INSTITUTE FOR
PRACTICAL LIFE
"your place for psychotherapy and wellness"

328 Denison Street / Highland Park, NJ 08904
Phone: (732)610-5119 / Fax:(908)275-8073
Mailing address: P.O.Box 23 / Edison, NJ 08818
info@practicallifepsychotherapy.org
www.practicallifepsychotherapy.org

GENERAL INTAKE FORM AND PRACTICE POLICIES

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started we need to collect some general information from you. ***This form must be filled out before your first appointment.***

Jusleine Exprsessions, LLC, D.b.a. Institute for Practical Life, Highland Park, New Jersey, United States.

GENERAL INFORMATION (REQUIRED)

DATE:...../...../.....

How did you hear about us?.....

First name:.....

Last name: .....

Gender:..... Date of birth (mm/dd/yyyy):...../...../.....

Social security number:.....

Address:.....

City:..... State:..... Zip code: .....

Main phone:..... Secondary phone:.....

Email:.....

Services requested:.....

EMERGENCY CONTACT (REQUIRED)

First name:.....

Last name:.....

Phone:..... Email:.....

Relationship:.....

Do you authorize this person to discuss care or treatment with the office in the case of an emergency? YES / NO

Ⓧ ***Initial here to acknowledge you have read and understood the above statements:***.....

Ⓧ It must be acknowledged by your signature or your initials.

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WHAT TO EXPECT FROM COUNSELING

Counseling is an individually tailored process which is designed to assist you in dealing with your concerns, coming to a greater understanding of yourself, and using effective means of coping which utilize personal and interpersonal resources.
The counseling relationship usually involves sharing personal information with your counselor which may at times be sensitive, very private, or even distressing. Therefore, it is not uncommon during the course of counseling to feel somewhat more anxious or upset for a time. If you should feel this way, it is important to share this information with your therapist. While the outcome of counseling is most often positive, the degree to which any particular individual will reach their goals or achieve their desired level of satisfaction depends on the patient's particular situation.
At your Intake appointment (the first time you meet with your therapist), you and your therapist will review the concerns you came in to discuss and will consider these in light of your personal history and life experiences.
You and your therapist will clarify, in the first or second session, the goals of your counseling, and the options available to you, and create a plan for achieving your goals. If you have any questions, please ask. It is important that you feel comfortable about what you do with us here. Although we will make treatment recommendations, and we will try to be as clear as possible in explaining our recommendations, we want to emphasize that, unless it is an emergency, the decision about whether or not to proceed is yours. Please feel welcome to give us feedback on your experience here. We want it to be as helpful and positive as possible. We are not medical doctors and we do not prescribe medication.

CONFIDENTIALITY POLICY

Your privacy is important to us, and we believe that counseling is most effective when patients feel comfortable speaking openly with their therapist. We hope this information will clarify our privacy policies.
In the usual course of events, you have the right to keep your counseling here completely private. This means that, without your written permission, no information about your contact with Jusleine Expressions, LLC is available to anyone outside of the clinic.
Please ask us if you have any questions about this, as we want to be sure you are comfortable with our practices.
There are certain exceptions to confidentiality, noted below, with which you should be aware before you enter into a counseling relationship. Please read carefully through these exceptions, and be sure to ask your therapist if you have any questions.
Any professional colleague who wants to communicate about any patient is solely responsible for obtaining proper authorization from that patient for disclosure in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its accompanying privacy requirements.

EXCEPTIONS TO CONFIDENTIALITY

- *If you pose a threat of harm to yourself.*
- *If you pose a threat to another person.*
- *We will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening. This may include contacting your family and/or referring to our local Crisis Center.*
- *If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect.*
- *A court order, issued by a judge, could require us to release information contained in your records or could require a therapist to testify.*

CONSENT STATEMENT (REQUIRED)

I have read and understood the above information. I have been given the opportunity to ask questions and discuss any concerns about these matters. I understand the risks and benefits of counseling, the nature, and the limits of confidentiality.

Ⓧ ***First name:*** .....

Last name: .....

Date: .....

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*Release of Information (**MUST BE SIGNED** if you are using your insurance to cover your sessions).*

INSURANCE AND N.J. DEPARTMENT OF BANKING AND INSURANCE, ENTITY TO PROCESS MENTAL HEALTH CLAIM(S)

Insured's name (*please print*):

Insured's last name:

Insured's D.O.B.: Patient relationship:

Social security number:

Address:

Main phone: Secondary phone:

Insured employer's name:

Insured employer's adress:

Email address:

Patient's name (*if different from above*):

Patient's last name:

Patient's D.O.B.:

Patient's social security number:

Address:

Main phone: Secondary phone:

Email address:

AN IMPORTANT MESSAGE ABOUT INSURANCE COVERAGE (REQUIRED)

We file all insurance claims as a courtesy to our patients, however, your insurance policy reflects a contract between you and your insurance company. It is your responsibility to be familiar with your carrier and pay and co-pay or deductible required by your policy at the time of your visit. You are responsible for any charges not covered by your insurance policy. I understand that my eligibility for coverage by my insurance policy may not be confirmed at the time I wish to receive services. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payments of all services provided.

