made in compliance with those arrangements.

I understand should I not fulfill paying my balance on account, that this balance will be turned over to a collection agency and may affect my credit.

I understand that this office will bill insurance companies and other third party payers, but cannot guarantee such benefits, and is not responsible for collection of such payments.

I agree that if I do not provide Integrated Care Concepts and Consultation LLC with notice of cancelling and appointment 24 hours in advance of the scheduled appointment that I am responsible for the payment of that appointment at the posted rate above. I will provide a credit card impression so the credit card can be charged for this and collection fees.

I have read the client's right form and reviewed the fee schedule. In signing this form, I understand my rights as a client and my responsibilities for payment to Integrated Care Concepts and Consultation LLC.

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Credit Card Information

Please note we keep a credit card on file for no shows or for default in payment.

Credit Card Type: _____ Credit Card Code: _____
Credit Card Number: _____ Exp. Date: _____
Credit Card Name as it appears: _____

Client/Guardian Name:	Signature:
Date:	

Agency Representative Name:	Signature
Date:	

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Release of Information

I,_____, hereby authorize the release and disclosure of the following clinical and or therapeutic records for the following purposes:
{ } Authorization to release information regarding counseling and therapy care and treatment.
{ } Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.
{ } Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between (Agency), _____, and:

Specific Information to be released. Initials: _____

Assessments and Evaluations, Initials: _____

Continued Care and Treatment, Initials: _____

Psychosocial History, Initials: _____

Discharge Summary, Initials: _____

Correspondence (specify):

Other (specify):

Purposes for which information is to be released:

Revocation/Expiration: This release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a dated stated here (_____), this Release of Information will automatically expire after a period of 180 days from the date signed. I have the rights to receive a copy of this Release of Information upon my request.

Client/Guardian Name: Signature:

Date:

Agency Representative Name: Signature

Date:

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Cancellation Policy

To all our clients,

The need is great for effective and integrated holistic clinical care. We are often required to place individuals and families in need on wait lists. It is uncomfortable and unsustainable to have opportunities to be of service to these individuals and families go unutilized. We are also respectful to those times when emergencies prevent a session or an appointment from being kept. Please be aware that as of June 1st, 2015, Integrated Care Concepts and Consultation, LLC will be maintaining the boundary around effective use of the therapeutic opportunities available in that we will be enforcing our 24 hour cancellation policy. Though this has been our policy, as you are aware in our client intake agreements, we have been reluctant to call attention to it. The conditions are now present due to need that we are called to be more mindful of our availability.

If you are unable to make your appointment it is requested that you contact the office with 24 hours' notice so we may be able to offer that opportunity to someone else. If notice is not received, we will charge a cancellation fee related to the appointment missed.

Psychotherapy Appointment: $75.00
Psychiatric Appointment: $175.00

It is not our intention to create more restrictions or conditions to your care as it is our concern that those who need will be provided for effectively.

Client/Guardian Name:	Signature:
Date:	

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NOTICE OF PRIVACY PRACTICES
FOR
PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the confidentiality of all communications between a client and counselors and clients and medical providers. Integrated Care Concepts & Consultation can only release information to individuals outside of the practice about your care with your written permission. However, there are a number of exceptions. Should such a situation occur, your counselor and/or provider will make every effort to fully discuss it with you before taking any action.

Examples of use of your health care information for payment purposes are to: process claims, verify your insurance coverage and obtain authorization for additional sessions

There are some situations in which Integrated Care Concepts & Consultation is legally required to take action to protect you and/or others from harm even though that requires revealing some information about your treatment without obtaining your consent.

- Integrated Care Concepts & Consultation is required by law to report suspected child abuse or neglect to the New Jersey Division of Child Protection and Permanency (DCPP).

- Integrated Care Concepts & Consultation is required by law to report suspected abuse, neglect or exploitation of a vulnerable adult to Adult Protective Services. A vulnerable adult is someone 18 years of age or older who because of a physical or mental disability or illness, lacks sufficient understanding or capacity to make, communicate or carry out decisions concerning his or her well-being.

- If, in your counselor and/or medical provider's professional opinion, it seems likely that you may harm yourself, Integrated Care Concepts & Consultation is required to take steps to try to protect you including telling others such as relatives, police, or other health care providers who can assist in protecting you.

- If, in your counselor's and/or medical provider's professional opinion, believe that you have serious intent to harm someone, Integrated Care Concepts & Consultation is required by law to take steps to

protect that person. These steps may include informing that person, the police, and/or other health care providers.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that Integrated Care Concepts & Consultation has provided you and/or the records thereof, such information is privileged under state law, and Integrated Care Concepts & Consultation must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. Your clinician must inform you in advance if this is the case.

- Integrated Care Concepts & Consultation may use and disclose your health information for law enforcement purposes to a law enforcement official if required by law, or where permitted by law, or in response to a valid subpoena or for law enforcement officials to identify or locate an individual.

- When children under the age of 14 enter treatment, parents/guardians are entitled to personal health information. Parents or guardians of children adolescent 14-17 do have the right to general information, including how therapy is going. Additionally, adolescents ages 14-17 have the right to sign a release of information allowing the counselor and/or medical provider to disclose information to parents and guardians; however, this decision is at the discretion of the adolescent. The mental health provider may also be connected to parents or guardians about other family members the client presents in counseling if the child reports those family members to be a dancer to the child or others.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. Furthermore, I give my permission to Integrated Care Concepts & Consultation to use and disclose my protected health information according to the terms of the Notice of Privacy Practices.

