D Waters and Associates LLC
37 Village Court
Hazlet NJ 07730
732-334-8138

Welcome to our practice.
This form requests information about your needs and informs you of our services and policies. Please complete to the best of your ability. The questions on the following pages are designed to help us best meet your treatment needs.

Client's Name:_____
Cell Phone Number:_____ Email Address: _____
Permission to leave voice mail/text/send email: Y N
Address:_____
Date of Birth:_____ Age:_____ Last 4 Digits of SS#:_____
Relationship Status: _____ Identified pronouns: _____
Credit Card Number: _____
If you would like the office to send 1500 to your insurance for out of network billing, please note your Mental Health Plan and ID Number :_____
Primary Care Physician and phone number:_____
Permission to contact Physician: ☐ Yes ☐ No

Please list other members living in your household:
Name: Relationship: Age:
_____
_____
_____
_____

If We Need to Contact Someone about You
If there is an emergency during our work together, or our staff becomes concerned about your personal safety, the law requires that someone close to you is contacted—perhaps a relative, spouse, or close friend. We are also required to contact this person, or the authorities, if we become concerned about you harming someone else. Please write down the name and information of your chosen contact person in the blanks provided:

Name: _____
Address: _____
Phone: _____ Relationship to you:_____

Please explain your reasons for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:_____
_____
_____
_____

Please indicate how /if the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Impact	Mildly Impact	Moderate Impact	Significant Impact
Marriage/Partner/Relationship	1	2	3	4
Family	1	2	3	4
Job/School Performance	1	2	3	4
Friendships	1	2	3	4
Financial Situations	1	2	3	4
Physical Health	1	2	3	4
Anxiety level/Nerves	1	2	3	4
Mood	1	2	3	4
Eating Habits	1	2	3	4
Sleeping Habits	1	2	3	4
Sexual functioning	1	2	3	4
Alcohol/Drug usage	1	2	3	4
Ability to concentrate	1	2	3	4
Ability to control your temper	1	2	3	4

What results do you expect from treatment?

Have you ever sought mental health treatment before? Please list dates, provider names, and the issue for which treatment was sought in the past:

Confidentiality:

All information between provider and client is confidential unless:

1. The client authorizes release of information with her/his signature.
2. The client presents a danger to self.
3. The client presents a danger to others.
4. The welfare of a child or an elder is endangered, which includes alcohol and drug dependency in the presence of children.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Agreement to Pay for Professional Services

Fees, Payments, and Billing: For Dr. Waters, intake evaluations and therapy sessions are billed at $395.00 a session. Fees are the same for telehealth services. For Dr. Matsen, intake evaluations and therapy sessions are billed at $200.00 a session. For post-doctoral fellows, intake evaluations and therapy sessions are billed at $125.00. Please upload your credit card information to the Square invoice after your first session or make payment at the beginning of the session in the form of cash or check. Other payment or fee arrangements must be worked out before the end of our first meeting. Returned checks occasion a $25.00 fee.

Cancellation Policy: A scheduled appointment means that time is reserved for only you. If an appointment is missed or cancelled with less than 24 hours' notice, you will be billed $100.00. Please make arrangements for payment prior to scheduling your next appointment. If you cancel three or more consecutive sessions, have not attended a session over a three week period without prior discussion, and do not respond to outreach, your case will be closed.

Telephone Consultations/Letters and Supportive Documents*:* Telephone consultations that are not related to scheduling appointments are charged at the regular fee, prorated over the time needed. I understand that one clinical hour of therapy is approximately 45 minutes. I understand that letters and supportive documents written on my behalf will be billed to me prorated to the same rate as a clinical hour of therapy. We do not participate in disability claims nor any type of litigation.

Emergency Procedures: If you need to contact us, leave a message according to the instructions on the voicemail and your call will be returned. If you have a behavioral or emotional crisis, please call Dr. Waters's cell phone at (732) 581-4657. In case of a psychiatric emergency, you or your family members should call 911, a crisis worker at 732-776-4555, or go to the closest hospital emergency room. Please tell the emergency worker to contact Dr. Waters. Please be advised that phone calls are not answered during therapy sessions. You can always leave a message and calls will be returned as soon as possible.

Release of information: I authorize the release of information regarding my care to my health plan for the payment of out of network claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan. I reviewed HIPPA rules and regulations.

Telehealth Services: There is always a risk electronic communications can become compromised and both the office and clients will take steps to ensure the security of our communications by using secure networks for telepsychology sessions. If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call Dr Waters or your therapist back; instead, call 911, or go to your nearest emergency room. Call your therapist back after you have called or obtained emergency services. If the session is interrupted and you are not having an emergency, disconnect from the session and then you will be contacted you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, please text 732-581-4657. If there is a technological failure and it is not possible to resume the connection, you will only be charged the prorated amount of actual session time.

My Rights as a Client:

1. I have the right to decide not to begin therapy at D Waters and Associates LLC. I can ask for the names of referrals for other psychologists.
2. I have the right to end therapy at any time. The only thing I will have to do is to pay for any treatments I have already had.
3. I have the right to ask any questions, at any time, about the therapeutic process.
4. I have the right not to allow the use of any therapy technique.
5. I have the right to confidentiality.
6. I have the right to review my records at any time, to add to or correct them, and to get copies for other professionals to use.

Post Doctoral Fellows: I understand that post doctoral fellows at D Waters and Associates LLC are not yet licensed in the state of New Jersey, and that they receive weekly supervision from Dr Waters. All information will be keep confidential.

I understand and agree to all of the above information and my signature indicates my consent for treatment at D Waters and Associates LLC.

_____

Client (or Parent/Guardian) Name- Printed Date

_____

Client (or Parent/Guardian) Name- Signature Date