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (REQUIRED)

Authorization:

- *I understand that a copy of this form and enclosures may be sent to any party involved in recovering payment from your insurance, along with pertinent documentation, such as your Mental Health Assessment.*
- *I authorize the release of my medical records to my insurance and to the N.J. Department of Banking and Insurance or another entity involved in processing my claim for payment, including our affiliates, a company or a person, directly or indirectly, through one or more intermediaries, has common control, and managerial duties, such as, but not limited to Church of the Awakening Trinity, Inc.*
- *I authorize the release of my medical or other information necessary to process claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment to process the claim(s).*

Assignment of Benefits:

- *I authorize payment by my third-party payor (Insurance Company, Medicare/Medicaid, county, or other) or Credit Card to be paid directly to Jusleine Expressions, LLC for services rendered.*
- *I understand that I am financially responsible to Jusleine Expressions, LLC for charges applied to services provided, deductibles, co-pay, no-show, and for all charges limited by my third-party payer.*
- *I understand that a third party processing company will be used to process credit card payment, including, but not limited to, Paypal, Stripe or Square.*

Ⓧ ***Signature:*** ..... ***Date:*** .....

FINANCIAL AGREEMENT TO PAY / RESPONSIBILITY INFORMATION (REQUIRED)

First name: .....

Last name: .....

AGREEMENT TO PAY (REQUIRED)

I understand that I am financially responsible to IPL (Institute for Practical Life) for services rendered. I understand that having health insurance is not a guarantee that my condition is covered and that insurance payments will be made. I agree to pay the copayment, coinsurance, and any deductibles stipulated by my insurance plan. Payment is due at the time of my appointment. It is my responsibility to inform the IPL of any changes that affect the billing or charges to my account. This includes changes in any of my third-party payers, income, or family status. I understand that standard collection procedures will be followed if payment is not made. Collection procedures are managed by our affiliate, Church of the Awakening Trinity, Inc.

Ⓧ ***Initial here to acknowledge you have read and understood the above statements:*** .....

SERVICES, COMMERCIAL PRODUCTS AND CHARGES

To help our patients cover the cost of mental health services, we are in network with most commercial insurances:
Horizon Blue Cross Blue Shield of New Jersey; Cigna, Molina Healthcare Inc; United HealthCare, Optum, and many others. In addition we accept Medicare, and Horizon NJ Health (Medicaid). If you are covered by more than one health benefit plan, and you wish to use it, you should provide us with appropriate information.
Each commercial product has a dedicated mental health provider that we contract with to provide you with efficient, affordable mental health care. Note that we use ***Paypal, Stripe, and Square*** *as the main credit card processing companies.*

- ***Mental Health Evaluation:*** *$135.00 USD (45-60 minutes).*
- ***Mental Health Individual and Family Therapy:*** *$76.00 USD to $135.00 USD (A sliding scale is available. The patient is responsible to bring proof of income to determine eligibility) (30-60 minutes).*
- ***Art Therapy, Dance Therapy, and Couples Therapy:*** *$135.00 USD (60 minutes).*
- ***Group Therapy:*** *$65.00 USD and up (50 minutes).*
- ***On-Demand Programs and Workshops:*** *$65.00 USD and up.*
- ***Clearance Letters and Court Letters:*** *$65.00 USD and up.*

