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: Single Married Domestic Partner Widowed Separated Divorced
Occupation: ___________________ Full Time Student ☐ Yes ☐ No
Mental Health Plan and ID Number : ____
Co-pay:______________________ Number of Sessions Authorized:_____________
Authorization Number:____
Primary Care Physician and phone number:__________________________________
Permission to contact Physician: ☐ Yes ☐ No
If no, please explain why:____

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

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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 are charged at $200.00. For a session of individual therapy, which is 45 minutes, the fee is $175.00. For post doctoral fellows, intake evaluations are charged at $100.00. For a session of individual therapy, which is 45 minutes, the fee is $100.00. Please pay for each session at the beginning of the session in the form of cash, check or credit card prior to each session begins, so that our time will be used best. Other payment or fee arrangements must be worked out before the end of our first meeting. Returned checks occasion a $25.00 fee.

Extended Sessions: Sessions that are extended beyond 10 minutes will be charged on a prorated basis.

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 directly billed $75.00. Please make arrangements for payment prior to scheduling your next appointment. Your health plan does not cover payment for missed or cancelled appointments. 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 ($175.00). Insurance plans do not reimburse for telephone sessions, collaboration with other professionals, and/or written supportive documents.

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 claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan. I reviewed HIPPA rules and regulations.

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.

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Client (or Parent/Guardian) Name- Printed Date

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Client (or Parent/Guardian) Name- Signature Date