Associates for Life Enhancement, Inc.

505 New Road ~ PO Box 83 ~ Northfield, NJ 08225
Phone (609) 569-1144 ~ Fax (609) 569-1510 ~ 1-800-356-2909

Client Information Sheet

Parents Names (If Client is a Minor) _____

Client's Last Name _____ ***First*** _____ ***M.I..*** _____

Social Security No. _____ ***Date of Birth:*** _____ ***Age*** _____ ***Sex M / F***

Home Phone No.( ) _____ ***Education Level:*** _____ ***Marital Status:*** _____

Please let us know if it is ok to call you at home to change, cancel or confirm your appointments? Yes / No

If No, please tell us how we may contact you? _____ ***Phone No. ( )*** _____

Home Address:

_____ ***City*** _____ ***State*** _____ ***ZipCode*** _____

Name of Employer:

_____ ***Department*** _____ ***Shift*** _____

Employer's Address _____ ***City*** _____ ***State*** _____ ***Zip Code*** _____

_____ _____ _____ _____
Last Name of Insured (if different from patient) ***First Name*** ***Insured's Social Security No.***

_____
Address ***City*** ***State*** ***Zip Code***

_____ _____ _____ _____
Date of Birth of Insured ***Name of Insured's Employer*** ***Department*** ***Shift***

Insurance Company: _____ ***Relationship to the Insured:*** _____

Policy :# _____ ***Group#*** _____ ***Phone No. ( )*** _____

Name of Employer:

_____ ***Department*** _____ ***Shift*** _____

Personal Guarantee: I will be personally responsible for all charges incurred by me during therapy.

Signature: _____ ***Date*** _____

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CLIENT RIGHTS AND RESPONSIBILITIES AND CONSENT TO TREATMENT

I am asking my therapist to help me help myself, and I understand that the following client rights and responsibilities are to help me reach my goals.

1. I know that all sessions and reports are private, unless I threaten to seriously harm myself or someone else or if I am physically, emotionally or sexually abusing a child or unless I give my written permission to release such information.

2. I will share in planning my treatment and will be actively involved in my treatment.

3. I have a right to privacy and dignity.

4. I have a right to refuse any treatment intervention with which I feel uncomfortable.

5. I have a right not to be discriminated against unfairly for any cause (Example: race, religion, national origin, disability or sexual orientation).

6. I have a right to terminate services at any time and I agree to work out appropriate closure with my therapist.

7. I will keep scheduled appointments and arrive on time. (Please refer to Cancellation Policy for more information).

If I am unable to understand these rights and responsibilities, my parent, guardian or legal agent has been informed of them and will sign on my behalf.

THERE ARE NO PROMISES OR GUARANTEED OUTCOMES MADE BY ALE STAFF AS TO THE ATTAINMENT OF YOUR GOALS.

I agree to participate in treatment with my assigned therapist under these terms.

_____ _____

Client Signature (or guardian for client under 18) Date

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SOCIAL MEDIA POLICY/CONTACTING COUNSELOR OUTSIDE OF BUSINESS HOURS

Friending We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We 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.

Following We publish a blog on our website and post counseling related items on Twitter and our Facebook page. We have no expectation that you as a client will want to follow our blog, Twitter or Facebook page. Our primary concern is your privacy.

Interacting Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with us in public online forums if we have an already established client/therapist relationship. Engaging with us in this way could compromise your confidentiality

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with your counselor.

Furthermore, we request that you not use email to inform your counselor that you are in crises. Associates for Life Enhancement has a counselor on call 24/7. If you are experiencing a crisis or have an urgent need to speak to a counselor you must call our office (609) 569-1144 and you will be connected to a "live" operator. If you need to speak to your counselor and it is not urgent, we request that you leave a message for your counselor with our answering service and your call will be returned the next business day. If you decide to use email to communicate to your counselor you must understand that your counselor may not have access to their email and it can take up to 24 hours to respond to your request. We further ask that you contact the office directly to schedule or change appointments.

Presently, we are unable to confirm or accept requests to cancel appointments through email or text messaging due to privacy matters.

Client Name: _____

Signature: _____

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Financial Policy

Authorization to release information to pay benefits to Associates for Life Enhancement, Inc.

I hereby authorize hereby authorize Associates for Life Enhancement, Inc. to release any information acquired during my treatment as required by my insurance company/EAP referring program to obtain payment for services. Further, I authorize the insurance company or referring EAP program to make payments on my behalf directly to Associates for Life Enhancement, Inc. that might otherwise be paid to me. I understand that I am financially responsible for all charges that are not covered or paid by my insurance or EAP program as outlined in their policies.

INSURANCE: If we participate with your insurance company, we will bill them directly. As a courtesy prior to your first session, we will verify your insurance benefits. **Please be advised that we will not be responsible for incorrect information received by your insurance company.** If we do not participate with your insurance company, or you are not utilizing insurance, full payment is due at the time of your office visit. Any amount remaining after insurance payments have been applied is your responsibility and must be paid in full. **All co-pays, deductibles and co-insurance must be paid at the time of service. We only accept cash or checks, no debit or credit cards.** We only bill primary insurance plans. If you have a secondary policy you want to cover expenses for services with us you will need to submit your explanation of benefits from your primary to your secondary to receive payment from them directly.