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- ***Service Dog Registration Certificate:*** *$75.00 USD (certificate + ID Card): $95.00 USD.*
- ***Community Plan:*** *$65.00 USD (30-45 minutes).*
- ***Life Skills Coaching:*** *$65.00 USD (30-45 minutes).*
- ***Recovery Program:*** *Provides up to five individual therapy sessions per week, 45 minutes each session $395.00 USD per week, and daily access, up to three times daily, to your therapist, via text messages for additional support (ask for details). We are not medical doctors and we do not prescribe medication.*
- ***Counseling Sessions:*** *Clients must pay for services at the beginning of each session. If a client is insured for mental health services and has a copay, the copay is due at the beginning of each session. A sliding scale based on the ability to pay for services is also offered for those clients falling into the low to moderate-income levels and for those clients that prefer not to use their mental health insurance. If the client chooses not to provide income verification, the client will be billed at $135.00 USD per session.*
- ***Cancellation and Missed Appointments:*** *Clients must cancel sessions 24 hours in advance, or they will be charged a flat fee of $65.00 USD for the missed session. Clients who cancel and /or miss three consecutive sessions, upon written notification, will be placed on the waiting list and will be given an outside referral.*
- ***Court Evaluations/Documentation:*** *The fee for document preparation is $280.00 USD. The evaluation fee must be paid before the release of the Court Evaluation Report. The fee for a simple one-page counseling letter is $30.00 USD.*
- ***Transferred or released records to outside agencies or persons:*** *A written, dated, and signed consent form must be obtained from the client or legal guardian prior to the release of the client's file. A service fee of $30.00 USD will be charged for records release, not to exceed ten pages.*
- ***Returned checks:*** *Clients are responsible for any bank fees incurred due to returned checks. A bank service fee of $65.00 USD per check will be charged to the client.*
- ***Account servicing fee:*** *All overdue invoices will be charged a 15 percent late fee, applicable to all past due accounts.*

Our payment terms are "net (10) ten days". Prices are subject to change without notice.
In the event that this account is placed with an attorney or collection agency because of an unpaid balance remaining on my account, I hereby agree and promise to pay a collection fee of $50.00 USD or 20% of the total balance due, whichever is greater, upon placement with an attorney or collection agency because of an unpaid balance remaining on my account.
Any refunds will not include any the transaction fees charged to use by the third this third-party credit card processor company, that includes a flat fee, and a percentage of the initial transaction.

Ⓧ ***Initial here to acknowledge you have read and understood the above statements:*** .....

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. *You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.*

Credit Card Guarantee: VISA / MC / DISCOVER / AMERICAN EXPRESS

Name on the card: .....

Account number: .....

Security code: ..... Expiration date (mm/yy): ...../.....

Billing address: .....

Apt.: ..... City: ..... State: ..... Zip: .....

Phone: ..... Email: .....

I, ... *, authorize Institute for Practical Life to charge my credit card above for agreed upon services. These charges include deductible costs or co-insurance / co-payments once the deductible has been met. I understand that my information will be saved to file for future transactions on my account.*

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INSTITUTE FOR PRACTICAL LIFE INFORMED CONSENT FOR TELEHEALTH SERVICES

Definition of Telehealth

Telehealth involves the use of electronic communications to enable IPL mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. *The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.*

2. *I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.*

3. *I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. IPL utilizes secure, encrypted audio/video transmission software to deliver telehealth.*

4. *I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.*

5. *I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.*

6. *I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.*

7. *I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and this will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.*

8. *I understand that my express consent is required to forward my personally identifiable information to a third party.*

9. *I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state of New Jersey.*

10. *By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area.*

11. *I understand that different states have different regulations for the use of telehealth.*

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PAYMENT FOR TELEHEALTH SERVICES

IPL will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage. We will bill your credit card on record for the session, if you do not have insurance. We will also bill your co-payments to your credit card on record. We will provide you with a statement of service to submit to your insurance company if you wish.

PATIENT CONSENT TO THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.
I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.
By my signature below, I hereby state that I have read, understood, and agree to the terms of this Intake form (document).

Print name: .....

Client's signature date: .....

Parent or guardian signature date: .....

TELEPHONE & EMERGENCY PROCEDURES

If you need to contact us between sessions, please leave a message at the answering service (908) 992-1493, and your call will be returned as soon as possible. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away, call Psychiatric Emergency Services at Rutgers Behavioral Health Care at Piscataway, NJ (800) 969-5300, or Call 911 right away.

SOCIAL NETWORKING POLICY

As per our professional, and ethical guidelines of our therapists do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and communicating via such sites can compromise their privacy and confidentiality.

Initial here to acknowledge you have read and understood the above statements: .....

TEXT MESSAGING, EMAIL AND PHONE CALL CONSENT FORM (REQUIRED)

Client information (please print)

First name: .....

Last name: .....

Address: .....

Main phone: ..... Secondary phone: .....

I. Risk of using text messaging, email and phone messages: *IPL offers clients the opportunity to communicate via voice messages, text messages, and emails.*
II. *Transmitting client information by voice messages, text messaging, or email has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:*

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a. Senders can easily misaddress a voice message, text message, or email.
b. Text messages and email messages are easier to falsify than handwritten or signed documents.
c. Text messages and emails can be intercepted, altered, forwarded or used without detection or authorization.
d. Text messages and emails can be lost in transmission.

