Suzanne M. Cohen LCSW

LifeDesign Behavioral Health

57 Cooper St. Suite B Woodbury, NJ 08096

Dear Client _____,

Welcome to LifeDesign Behavioral Health. We appreciate you taking the time to complete this intake packet to insure that we have accurate information in your file.

Sincerely,

Suzanne Cohen, LCSW

Licensed Clinical Social Worker

LifeDesign Behavioral Health

Information and Consent for Treatment

We are pleased that you have selected LifeDesign Behavioral Health. This document is designed to ensure that you understand our professional relationship.

I. Client Agreement

All the clinicians at LifeDesign Behavioral Health are experienced and professionally trained.

The model of treatment within LDBH involves weekly mental health therapy with clients who are willing and able to work on their mental health issues. Some clients need only a few sessions to achieve their goals, while others may require months or years of counseling. We desire to work with clients who have the capacity to resolve their own challenges with our assistance.

The number of sessions will be decided between you, your therapist (and your insurance company if you are using insurance to cover treatment cost).

Although your sessions may be very intimate psychologically, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your counselor to relate to you in any way other than in the professional context of your counseling sessions. We will keep confidential anything that you say to your counselor with the following exceptions: (1) you direct us to tell someone else, (2) we determine

that you are a danger to yourself or others, or (3) we are ordered by a court to disclose information. Also, (4) it is mandatory that we report child abuse.

If at any time for any reason you are dissatisfied with services you receive, please let your counselor know.

Sessions are approximately 45 minutes in duration. Please note that it is impossible to guarantee any specific results regarding your counseling goals. We will help you identify your issues, but it is up to you to do the work. Together we will work to achieve the best possible results for you. Our policy is that no weapons of any kind are permitted in any of our offices.

Therapy/treatment can be terminated by either the client or the clinician under the following circumstances: 1) If either the client or the clinician/psychiatrist believes therapy/treatment is not being helpful to the client; 2) If the client is not complying with those elements of therapy/treatment essential for progress; 3) If the client's behavior or the behavior of someone in a relationship with the client is harmful or potentially harmful to other clients or the clinician/psychiatrist.

II. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform your counselor immediately. Please be aware that in child custody cases, we typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved. Authorizations to release information regarding legal matters must be on LDBH letterhead. Please remember that LifeDesign Behavioral Health has no control of, or responsibility for how information is handled once it is released to third parties. **If you are using your insurance, and that insurance provider changes or your card numbers or co-pay changes, please let us know as soon as possible. It is your responsibility to bring this to our attention.**

III. Cancellation/Office Hours

In the event that you will not be able to keep an appointment, you must notify us 24 hours in advance. If we do not receive such advance notice, you will be responsible for paying a $25.00 cancellation fee (not covered by insurance) at the discretion of your

therapist. Our offices are open during regular business hours and our voice mail system for leaving your therapist a message is available 24 hours a day.

IV. Emergencies

LifeDesign Behavioral Health is an outpatient facility. Our clinicians cannot assume responsibility for client's day to day functioning, as some more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the therapist upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please dial 911or go to your nearest emergency room, as we are not an emergency facility.

V. Social Networking

It is the policy of LifeDesign Behavioral Health that employees do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, and MySpace. This list is not exhaustive and applies to non-active and active clients for a minimum of two years after discharge.

My signature below indicates that I grant consent for LifeDesign Behavioral Health to provide psychological services and counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of *Client Rights and Responsibilities (pg.5-6)*, and *Crisis/Emergency Procedures (pg.22)*.

My signature also indicates that I have received information with which I can express any dissatisfaction.

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist Signature _____Date _____

VI. Insurance Assignment

I, the undersigned, have insurance coverage with _____ and assign directly to LifeDesign Behavioral Health all medical benefits. If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize LDBH to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions.

Client/Guardian Signature

_____Date_____

VII. To Parents of Adolescents

I understand the need for confidentiality between my son/daughter and his/her therapist and that confidentiality will be maintained unless the therapist determines that my son/daughter is a danger to self or others.

Parent/Guardian Signature

_____Date_____

Clients' Rights and Responsibilities Statement
Statement of Clients' Rights

*Clients have the right to be treated with dignity and respect.

*Clients have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

*Clients have the right to have their treatment and other client information kept private.

*Client treatment records may be released without client permission only if an emergency happens or if required by law.

*Clients have the right to easily access timely care in a timely fashion.