_____	_____	_____
Print Client's Name	Client's Signature	Date
_____	_____	_____
Print Guardians name if under 18 or cannot consent	Guardians Signature	Date

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Social Media Policy

This document outlines Integrated Care Concepts & Consultation's policies related to use of Social Media. Please read it to understand how ICC conducts themselves on the Internet and how you can expect to be responded to through various interactions that may occur on the Internet.

If you have any questions about anything within this document, you are encouraged to address them with your counselor. This policy may change as new technology develops and the Internet changes. If so, ICC will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

Staff members do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise your confidentiality and the staff members' respective privacy. It may also blur the boundaries of therapeutic relationships. If you have more questions about this please bring them up in session so that they can be further addressed.

Social Media Profiles

Integrated Care Concepts & Consultation operates both a Facebook account and an Instagram account. Clients are also free to "like" the Facebook Page and "follow" the Instagram account; however, this may compromise client confidentiality. Integrated Care Concepts & Consultation will not follow you back on Instagram or request to be your friend on Facebook. Integrated Care Concepts & Consultation only follows other mental health care and mind body social media accounts. Integrated Care Concepts & Consultation believes providers casually viewing clients' online content can create confusion in regard to whether it's being done as a part of your treatment or to satisfy providers' personal curiosity. In addition, viewing clients' online activities without your consent and without explicit arrangement towards a specific purpose could potentially have a negative influence on the therapeutic relationship. If there are things from your online life that you wish to share with your provider, please bring them into our sessions where you and the provider can view and explore them together.

Online Interactions

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Instagram, Facebook, or LinkedIn to contact ICC or any of its staff members. These sites are not secure and your provider is most likely not the one to receive these messages. Do not use Wall postings, @replies, or other means of engaging with ICC staff in public online forums. Attempting to communicate in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your medical record and will need to be documented and archived in your chart. If you need to contact your provider between sessions, the best way to do so is by phone.

Use of Search Engines

It is NOT a regular part of practice to search for clients on Google or Facebook or other search engines. Integrated Care Concepts & Consultation asks that you also respect your providers' privacy and refrain from searching their name on a search engine. If you have questions about your providers' qualifications you are encouraged to discuss this and ask your questions in session. Both your privacy and staff members' privacy is extremely important in the therapeutic relationship. Only extremely rare exceptions may be made during times of crisis. If your provider has a reason to suspect that you are in danger and you have not been in touch with ICC via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and ICC staff ever resorts to such means, it will fully be documented and discussed with you in your next counseling session.

Business Review Sites

You may find Integrated Care Concepts & Consultation on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find a listing on any of these sites, please know that this listing is NOT a request for a testimonial, rating, or endorsement from you as a client. Clients have the right to express themselves on any site they desire. Due to confidentiality, providers are not

allowed to respond on any of these sites. It is important to be aware that if you are using these sites to indirectly communicate with your provider about your feelings regarding your therapeutic work they will most likely never see it. It is encouraged to bring your feelings about the therapeutic relationship and process directly into session. This can be a very powerful part of therapy even if the outcome is a transition to another provider. Integrated Care Concepts & Consultation cannot and will not identify you as a client but you are welcome to tell anyone you are an ICC client and how you feel about your treatment in any forum of your choosing. If you do choose to write something on a business review site, keep in mind that you may be sharing personally revealing information in a public forum. A pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection may be a more confidential way to communicate electronically

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. Facebook allows you to check-in to Integrated Care Concepts and Consultation. If you choose to do this, you are allowing your friends and other Facebook users you are not friends with to see your location. Furthermore, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a client due to regular check-ins at the office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from an ICC office or if you have a passive LBS app enabled on your phone.

Email

It is asked that you do not use email to communicate with ICC or your provider unless you and your provider have agreed to communicate via email to schedule appointments. Please do not email ICC content related to your therapy sessions, as email is not completely secure or confidential. f you are having a clinical emergency please call 911 or go to your local emergency room. If you are having a clinical emergency please call 911 or go to your local emergency room.

Text Messaging

If your provider has provided you with a telephone number with text messaging capability please know text messaging is not encrypted and therefore, may not be private. Furthermore, it cannot be guaranteed the provider will respond immediately. If you are having a clinical emergency, please call 911 or go to your local emergency room.

Conclusion

Thank you for taking the time to review Integrated Care Concepts & Consultation's Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to your provider's attention so that they can be addressed in counseling.

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I have read and understand Integrated Care Concepts & Consultation's Social Media Policy. Initials: ____

I understand I am free to follow Integrated Care Concepts & Consultation on social media platforms. Initials: ____

I understand the reasons behind keeping my personal social media account and my provider's personal social media account private. Initials: ____

I agree not to search for my provider and/or request to follow/friend them on social media. Initials: ____

I understand the best way to get in touch with my provider is by calling the office at 732-389-0697 or by calling my provider's direct extension. Initials: ____

I understand information communicated via email or text has compromised confidentiality. Initials: ____

I understand if I am experiencing a clinical emergency to call 911 or go to my locat emergency room. Initials: ____

I understand Integrated Care Concepts & Consultation will not attempt to use a search engine to find my location except for under extreme situations where my safety may be at risk. Initials: ____

Client/Guardian Name	Signature:
Date:	