HEALING BRANCH COUNSELING
Brian P. Croak, MDiv, MS, LPC
1451 Route 88 Suite 4B, Brick, NJ 08724

License # 37PC0019200

Authorization for Counseling Services

Name:_____ Date of Birth: _____

Home address:

_____

_____

Home Phone: _____ Cell Phone:_____ Email:_____

Can I contact you at these numbers? Home ___Y___N Cell ___Y____N

Referred By: _____ OK to thank: ___Y ___N

Emergency Contact #: _____ Relationship: _____

Please briefly describe the problem(s) for which you are seeking assistance: _____

_____

_____

_____

How long have you been aware of the problem(s)? _____

Is there anything other information that may be relevant at this time: _____

_____

_____

Please check any additional concerns you are currently experiencing or have experienced:

Present /Past

_____ _____ Anxiety
_____ _____ Depression
_____ _____ Bipolar disorder
_____ _____ Sleep disturbance
_____ _____ Changes in appetite
_____ _____ Relationship (break up, conflict)
_____ _____ Relationship violence
_____ _____ Panic attacks
_____ _____ Shyness or Social Anxiety
_____ _____ Obsessive compulsive behavior
_____ _____ Phobia
_____ _____ Stress
_____ _____ Thoughts of suicide
_____ _____ Self-Injury (e.g. cutting, burning, banging head, etc.)
_____ _____ Difficulty concentrating
_____ _____ ADHD
_____ _____ Low motivation or energy
_____ _____ Severe mood swings
_____ _____ Loneliness
_____ _____ Disordered eating

Present/Past

_____ _____ Anger management
_____ _____ Family concerns
_____ _____ Traumatic event
_____ _____ Physical abuse
_____ _____ Sexual abuse
_____ _____ Recent death or loss
_____ _____ Legal/Judicial Affairs problem
_____ _____ Alcohol abuse
_____ _____ Marijuana use
_____ _____ Other drugs (e.g. methamphetamine, cocaine, etc.)
_____ _____ Health concern
_____ _____ Work-related concern
_____ _____ Identity problem
_____ _____ Religious or spiritual problem
_____ _____ Cultural concerns
_____ _____ Excessive video or online game use
_____ _____ Other:
_____

_____

Client Right to Confidentiality

What a client tells a mental health professional is private and kept confidential. This trusting relationship is the foundation for the treatment to work. There are times when the law supersedes confidentiality, such as: (1) you are a danger to yourself, (2) you are a danger to another person, or (3) these records are court subpoenaed. If such a situation does occur, I will fully discuss the situation with you before we do anything else, unless (in exceptional situations) there is a very good reason not to. Furthermore, if it is believed or suspected that a child, an elderly person, or a disabled person is being abused (by your neglect, assault, battery, or sexual molestation) a report must be filed with the appropriate state agency. A minimal amount of information would be given in such an instance and only that information that is pertinent to keep the other individual protected. Beyond the aforementioned limitations, any information you would like revealed to another party, i.e. another mental health professional, doctor, attorney, etc., would be released only after you have completed a "Release of Information Form".

If you are using insurance to pay for part or all of your treatment, they may request information in order to continue payment. Generally, this is administrative information, diagnosis, patient status, reason for continuation of treatment, and prognosis. Similarly, if you have been referred by your employer or your employer's Employee Assistance Program, I may have to give them some information.

If your account is unreasonably overdue(unpaid), I can use legal means to get paid. The only information given to the court, a collection agency, or a lawyer would be your name, address, the dates we met "for professional services" and the amount overdue.

In cases where I treat several members of a family, the confidentiality can become more complicated. In couples' counseling the couple together is identified as "the client". Important information divulged by one party that could be detrimental to the other party or to the common good of both will not be held confidential from the other party, if such is the case.

I have read and understand the above information and have discussed any questions I may have with my therapist. Additionally, I have received a copy of the NJ Duty to Warn Law that was amended 06.13.18 and have read and understood the contents thereof.

_____ _____

Client, Parent or Guardian Signature Signature of Therapist

_____

Print Client's name

Consent for Treatment

Counseling with a professional counselor is a collaborative effort to better your quality of life. During treatment, personal and private information may be discussed, and, at times, may trigger intense feelings or discomfort. Furthermore, issues may surface during treatment that neither you nor I had anticipated. Should this occur, I will make every reasonable effort to support and guide you through these periods. I may also refer you to additional qualified professionals should I believe this is indicated.

I hereby authorize Brian P. Croak, (MDiv, MS, LPC) to perform counseling/psychotherapy to the address the problem(s) for which I am seeking assistance. Although, Brian P. Croak, (MDiv, MS, LPC) is appropriately qualified and licensed, with my signature below I acknowledge that no claims of guarantee of success have been made to me. I understand the confidentiality agreement and no information regarding my treatment to anyone, unless a consent is provided that will authorize the release of information to a specific third party.

If I am signing this contract on behalf of another individual (for example, minor child), I certify with my signature below, that I am the person's legal parent or guardian and that I have the legal authority to authorize Brian P. Croak, (MDiv, MS, LPC) to perform services. I understand that if I do not have the legal authority to provide such an authorization, I am committing fraud and I will be legally and financially responsible for any and all damages that may arise as a result.

With my signature below, I certify that I understand, and I agree to abide by all of the above provisions, terms and conditions.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Print name of client/parent/guardian

Financial Policy

Having a thorough understanding of your financial responsibility for treatment is essential before beginning treatment. Several things for you to keep in mind before we enter this relationship.

1. Knowing your insurance coverage, including deductibles, copayments, coinsurance, pre-authorization and anything else pertaining to your insurance coverage is **YOUR** responsibility.
2. At no time can I wave any co-payments as per my contract agreement with your insurance carrier because they prohibit any such arrangements.
3. At no time will I agree to commit any kind of insurance fraud in order to lower your out-of-pocket costs or for any other reason.
4. If you are not using insurance, **payment in full is expected at time of services**.
5. The cost of service for an initial intake session is $150. After the initial session, a full counseling session (50 minutes) is $140. A half session (30 minutes) is $60.
6. Letter writing will be a minimum of $50.
7. A cancelled appointment with less than 24-hour notice will be billed to your credit card on file for $60.
8. **All payments are due at time of service. A balance will not be carried over at any time.** Therefore, a current credit card (Amex, Discover, Visa or Mastercard) must be entered below. By signing below, you are signing that you understand **you will not be notified** when your credit card is being charged for any outstanding balance.
9. Please ask any questions for clarifications if there is any part of this financial agreement that you do not understand.

Credit Card Information:

Card #_____ Expiration Date: _____

Zip Code _____

Signature for approving credit card charges _____

Insurance Information

Primary Insured _____ (same as client) _____

Birthdate _____

Address _____

City_____ State_____ Zip Code_____

Carrier Name _____

Group Number _____

Policy Number _____

Relationship to Insured: Self Child Spouse Other

I, the undersigned, have provided accurate insurance information. I fully understand my benefits and know that I am responsible for all copayments and any payments denied by insurance. I also will be responsible for obtaining any referrals or authorizations prior to my first session, if necessary. In order to use insurance benefits, I have provided a credit card to be kept on file and charged for copayments or denied coverage.

_____

(Client Signature and Date)

_____

(Print Name and Date)