*Clients have the right to know about their treatment options. This is regardless of cost or coverage by the client's benefit plan.

*Clients have the right to share in developing their plan of care.

*Clients have the right to information in a language they can understand.

*Clients have the right to have a clear explanation of their condition and treatment options.

*Clients have the right to information about LifeDesign Behavioral Health, its practitioners, services and role in the treatment process.

*Clients have the right to information about clinical guidelines used in providing and managing their care.

*Clients have the right to ask their provider about their work history and training.

*Clients have the right to give input on this Clients' Rights and Responsibilities policy.

*Clients have a right to know about advocacy and community groups and prevention services.

*Clients have a right to freely file a complaint or appeal and learn how to do so.

*Clients have the right to know of their rights and responsibilities in the treatment process.

*Clients have the right to receive services that will not jeopardize their employment.

*Clients have the right to list certain preferences in a provider.

Statement of Clients' Responsibilities

*Clients have the responsibility to treat those giving them care with dignity and respect.

*Clients have the responsibility to give providers the information they need, so providers can deliver the best possible care.

*Clients have the responsibility to let their provider know when the treatment plan no longer works for them.

*Clients have the responsibility to discuss concerns about their care.

*Clients have the responsibility to follow the treatment plan

*Clients have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.

*Clients should call their providers with a minimum of 24 hours notice if they are not able to keep an appointment.

*Clients have the responsibility to pay their co-pay at the time of service and to inform the provider of any change in their insurance or required copay.

*Clients have the responsibility to openly report concerns about the quality of care they receive.

*Clients are ultimately responsible for payment should their insurance decline payment for any reason**.**

For New Jersey Only-- Statement of Client Rights (N.J.A.C. 10:37-4.5(b) & (h) 1-6

1. The right to be free from unnecessary or excessive medication.

2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice.

3. The right to treatment in the least restrictive setting, free from physical restraints and isolation.

4. The right to be free from corporal punishment. 5. The right to privacy and dignity.

6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

My signature below shows I have been informed of my rights/responsibilities and understand them.

Client_____ Date_____

Legal Guardian_____ Date_____

PSYCHIATRIC ADVANCE DIRECTIVE

On November 3, 2004, Governor Rendell (PA) signed into law Act 194, which allows you to create a Psychiatric Advance Directive for mental health care, usually used for inpatient treatment. This is a tool that helps you plan ahead for the mental health services and supports that you might want to receive during a crisis if you are unable to make decisions for yourself at that time. It allows you to document your decisions about your treatment before it is needed, for example, your choice of hospital, types of treatment and who should be notified. A blank copy of a Psychiatric Advance Directive may be available in the office you visit upon your request.

Psychiatric Advanced Directive Questions

Do you have a Psychiatric Advanced Directive? Yes ___ No____

If you do have one, will you provide a copy to TLP/LCS? Yes ___ No ___

If you want one, please ask for it from your psychiatrist or clinician.

Client signature_____ Date_____

Legal Guardian signature_____ Date_____

HIPAA PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

LifeDesign Behavioral Health is committed to protecting your information.

You have the right to inspect and receive a copy of your records.

All responses to requests for PHI will be limited to the minimum amount of information needed to accomplish the purpose of the request or disclosure.

LifeDesign Behavioral Health may use or disclose individual's Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act of 1996, for the purpose of conducting, planning and directing your treatment, making or obtaining payment for care, or otherwise allowed by HIPAA. We may use or disclose your PHI for purposes permitted or required by federal, state, or local law, for example, if we are court ordered, or we determine that you are a danger to yourself or others.

Also, it is mandatory that we report child abuse. Finally, you may give us permission to release your information.

We do not share your information with anyone for their own marketing purposes. For this reason we are not required to obtain and "opt-in election," or an "opt-out election."

The HIPAA Privacy Officer will receive questions or complaints with regard to the use and disclosure of PHI.

PATIENT DISCLOSURE AUTHORIZATION (HIPPA)

It is acceptable for you to leave information on the following phone numbers including appointment reminders: Ph#:_____ Ph#:_____

It is acceptable for you to speak with only the following family member(s)/friend(s) regarding my treatment:

Name: _____ Ph#:_____ Relationship:_____

Name: _____ Ph#:_____ Relationship:_____

I have read the HIPAA Privacy Policy and Patient Disclosure Authorization.

