Child and Family Counseling Center, LLC
Larry Fisch, MSW, LCSW
320 Raritan Ave., Suite 307A
Highland Park, NJ 08904

Patient Registration

****Confidential Information****

Today's Date:_____

Patient's Name _____

Patient's Date of Birth_____ Sex: M/F/Other (circle one)

Patient's Address_____

City_____ State_____ Zip_____

Phone (C): _____ Phone (H): _____ Phone (W): _____

E-mail:_____

Child's School_____

Marital Status: Single_____ Married_____ Other_____

Employment: Active/Other Student: Full-time/Part-time School_____

Employer:_____ Occupation:_____

Emergency Information:

Primary Care Physician:_____ Phone:_____

Name of Emergency Contact:_____ Phone:_____

Relationship to Patient:_____

Family Members and Ages

_____

_____

_____

Referral Source

_____

Billing Information

Primary Insurance Policy:

Patient's Relationship to Cardholder: Self Spouse Child Other (circle one)

Policy Holder's Name_____ DOB_____ M/F

Address_____

City_____ State_____ Zip_____

Phone (H)_____ Phone (W)_____

Employer_____

Insurance Company_____

Address_____

City_____ State_____ Zip_____

Phone_____

Policy #_____ Group #_____

Secondary Insurance Policy: Yes/No (If yes Complete)

Patient's Relationship to Cardholder: Self Spouse Child Other (circle one)

Policy Holder's Name_____ DOB_____ M/F

Address_____

City_____ State_____ Zip_____

Phone (C)_____ Phone (H)_____ Phone (W)_____

Employer_____

Insurance Company_____

Address_____

City_____ State_____ Zip_____

Phone_____

Policy #_____ Group #_____

Patient Information and Signature Sheet

Welcome to the practice. We hope you find our services helpful and that your experience here is both positive and constructive. It is important for you to be aware of our general procedures, which are explained below. Please read them over carefully, and sign and date where indicated. A copy will be provided upon your request. We work with families/individuals like you(rs), who experience personal, marital, and family difficulties. Counseling sessions are arranged by appointment, typically on a weekly or bi-weekly basis.

Confidentiality

We fully understand that you are addressing very personal and sensitive concerns and feelings. One of our primary objectives is that our staff treats this information with respect and holds it in strict confidence. The only exceptions to this rule are: 1) when a child is being abused, or 2) when someone's life is in danger. We would then work with other agencies to prevent endangering incidents and with all involved to resolve these potentially traumatic situations. By signing below, you are indicating that you fully understand and agree to these limitations on confidentiality as a condition of accepting counseling at Child and Family Counseling Center. In addition, to safeguard confidentiality, your signature indicates that you will not subpoena materials disclosed in counseling sessions for purposes of personal litigation against a spouse or other related persons.

_____ _____

Signature (Patient or Parent/legal Guardian if patient is a minor) Date

Fees

Payment is expected at time of service. All fees are determined based upon the services provided.

Insured Patients:
Copayments are determined by insurance.
Fees based on contracted rates, including copay and deductible if applicable.

Private pay / or non-insured Patients:

Initial appointment for psychotherapy (60 minutes)	$180
Psychotherapy session (45-50 minutes)	$130
Substance abuse evaluation and brief report (two 50 minute sessions)	$250

Completion of forms for schools or other agencies are billed at $30 per page.

- Full written reports are extra.

Comprehensive psychological reports for courts, DCP& P etc., will be billed at $60 per page.

❒ I agree to pay my fee after each session
❒ I understand that failure to pay for two sessions may result in discontinued service until the balance is paid in full.

My agreed-upon fee is _____ effective___/___/____

Please circle appropriately:

Insurance co-pay: Yes No

_____ _____
Signature (Patient or Parent/legal Guardian if patient is a minor) Date

Patient Bill of Rights

I have received, read, and understand this document.

_____ _____
Signed (Patient or Parent/legal Guardian if patient is a minor) Date

Financial Responsibility

I understand and acknowledge that I am financially responsible for all charges incurred during the course of my treatment at Child and Family Counseling Center, and should my account become delinquent, it may be forwarded to an outside collection agency.

_____ _____

Signed (Patient or Parent/legal guardian if patient is a minor) Date

Insurance Agreement

- I hereby authorize payment from my health insurance carrier directly to Child and Family and Counseling Center for services which would be otherwise payable to me.

- I agree to provide insurance information and complete my part of the claim form. I understand that failure to do so will make me responsible for the full fee.

- If my insurance company deliberately or erroneously mails a reimbursement check to me, I agree to endorse this check to Child and Family Counseling Center and submit a copy of the insurance company's explanation.

- I will report any changes in benefits to my treating clinician at Child and Family Counseling Center.

_____ _____

Signed (Patient or Parent/legal guardian if patient is a minor) Date

Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy practices.

_____ _____

Signature (Patient or Parent/legal guardian if patient is a minor) Date

Patient Bill of Rights

I have received, read, and understand this document.

_____ _____

Signed (Patient or Parent/legal Guardian if patient is a minor) Date

Cancellation Policy

All appointments are scheduled in advance. This time is set aside specifically for you. We adhere to a no less than 24 hour notice for cancellation (circumstances permitting). If you have not cancelled within this time frame, you will be charged the scheduled fee for the session. When courtesy confirmation calls are made, please be aware that they are exactly that. This is not an opportunity to cancel in less than 24 hours without being charged a missed appointment fee.

It is important for you to be aware, that a psychotherapeutic relationship is considered to be ongoing, until it is clearly ended, either verbally or in writing, by the client. If you have not specifically terminated services or made special arrangements, either verbally or in writing, and a period of 5 weeks has elapsed since you have last seen your therapist, we will consider your case to be closed. We would, however, like to remind you, that you may reinitiate the psychotherapeutic relationship at any time renegotiating terms of treatment with your therapist.

_____ _____

Signed (Patient or Parent/legal Guardian if patient is a minor) Date

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Thank you for your cooperation.