If your insurance changes at any time during your treatment, you must notify us prior to your next scheduled session. If you fail to notify us prior to your appointment you will be expected to pay for the service in full and once the claim has been filed we will reimburse any money that may be owed to you. Any unpaid balances will be turned over to a collection agency if you are no longer in treatment and our attempts to collect from you are unsuccessful. If your account is turned over to a collection agency, **a collection fee of 35%** will be added to your total balance and will be listed on your credit report. If this course of action is necessary then your patient rights and privileges will be revoked.

Bounced Checks

There is a **$35.00 fee** for any checks returned to this office for any reason. If you bounce a check to us all future payments must be made by cash and fees will need to be paid in full at the time of your next scheduled appointment.

Other Fees

Short letter of one paragraph: **$40.00**. Request for letters must be made at least **5** days in advance and must be paid in full at time of request. More than one paragraph will be considered a report and is charged at **$125.00** for the first page. Additional pages are charged at **$100.00** for every additional page. Retainer fee of **$125.00** must be paid upon request to begin preparation of the report. All reports require a minimum of two weeks of preparation and the balance for the report must be paid in full before report is released. Requests for disability forms to be completed are charged at **$20.00** per request. If you are involved in any type of legal or court case and you request that your counselor read documents pertaining to your case there will be a fee charged at **$50.00** per hour and a retainer of **$200.00** must be paid upon receipt of the documents. Drug testing **$15.00**. This fee is not reimbursable by insurance.

I fully understand and accept my financial obligations to Associates for Life Enhancement. I will fulfill my obligations by following this financial policy and understand the consequences if I do not.

Name_____ _____Signature

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CANCELLATION POLICY

When you make an appointment, we reserve a block of time especially for you and only you. As a courtesy, we will try to call you the day before to remind you of your appointment**. However, this is a courtesy and if you do not receive a call from us it is still your responsibility to remember that you scheduled the appointment.**

We have a 24-hour answering service available for you to leave a message when the office is closed. **All incoming calls are recorded.**

If you do not appear for your appointment or phone to cancel within 24 hours, that block of time is unavailable to anyone else who is waiting for our service.

We require 24 hours notice to cancel or reschedule an office appointment. You must provide us with documentation in emergency situations. We will take it into consideration as to whether a fee will be assessed.

If you fail to give the required notice, you will be charged a $55.00 cancellation fee. This fee is not reimbursable through insurance and needs to be paid before you schedule your next appointment.

We appreciate your cooperation and consideration in adhering to this policy.

Signature: _____

Date: _____

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Consent to use and disclose your health information
HIPAA POLICY

This form is an agreement between you, _____ and me/ us Associates for Life Enhancement Inc. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here_____.

This form is an informational document only. It is regarding our health care privacy practices.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information to arrange payment for your treatment.

The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. This information is available to read on our website at www.eapale.com.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 609-569-1144.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have shared or used some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

Associates For Life Enhancement
ADULT CHECKLIST OF CONCERNS

NAME: _____ *DATE:* _____

PLEASE MARK ALL OF THE ITEMS BELOW THAT APPLY TO YOU, HOW YOU FEEL, WHAT YOU EXPERIENCE (D), OR WHY YOU ARE HERE.

- ☐ I have no problem or concern bringing me here.
- ☐ Abuse: physical, sexual, emotional, neglect (also of children or elderly), cruelty to animals.
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Angry / Hostile
- ☐ Argumentative
- ☐ Distractibility
- ☐ Career concerns, goals, choices
- ☐ Childhood issues (your own childhood)
- ☐ Children ,parenting, child management, child care
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of child/ children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce or Separation
- ☐ Drug Use: prescription medications, over the counter medications, street drugs
- ☐ Eating problems: overeating, under eating, appetite, vomiting (also see "weight & diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears / Phobias
- ☐ Financial / Money problems/troubles: debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches / Other aches and pains: _____ _____
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts

Associates For Life Enhancement
ADULT CHECKLIST OF CONCERNS

- ☐ Impulsiveness, loss of control, outburst
- ☐ Irresponsibility
- ☐ Judgment problems
- ☐ Risk taking
- ☐ Legal Matters: charges, suits
- ☐ Loneliness
- ☐ Marital conflict: distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems: PMS or Menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity
- ☐ Rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School Problems (also see "career concerns")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (also see "abuse")
- ☐ Shyness
- ☐ Oversensitivity to criticism
- ☐ Sleep Problems (too much, too little, insomnia, nightmares)
- ☐ Smoking/ Tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control issues, low frustration tolerance
- ☐ Thought disorganization & confusion
- ☐ Threats / Violence
- ☐ Weight / Diet issues
- ☐ Withdrawal / Isolating yourself
- ☐ Work problems, employment, workaholic/overworking or can't keep a job
- ☐ OTHER CONCERNS/ISSUES:

  _____
  _____
  _____
  _____

- ☐ TOP CONCERNS/ISSUES TO FOCUS ON:

  _____
  _____
  _____