_____ _____

Signature Date

LifeDesign Behavioral Health

DEPRESSION SCREENING

Name _____ Male/Female Age_____ Date _____

Please write the appropriate response as felt during the past two to three weeks.

Feelings Never or Rarely(0) Sometimes(1) Often(2) Always(3)

____ I feel sad
____ I feel like a failure
____ I have lost interest in my work
____ I do not look forward to the future
____ I feel guilty
____ I have lost interest in my hobbies
____ I feel that others do not like me
____ I am unhappy with myself
____ I doubt my own judgment
____ I am easily frustrated
____ I wish I were dead
____ I feel lonely
____ I avoid being around people
____ My eating patterns have changed i.e. Overeating or loss of appetite
____ I have suicidal thoughts
____ I deserve to be punished
____ I have difficulty making decisions
____ I fell emotionally shut down
____ I feel worn out
____ I feel worthless
____ I am not interested in sex
____ I feel hopeless
____ I blame myself for other people's problems
____ I feel spiritually dead
____ I have difficulty paying attention

Total Scores

Sum Total of Scores _____

LifeDesign Behavioral Health
INITIAL SYMPTOM CHECKLIST

Name:_____

Today's Date:_____

Cell phone:_____

Email:_____

What is the reason(s) for coming to treatment at this time?
Describe
1---2 primary concerns.

_____
_____
_____
_____
_____

Please describe 1---2 goals you would like to achieve by coming to **LifeDesign Behavioral Health**

_____
_____
_____
_____
_____

Please rate the symptoms you have been experiencing in the **last week** on a scale of 0 to 3

Has not happened in the last week = 0
Has happened 1---2 days this past week =1
Has happened 3---4 days this past week =2
Has happened 5---7 days this past week =3

_____Sleeping **Less Than** 6 hours most nights
_____Sleeping **More Than** 10 hours most nights
_____Unable to get to sleep
_____Unable to stay asleep
_____Unable to get back to sleep

In **past month**---Please check ___
_____ decreased appetite (lost ___lbs) ____increased appetite (gained ____lbs)
_____Feeling anxious
_____Feeling overwhelmed
_____Feeling hopeless
_____Panic attacks

_____Sweating that is not due to exercise or heat
_____Sudden pounding heart
_____Sudden shortness of breath
_____Feeling dizzy or unsteady
_____Fear of losing control or going crazy
_____Fear of dying
_____Excessive worrying or obsessions
_____Fear of talking with others
_____Not wanting to leave the house
_____Fear of traveling in a car, bus, train, or plane
_____Feeling depressed
_____Thoughts of homicide
_____Thoughts of suicide
_____Isolating or avoiding interaction with others
_____Having negative thoughts about your future
_____Having negative thoughts about yourself
_____Having negative thoughts about your situation
_____Feelings of apathy or indifference
_____Feeling lonely
_____Being tearful
_____Feeling overly guilty
_____Feeling or thinking that you are worthless or don't matter
_____Thinking or feeling like you deserve to be punished
_____Having trouble remembering things
_____Having trouble concentrating
_____Feeling unable to go to work, school, etc.
_____Feeling unable to keep up with family and social life
_____Thoughts of hurting yourself
_____I have hurt myself by (____cutting _____substances _____ not eating
_____overeating_____purging) (check all that apply or describe other ways)
_____
_____Impulsive behavior
_____Thoughts ranging from great self---confidence to severe self-doubt
_____Feeling and thinking that you just don't need sleep
_____Being much more talkative or speaking faster than usual
_____Having irrational thoughts or fears
_____Engaging in compulsive behavior
_____Feeling confused
_____Feeling restless or on edge
_____Having mood swings
_____Having problems in relationships
_____Feeling irritable, angry or argumentative (circle all that apply)
_____Feelings of unreality or detached from oneself
_____Nightmares
_____Having racing thoughts
_____Restricting your food intake

_____Binging on food
_____Purging
_____Using diet pills, laxative or diuretics (circle all that apply)
_____Obsessing over food or counting calories
_____Weighing yourself
_____Having negative thoughts about your body
_____Avoiding eating around or with others
_____Exercising compulsively or excessively

TOTAL SCORE _____

Thinking about reasons you are seeking counseling services, which response(s) are true for you?

