Triangle Psychotherapies & Consultation, LLC

Triangle Registration Form

Date: _____

Patient's Full Name: _____ **M F SS#:** _____

Home Address: _____ **City, State, Zip:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____ **Business ( )** _____

Email: _____

DOB: _____ **Age:** _____ **Referred By:** _____

Full Name of Spouse: _____ **Phone Number: ( )** _____

Family Physician: _____

Person to Contact in Case of Emergency: _____

Insurance:

Insurance Company: _____ **Insurance ID#:** _____

Customer Service Phone: _____ **Group #:** _____

Insurance Policy Holder Information:

If Same Information as above, Check here: _____

Full Name: _____ **Relationship:** _____

Home Address: _____ **Home Phone: ( )** _____

Occupation: _____ **Employer:** _____

Business Phone Number: ( ) _____ **SS#:** _____ **DOB:** _____

Medication Currently Taken by Client:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Known Adverse/Allergic Drug Reactions: _____

I acknowledge the above listed medication and information is complete and correct.

_____ _____

Signature **Date**

_____

Signature of Parent/Guardian

Triangle Psychotherapies & Consultation, LLC

How were you referred to our office?

☐ Physician ☐ Co-Worker ☐ Family ☐ Hospital ☐ Therapist ☐ Internet ☐ Friend

☐ Other_____

Presenting Symptoms: What physical or emotional symptoms brought you here today?

Current Stressors: Are there significant changes in your life, which may have contributed to the symptoms?

Previous Psychotherapy/Medication History:

1164 Raritan Avenue – Highland Park, NJ 08904
Website: http://triangle-psychotherapy.com/
732-284-3845

Triangle Psychotherapies & Consultation, LLC

Below you will find essential information about our practice, fees, confidentiality, cancellation policy, psychotherapy and psychoanalysis. Please read and sign at the bottom to indicate that you have reviewed this information.

Consent for Treatment: By signing this document you are authorizing the agents of Triangle Psychotherapies & Consultation, LLC to render appropriate treatment and mental health services to you.

Length and frequency of treatment: Psychotherapy and psychoanalysis typically involves regular sessions, usually fifty minutes in length. Duration and frequency vary depending on the nature of your concerns and individual needs.

Confidentiality: Information you share with me will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are put at risk (e.g., sexual or physical abuse or neglect). In order to assure that we provide you with the best treatment, we will often consult colleagues, in and outside of our practice, to discuss your treatment; and this is always done by careful disguise of identifying information, including use of a pseudonym.

Fee policies: The fee for an individual therapy session is _____ and payment is due at the end of each month. You are responsible for filing insurance claims. You will need to send invoices to your insurance company for reimbursement. You should make monthly payments to Triangle Psychotherapy & Consultation, LLC.

Phone and emergency contact: If you need to contact me by phone, do not hesitate. When not available, you can leave a message on voice mail at_____. You will not be charged for phone calls unless we have a scheduled conversation of an information-exchanging or problem-solving nature that lasts more than ten minutes. Phone sessions will be indicated on receipts. If you cannot reach us in an emergency, you can find help at the Emergency Services number of your local hospital.

Authorization to Release to Insurers: You authorize Triangle Psychotherapies & Consultation, LLC to release all patient information about you to 1) any insurance company or third party payer providing coverage for services rendered by Triangle Psychotherapies & Consultation, LLC , 2) any representative or agent of Triangle Psychotherapies & Consultation, LLC, and 3) any medical review agency provided, however, that any such disclosure shall be limited to information reasonably necessary to discharge the contractual or legal obligations of the person to whom, or the entity to which the information is released.

Release of Information: Information discussed in the therapy setting is held confidential and will not be shared without your written permission. However, STATE LAW may not protect information regarding threats of suicide or harm to another person, suspected child or elder abuse, or neglect or sexual exploitation from being reported to the appropriate state agency by a therapist.

Triangle Psychotherapies & Consultation, LLC

Guarantee of Payment: By signing the document, you hereby agree to guarantee payment for services rendered. In consideration of the services to be rendered, you agree to be jointly and individually obligated to pay the account of Triangle Psychotherapies & Consultation, LLC.

Physician contact: Physical and psychological problems often interact. We encourage you to seek medical consultation if warranted. When appropriate, we will arrange a referral for medication evaluation.

Cancellation Policy: If you fail to cancel an appointment within 24 hours you will be charged the full fee.

Patient Rights: You have the right to treatment regardless of race, creed, color, religion, or national origin; the right to treatment of the highest professional skill that can be provided; the right to a full understanding of the nature and goal of the treatment program; the right to refuse or terminate treatment at any time and in the event such a decision is made, you will be informed of the potential clinical consequences of refusal and every effort will be made to offer an alternative referral; you have the right to a statement of the cost of treatment.

Informed consent: I have read and reviewed the above and give consent for services. I understand the risks and benefits of the proposed treatment plan, in contrast with other forms of treatment or no treatment, and elect to proceed with the proposed service plan. I have had an opportunity to ask questions, and I agree to enter a professional psychotherapy relationship with_____.

_____ _____

Print Patient's Name Signature of Insured

_____ _____

Signature of Patient Signature of Legal Guardian

_____

Date

Triangle Psychotherapies & Consultation, LLC

Coordination of Care between Health Care Providers and Release of Information

Communication between mental health providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow Triangle Psychotherapies and Consultation, LLC and your therapist, _____ to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Authorization:

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentially of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

☐ I hereby refuse to give authorization for any release of information.

☐ I agree to give authorization. **(COMPLETE SECTIONS BELOW)**

_____ Is authorized to release protected health information related to the
(Provider Name- Please Print)

evaluation and treatment of _____ _____ _____
(Member Name) (Member ID#) (Date of Birth)

PCP Name: _____ PCP Phone: _____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply)

__ Psychological eval/testing results __ Medication Records __ Substance Abuse treatment record

__ Laboratory/diagnostic testing results __ Behavioral health/psychological consult __ Psychosocial Assessment

__ Discharge summary __ Psychiatric evaluation __ Summary of treatment records & contract dates

__ Other

_____ _____
Signature of Patient. Parent. Guardian or Authorized Representative. Date
(If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law.)

Triangle Psychotherapies & Consultation, LLC

Email/Texting Informed Consent Form

1. Risk of using email/texting The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court. g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name: _____
Client signature: _____ Date:_____

Parent/Legal Guardian name: _____
Parent/Legal Guardian signature: _____ Date: _____

Provider name: _____ Provider signature _____ Date _____