III. Conditions for the use of text messaging, email and phone messages: We will use reasonable means to protect the security and confidentiality of email messages sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of text messaging and email communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. Consent to the use of text messages and email messages, includes an agreement with the following conditions:

a. Texting is not appropriate for urgent or emergency situations. Neither is emailing or voice calling us. Please call 911.
b.Texts should be concise.
c. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
d. Although our staff will endeavor to read and respond promptly to a text message, we cannot guarantee that any particular text message or email will be read and responded to within any particular period of time.
e. The client should not use text messaging or emails for communications regarding extra sensitive materials, including physical health issues, mental health diagnoses, and/or substance abuse issues. Note that we respond to our text messages, email communication, and voice messages between the hours of 9:00 am and 6:00 pm. Note that messages are responded to within 48 hours.
f. The client is responsible for protecting his/her password or other means of access. We are not liable for breaches of confidentiality caused by a client or other third party.

IV. Client acknowledgment and agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. I further waive any and all claims that may arise against Jusleine Expressions, LLC dba IPL resulting from the use or misuse of text messages, voice messages, or email messages.

Ⓧ ***Client signature:***.....

Guardian signature (if applicable):.....

Date:.....

NON-DISCRIMINATION POLICY

We do not discriminate against any patient concerning service quality or accessibility. We do not discriminate against any patient based on:

- *Race*
- *Ethnicity*
- *National origin*
- *Religion*
- *Sex*
- *Age*
- *Mental or physical disability or medical condition*
- *Sexual orientation*

DISCLOSURE FOR THE PROVISION OF SUPERVISED TREATMENT SERVICES

I have been informed that treatment services may be provided to me by a counselor intern, credentialed interned, or certified counselor, under the clinical supervision of a New Jersey Licensed Professional Counselor, as per N.J.A.C. 13:34-6.2 ©.
By signing this provision, I understand all of the above and consent to participate in the treatment and recovery process.

Client signature:.....

Date:.....

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GROUP THERAPY

In group therapy, it is of utmost importance that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

Initial here to acknowledge you have read and understood the above statements: .....

LIFE SKILLS COACHING INFORMED CONSENT

- *I understand that life coaching neither treats mental disorders nor conducts mental health evaluations.*
- *I understand that if my life coach detects or suggests that I suffer from a mental disorder or determines that I need to be evaluated for mental health concerns he/she should refer me to a licensed mental health practitioner.*
- *I fully understand that life coaching is not psychotherapy or counseling and that professional referrals will be given if needed.*
- *I understand that life coaching is not a substitute for counseling, psychotherapy, psychoanalysis, mental health care, or substance abuse treatment and I will not use it in place of any form of psychotherapy.*

Initial here to acknowledge you have read and understood the above statements: .....

COVID-19 POLICY (REQUIRED)

Due to the outbreak of the novel Coronavirus (COVID-19), our business is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfecting procedures in compliance with CDC guidance.
Symptoms of COVID-19 include:

- *Fever*
- *Fatigue*
- *Dry cough*
- *Difficulty breathing*

I agree to the following: *I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.*
I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the past 30 days.
I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the past 30 days.
I affirm that I, as well as all household members, have not traveled outside of the country or to any city considered to be a "hot spot" for COVID-19 infections within the past 30-days.
I understand that Jusleine Expressions, LLC cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each client. Our business is following these enhanced procedures to prevent the spread of COVID-19, as recommended by the CDC.
By signing below, I agree to each statement above and release Jusleine Expressions, LLC from any and all liability for unintentional exposure or harm due to COVID-19.
I herewith release and hold harmless Jusleine Expressions, LLC.

Ⓧ ***Patient signature:*** .....

Guardian signature (if applicable): .....

Date: .....

While the amount of people with COVID-19 has greatly reduced here in New Jersey, it is not over with, and we want to ensure the good health and safety of our patients and staff. If you have any questions about these procedures, please feel free to contact our office.

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ACKNOWLEDGMENT FORM (REQUIRED)

- ☐ *I acknowledge receipt of the Patient's Bill of Rights and Responsibilities (also available to you by visiting our website).*
- ☐ *I acknowledge receipt of the Grievance Policy and Procedures (also available to you by visiting our website).*
- ☐ *I have read the above General Intake Form and Practice Policies, a total of 10 pages. Jusleine Expressions, LLC reserves the right to modify the terms and conditions of this Agreement at any time by posting a revised version of this Agreement at www.practicallifepsychotherapy.org/practice-policy*
  My questions have been answered, and I understand and agree with its content. I agree to receive services under the outlined policies.

Print patient full name: .....

Patient's signature: .....

Date: .....

Print authorized representative full name: .....

Authorized representative's signature: .....

Authorized representative relationship: .....

Date: .....

The patient is unable to sign because: .....

Print witness full name: .....

Witness signature: .....

Date: .....

Revised: 06/14/2021