__ I am hoping this place will help me to better understand myself.

__ As far as I'm concerned, I don't have any problems that need changing.

__ I am already doing something about the issue that is bothering me.

__ I am not the one with the problem, so it doesn't make sense for me to be here.

__I have a problem and I really think I should work on it.

__ I worry that I might slip back on a problem I have already worked on, so I am here to prevent that from happening.

__ I thought that once I had worked on the problem I would be free of it, but sometimes I still find myself struggling with it.

Counseling is usually a process that takes place over time. Most counseling clients are helped when they attend weekly sessions for at least 6-8 weeks. How likely is it that you will come for weekly appointments?

1. Very unlikely. I doubt that I would attend on a weekly basis.
2. Somewhat likely. I am curious, but a little skeptical about the process.
3. Possible, though I might miss a few times.
4. Somewhat likely. I am pretty sure I would attend on a regular basis.
5. Very likely. I am fully committed to doing whatever it takes to address my concerns.

Choose a number: _____

INITIAL CLIENT INFORMATION
PERSONAL DATA INVENTORY

Client Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Business / Cell Phone: _____

Date of Birth: _____ Gender: M ____ F ____ Sexual Orientation _____

Occupation/School:_____

Relationship Status: Single __ Married __ Partner/Civil Union ___Separated ___

Divorced ___ Widowed ___

Who do you live with:_____

RELATIONSHIPS AND FAMILY INFORMATION (if appropriate)

Name of Partner: _____ Address: _____

Phone: _____Occupation: _____

Is your partner willing to come for counseling? Yes _____ No _____ Not sure _____

Have you ever separated? Yes _____ No _____ When? From _____ to _____

Have either of you ever filed for divorce? Yes _____ No _____ When _____

Date of Marriage/Union: _____ Any previous marriage/Union? No ___ Yes ___

When?_____

List children and ages (where do they live?)

_____

_____

_____

Please list 1-2 emergency contact people. Reasons to contact them include: Physical Health Emergency and/or Danger to Self. Please list their name and contact phone number:

_____

_____

_____

RELIGIOUS BACKGROUND

Denominational preference:

_____

Church attended in childhood:

_____

Religious background of spouse:

_____

Is faith an important part of your life?

_____

HEALTH HISTORY

List all important illnesses present or past, injuries, handicaps, or learning disabilities:

_____

_____

_____

Do you currently have, or have you ever had any of the following health problems?

High blood pressure ____ Yes ____ No Kidney disease ____ Yes ____ No

Heart disease ____ Yes ____ No Jaundice of liver ____ Yes ____ No

Stroke ____ Yes ____ No Anemia ____ Yes ____ No

Diabetes ____ Yes ____ No Thyroid/endocrine ____ Yes ____ No

Cancer ____ Yes ____ No STD ____ Yes ____ No

Asthma ____ Yes ____ No Ulcer/gastritis ____ Yes ____ No

Head injuries ____ Yes ____ No Epilepsy/seizure ____ Yes ____ No

Date of last medical exam: _____Family Doctor:_____

Phone: _____ Address: _____

List known allergies and negative reactions to drugs:

_____

_____

HISTORY OF PRESENT CONDITION

Why are you seeking treatment at this time?

_____

_____

_____

When did the problem first occur? Were there any precipitating events? Is this the first occurrence?

_____

_____

_____

CURRENT MEDICATIONS

Condition	Medication	Dose(mg)	Frequency	Duration	Compliant	Start Date	Effective
					Yes No		

PREVIOUS TREATMENT EXPERIENCE - Mental Health (MH) & Substance Abuse (SA)

*Level of care In-patient? Out-patient? Day Program? Intensive Outpatient (IOP)?

Date	Provider	Level of Care *	Duration	Condition (MH/SA)	Outcome

Do you have an individual therapist? If so, please provide his/her information.

Current Therapist Name: _____

Address: _____

_____

Phone: _____

Will you be returning to your current therapist? ____ Yes ____ No If not, why not

_____

_____

Do you have a psychiatrist? If so, please provide his/her information.

