Connections Counseling, LLC
Individual (Adult) Personal Information

Name: DOB/Age:

Home Address:

How were you referred?

Home Phone: May we call you or leave a message at this number? Yes No

Work Phone: May we call you or leave a message at this number? Yes No

Cell Phone: May we call you or leave a message at this number? Yes No
Text? Yes No

Emergency Contact Name(s): Phone:

E-Mail Addresses: May we e-mail you? Yes No

Occupation:

Employer's Name and Address: (will not be contacted)

Current Primary/Health Care Provider: Phone:

Current Medications: Allergies (Food/Med/Etc.):

Current Psychiatrist: Phone:

Current Medications:

Current Relationship Status: single married separated divorced widowed committed other
Do you reside with your partner: Yes No

Please List Previous Marriage Partner First Names and Dates of Marriage(s):

Do you have any children? If so, please list their names, ages, other biological parent's name and if they reside with you? Who else resides with you?

Do any family members (in the home) own any firearms? Yes No
Do you have access to firearms? Yes No Are the firearms locked and secured? Yes No N/A

Reason(s) for seeking counseling?

Client's Signature: Date:

Policy Regarding Fees and Communication

All fees are paid directly to Connections Counseling, LLC at the time of service. We accept cash, check or credit card.

We have a 24-hour cancellation policy. This is simply a business policy as making an appointment is reserving a time slot that cannot be filled in short notice. The entire fee is rendered for all cancellations without at least 24 hours notice.

As a matter of ethics, counselors cannot connect personally with clients on social media. Please know that your counselor cannot accept personal requests or contact via any form of social media.

If, at any time, you (or someone you know), is a danger to self, others or property, call 911 or proceed to the local emergency room or crisis center immediately. Clients should not wait for their counselor to return calls in emergency situations.

Although Connections Counseling, LLC takes measures to secure technology communication, please know that all means of technological communication is not secure and cannot be guaranteed by Connections. As such, please do not email or text clinical information. Email, voice mail and text may be used, at your counselor's discretion, for appointment scheduling only. Your counselor has the right to not accept text messages. In addition, any clinical or personal concerns should be addressed in-person with your counselor, and not via technology, to ensure proper care.

Initialing this agreement implies that the undersigned has read and agree to the above policy and has discussed any concerns with the counselor prior to the beginning of the counseling relationship.

______________ ______________
Client's Initials Date

Risks and Benefits of Counseling/Client Rights

Benefits of Counseling: Research indicates that most people who engage in counseling benefit from the experience. Counseling provides the person(s) with the opportunity to talk and learn about themselves and their problems in a safe, non-judgmental, caring environment. Counseling can impact and improve relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals, increase productivity in work, school and relationships; and an improved ability to deal with everyday stresses. Counseling may help relieve the stress and impaired functioning associated with trauma, grief and mental disorders.

Risks of Counseling: The risks associated with the counseling process may include remembering unpleasant events that may arouse strong feelings, and, as an outcome, may result in ill-advised or risk-taking choices/behaviors. The risks also include continuation of presenting problems, increased feelings of loneliness, sadness, depression, anxiety, feelings of hopelessness or suicide. Counseling for relational issues may result in the growth of only one partner and/or the decision to end the relationship. There may be other risks as well.

The client has the right to:

A) To be treated with dignity, consideration and respect at all times;

B) To expect quality service provided by concerned, trained, professional and competent staff and to discuss concerns about the risks associated with counseling with the counselor at any time;

C) To expect complete confidentiality, within the limits of the law, to be informed about the legal exceptions to confidentiality and to expect that no information will be released without the client's knowledge and written consent;

D) To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures and third-party reimbursement procedures are discussed;

E) To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to, or likely to affect, the ongoing mental health counseling relationship;

F) To appropriate information regarding the mental health counselor's education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate;

G) To full, knowledgeable and responsible participation in the ongoing treatment plan to the maximum extent feasible;

H) To obtain information about their case record and to have this information explained clearly and directly;

I) To request information and/or consultation regarding the conduct and progress of their therapy;

J) To refuse any recommended services and to be advised of the consequences of this action;

K) To a safe environment free of emotional, physical and sexual abuse;

Risks and Benefits of Counseling/Client Rights (Continued)

L) To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor, and/or the appropriate credentialing body; and

M) To a clearly defined ending process and to discontinue therapy at any time.

Initialing this agreement implies that the undersigned has read and understood the above disclosures and has discussed any concerns with the counselor prior to the beginning of the counseling relationship.

______________ ____________

Client's Initials Date

Informed Consent and Confidentiality for Mental Health Counseling

Prior to receiving mental health treatment and/or counseling you, as the client, have the following rights to be fully informed as to:

1. the nature of the proposed treatment and any reasonable treatment alternatives
2. the training, credentials, and licensure of your counselor
3. truthful disclosure of reasonably foreseeable benefits, risks and hazards of the proposed treatment, alternative treatments and of not doing anything
4. the right to fully withdraw consent for treatment at any time

You also have the right to the confidential treatment of information about you and/or a minor child (New Jersey Mental Health Law allows for children 14 and older to consent to treatment without a parent/guardian). Information maintained in your client record will not be released to anyone outside the direct therapeutic relationship (and Connections Counseling, LLC supervisors and staff) without your approval under the Federal HIPPA guidelines unless required by law. These exceptions include, but are not limited to: 1) the mandatory reporting of suspected child/elderly abuse or neglect, 2) the duty to warn to prevent harm to others, 3) concern from the counselor of the dangerousness of the client(s) to self, others or property due to a mental disorder etc., 4) in the event of legal proceedings against the counselor/practitioner, 5) disclosure as mandated by Third Party payment requirements, or, 6) under specific circumstances, a court subpoena.

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By providing your initials next to the items below and signature to this document, you attest that you, as the client:

_____Have discussed all policies in this packet with your counselor and, without reservation, provide your consent for treatment.

_____Understand the legal right to provide voluntary consent for mental health treatment and are competent to make decisions regarding the course and/or discontinuation of treatment.

_____Understand that the counselor is bound by confidentiality laws, with the exceptions listed above, and that your treatment will only be discussed with Connections Counseling, LLC supervisors and staff who are also bound by these laws.

_____Received the link (above) for Federal HIPPA guidelines.

_____Received a copy of the Mental Health Bill of Rights and read (and understood) the risks and benefits of counseling.

_____Read and agree to the policies regarding fees and communication and understand that at least 24 hours notice is required for cancellations or the full fee for the appointment is rendered.

______________________	______________________	____________
Client's Name-Printed	Client's Signature	Date

By signing below, the counselor has reviewed the completion of this document by the client and has addressed any concerns with the client:

______________________	______________________	____________
Counselor's Name-Printed	Counselor's Signature	Date