Toni Genovese, LCSW
STRONG AT THE CORE LLC
Child, Adolescent and Adult Counseling

15 School Road East, Suite 3
Marlboro, NJ 07751

WELCOME to my practice. I look forward to helping you reach your goals. This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them. After filling it out, please make a copy for yourself and bring a copy to give to me at your first appointment. I am pleased to have the opportunity to work with you.

Client Name _____ Birthdate _____
Address _____ Age _____
City, State, Zip _____ Gender _____

Home Phone: (_____)_____ Is it OK to contact you at this number? Y N
Work Phone: (_____)_____ Is it OK to contact you at this number? Y N
Email address _____

Relationship Status (circle)
Single Married Domestic Partner Separated Divorced Widowed

Emergency Contact:
Name: _____
Relationship to client :_____
Phone number: (_____)_____

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Please list other persons living in your household and their relationship to the client:

_____

_____

Mental Health Plan _____ Full Time Student? Y N
Medical Health Plan_____ Occupation_____
Primary Care Physician_____ Phone Number (_____)_____

Insurance Information

Primary Insurance Information
Insured Name _____
Insured Birthdate _____
Employer _____
Health Plan /Payer _____
Client's Relationship to the Insured:
___Self ___Spouse ___Dependent
Member #: _____
Policy/Group #: _____

Secondary Insurance Information
Insured Name _____
Insured SSN _____
Insured Birthdate _____
Employer _____
Health Plan /Payer _____
Client's Relationship to the Insured:
___Self ___Spouse ___Dependent
Member #: _____
Policy/Group #: _____

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Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event.

_____

_____

_____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not Applicable
Marriage/Relationship						
Family						
Job/School performance						
Friendships						
Financial situation						
Physical health						
Anxiety level/Nerves						
Mood						
Eating habits						
Sleeping habits						
Sexual functioning						
Alcohol/Drug usage						
Ability to concentrate						
Ability to control your temper						

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What results(s) do you expect from treatment?

_____

_____

Have you ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:

_____

_____

Please list any medications you're currently taking:

_____

_____

TREATMENT PHILOSOPHY

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. You are an important part of the process of creating goals. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time-efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please do not hesitate to ask.

CONFIDENTIALITY

All information between provider and patient is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measure can be taken.

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FINANCIAL TERMS

You are responsible for payment at the time services are rendered. I will provide you with a receipt to submit to your insurance carrier if you so choose.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled, with less than twenty-four hour notice, you will be billed directly according to the scheduled fee: $65.00 for missed appointments. Please provide your credit card info below to keep on file in the event of a last minute cancellation. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

Initial_____

Credit Card #:_____ CVV: _____

Expiration Date: _____

EMERGENCY PROCEDURES

If you need to contact me, leave a message and I will return your call as soon as I am able. You can reach me at **(732) 456-7780**. However, if a true emergency situation arises, ***you need to call 911 or have someone help you get to the emergency room immediately for care***. In the case of a crisis, you do not want to wait for me to return your call. It is important that you receive treatment right away. If you need to talk to someone you can also call the crisis lines below.

24-Hour Crisis Numbers

NJ Hope Line: 1-855-NJ-HOPELINE

For Youth 18 and Under: Mobile Response Team, 1-877-652-7624

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RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan.

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedure will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

_____

Client (or Parent/Guardian) Name-Printed Date

_____

Client (or Parent/Guardian) Name-Signature Date

_____

Therapist Name & Signature Date