Current Psychiatrist Name: _____

Address: _____

_____

Phone: _____

Will you be returning to your current psychiatrist? ____ Yes ____ No If not, why not

_____

_____

_____

List Previous Medications:

_____

_____

_____

_____

SUICIDAL IDEATION

Is there evidence of suicidal ideation? Use the following scale and describe:

0=No 1=Yes 2=Suspected 3=Unknown

_____ Ideation

_____ Intent

_____ Plan

_____ History of violent behavior

_____ Need for physical restraint

HOMICIDAL IDEATION

Is there evidence of homicidal ideation? Use the following scale and describe:

0=No 1=Yes 2=Suspected 3=Unknown

_____ Ideation

_____ Intent

_____ Plan

_____ History of violent behavior

_____ Need for physical restraint

Describe your primary support (i.e. Spouse, Parent, Significant Other):

_____

_____

_____

What is the attitude of your primary support regarding treatment? □ N/A □ Supportive □ Willing to be involved □ Passively opposed □ Actively opposed

How is your situation affecting your relationships with family members?:

_____

_____

_____

_____

FAMILY HISTORY

Parental/guardian unit (nos. of parents): □ 1 parent (specify which one) ____ □ 2 parents

Siblings: # of siblings _____, birth order: _____

Type of relationship with family: □ Poor □ Fair □ Good

How would client describe childhood: □ Poor □ Fair □ Good □ Other

Socioeconomic status (class): □ Lower □ Middle □ Upper

Family history of illness:

Is there any history of mental health or substance abuse diagnoses in your family? _____Yes/No/Unknown

(If yes, place an X in the appropriate box below and specify mental health diagnosis, if known, e.g. depression, anxiety, alcoholism, etc.)

ABUSE ASSESSMENT *Check if any of the following apply*

As a child or adolescent, have you ever been abused: □ Physically □ Emotionally □ Sexually

As an adult, currently or ever have you been abused: □ Physically □ Emotionally □ Sexually

As an adolescent have you ever abused someone else: □ Physically □ Emotionally □ Sexually

As an adult have you ever abused someone else: □ Physically □ Emotionally □ Sexually

SOCIALIZATION

How and with whom do you spend leisure time?

_____

_____

_____

_____

Describe your strengths, needs, abilities, treatment preferences, interests and/or hobbies: _____

_____

_____

_____

_____

_____

_____

EDUCATION HISTORY

Dates	Schools attended	Performance	Degree obtained

Do you have any reading difficulties? ___ No ___ Yes If Yes, please describe_____

_____

_____

Is English your primary language? ___ Yes ___ No If No, please describe your primary language _____

Please describe any school problems or concerns:

_____

_____

_____

EMPLOYMENT/FINANCIAL SUPPORT STATUS

□ Occupation: 1=Unskilled (labor) 2=Semiskilled (service worker) 3=Not in labor force

4=Skilled (craftsman) 5=Manager/administrator 6=Clerical/office

7=Professional/technical

□ Employment pattern, past year: 1=Unemployed 2=Full time 3=Part time (irreg. Hrs.)

4=Part time (reg. hrs.) 5=Disability 6=Retired 7=Other:_____

Other sources of income (check all that apply):

□ Mate/spouse □ Family □ Friends □ Unemployment □ Welfare/public assistance

□ Illegal activity (specify) _____ □ Other

_____

EMPLOYMENT HISTORY *Most recent first*

Employer/job Dates Reason for leaving

To what extent does your current problem affect the following areas?

0=Not at all 1=Mild 2=Moderate 3=Severe Clarify if problems related to Psych,

Chemical Dependancy, or Dual DX

Voc/Ed _____ _____

Social/Envt _____ _____

Development _____ _____

Familial _____ _____

Behavioral _____ _____

Legal _____ _____

Financial _____ _____

Are you or do you anticipate being involved in any legal proceedings? ___ YES ____ NO

If yes, please explain:

_____

_____

_____

SUBSTANCE USE HISTORY

Have you ever used drugs before for purposes other than medical? __ Yes __ No If Yes,

please explain below:_____

_____

_____

Substance Date of last use _____
Amount Frequency and normal use _____
Current duration of frequency_____
Age at 1st use_____
Route*_____
____Alcohol
____Nicotine
____Cannabis
____Cocaine/crack
____Amphetamines:
____Ritalin/ Benzedrine/
____Methamphetamine/
____Benzodiazepines:
____Xanax/ Ativan/ Klonopin/
____Valium
____Sedatives/ hypnotic:
____Heroin/ Methadone/
____Percocets/ Darvocet/
____Oxycodone/ Codeine/
____Fentanyl/ Morphine
____Hallucinogens:
____LSD/ Mushrooms
____Barbiturates
____Inhalants
____Prescription meds:
____Other drugs:
* Route: 1=Oral, 2=Smoke, 3=Nasal, 4=Intravenous5=Intramuscular injection
How long was the most recent period of abstinence?
_____
Ever experienced any of the following withdrawal symptoms? ____Seizures _____
DT's _____ Hallucinations
Is there evidence of an addict living in the house? _____ (Y/N)
Do you have any non-chemically dependent social contacts who would be available to provide meaningful support during recovery? _____ (Y/N)
Do you currently smoke cigarettes? _____(Y/N) Have you in the past?_____(Y/N)
If Yes, Number of cigarettes daily _____ duration of use _____ years
Past cigarette use: Duration of use _____ year

