



Child and Family

— COUNSELING CENTER, LLC —

Larry Fisch, MSW LCSW

*Larry Fisch, LCSW
Child and Family Counseling Center, LLC
320 Raritan Avenue, Suite 307
Highland Park, NJ 08904
732-572-5300*

Patient Registration

Confidential Information

Today's Date: _____
Patient's Name _____
Patient's DOB _____
Gender Identity: _____
Patient's Address _____
City _____ State _____ Zip _____
Phone (H): _____ Phone (W): _____ Phone (C): _____
Child's School _____
Marital Status: Single _____ Married _____ Other _____
Employment: Active/Other _____ Student: Full-time/Part-time _____
Employer: _____ Occupation: _____

Emergency Information:

Primary Care Physician: _____ Phone: _____
Name of Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

Family Members and Ages

Contact Numbers

Fax: _____
E-Mail: _____
Emergency: _____

Referral Source

Name: _____
How are you connected to this person? _____

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 # _____

Social Security # _____

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 (H) _____ Phone (W) _____

Employer _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Phone _____

Policy # _____ Group # _____

Patient Information and Signature Sheet

Welcome to our group. 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 for your convenience. 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

Witness

Date

Fees

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

Initial appointment for psychotherapy (60 minutes) \$150

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 \$30 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.

Your fee is _____ effective date: _____ (Co-pay/ Sliding scale)

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

Witness

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

Witness

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

Witness

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 (full fee and/or the amount that would have been covered by insurance not just the co-insurance and or co-pay). 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 reinstate 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

Witness

Date

Thank you for your cooperation.