Patient Care Communication Form

Physician's Name _____ Telephone Number _____

Address _____

Dear Doctor _____

Your Patient, _____ was recently referred by _____.

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: _____ Date of Next Appointment:_____

Diagnoses and/or presenting problems:

_____

_____

Treatment Recommendations:

_____

_____

Medications:_____

Please call if further information would be helpful.

Clinician's Printed Name _____ Phone #: _____

Address _____

Sincerely, _____

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 24 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, _____ hereby authorize _____

Patient's Name ***Print Treating Clinician's Name***

Please **Check One** - To release any applicable mental health information to my primary care physician

_____(PCP) named above.

_____To release any applicable substance abuse information to my PCP named above.

_____To release only medical information to my PCP named above.

_____Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that the action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

_____ _____ _____

Print Name of Patient or Guardian Date ID Number Date of Birth

_____ _____

Signature of Patient or Guardian Date Date

LifeDesign Behavioral Health

Financial Responsibility Agreement & Authorization to Release Information to Insurance Company

The LifeDesign Behavioral Health agrees to provide me outpatient services for a fee. In return, I agree to pay the amount agreed upon per session. I understand that payment is due at the time of service, and that my balance must be paid by completion of my treatment. If for any reason I am not able to make a payment, I will inform my therapist before treatment to discuss options.

Cash and personal checks are acceptable for payment. There is a $25.00 service charge for all returned checks. We can provide you with a receipt for fees paid if you would like. Check with your insurance company to determine if your coverage honors outpatient counseling provided by your clinician. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. By using insurance you are granting permission for us to communicate confidential information to your insurance company.

Any changes in your insurance plan or card numbers, **please call 856-304-0578 to update your information immediately.** I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Authorization to release Information to my insurance company:

My signature below indicates my permission for LifeDesign Behavioral Health to bill my insurance for payment. I give my permission to disclose information such as my diagnosis, my medication and dates I will be attending, as well as other pertinent information in order for my insurance company to grant authorization of my attendance.

_____ _____ _____ _____

Patient signature Date Clinician signature Date

_____ _____

Parent/Guardian signature Date

PAYMENT OPTIONS

_____ Personal Check _____ Cash

Crisis/ Emergency Procedure

LifeDesign Behavioral Health is dedicated to assisting you through difficult life transitions. However, we have limits in our ability to assist you. In particular cases, we do not offer crisis services, such as 24-hour hotline or emergency sessions after regular hours. This means we are typically unable to provide immediate responses to calls that come in after business hours. Please take the following steps if you find yourself in a crisis situation or struggling in such a way that requires immediate attention.

1) IF IT IS A MEDICAL EMERGENCY PLEASE CALL 911 FIRST.
2) Call the 24-hour crisis hotline in the country /city in which you reside. You can call 1-800-SUICIDE (784-2433) from anywhere in the U.S. toll free.

Pennsylvania
Easton 610-252-9060
Bucks County Upper 215-257-6551
Bucks County Central 215-245-2273
Bucks County Lower 215-785-3785
Centre County 1-800-643-3432
Chester County 610-918-2100
Norristown- Montgomery County 800-452-4189
Montgomery County 610-279-6100
Philadelphia 215-686-4420
Delaware County 610-447-7600 / 610-237-4210
Lancaster County 717-394-2631
York County 717-632-4900

New Jersey
Atlantic County 24 hours 609-344-1118
Burlington County 609-835-6180
Mercer County 800-273-8255
Camden County 856-428-4357
Gloucester County 856-845-9100

Delaware
From anywhere in state – toll free 800-262-9800
From anywhere in state - local 302-761-9100

Maryland
From anywhere in state 800-422-0009

3) Our office staff is available from 9am-5pm Monday through Friday.

Voice mail is available for you to leave messages at any time day or night.

4) For after hours emergencies, dial 911 or go to your nearest emergency room, as we are not an emergency facility.