Trinity Counseling Service

353 Nassau Street
Princeton, New Jersey 08540

Phone: (609) 924-0060
FAX: (609) 924-7436
www.trinitycounseling.org

Whitney B. Ross, EdM, PhD
Executive Director

Peggy Grauwiler, PhD, LCSW
Director of Clinical Operations

Application for Counseling

Personal Information

Name _____
Social Security # _____
Billing _____
Address _____
_____

Physical Address if different from above:
_____
_____

(*P.O. Box is not acceptable, or if you reside on campus please provide a dorm or campus location*)

Date _____
Date of Birth _____
Contact Telephone Numbers
Home _____
Work _____
Cell _____
Please indicate preferred contact # 9-5 Mon.-Fri.
____*Please initial if you agree to receive text messages*

____*Please initial if you agree to allow your minor child to receive text messages.*
Email _____

Marital Status _____ **Name of Spouse** _____

Dependents:
Name _____ *Relationship* _____ *Age* _____
Name _____ *Relationship* _____ *Age* _____
Name _____ *Relationship* _____ *Age* _____
Name _____ *Relationship* _____ *Age* _____

Person to contact in case of Emergency
Name _____ *Relationship* _____
Telephone _____

Primary Care Physician
Name _____ *Telephone* _____
Address _____

May we contact your primary care physician if necessary to coordinate care? ☐Yes ☐No

Have you or a member of your family ever been seen at TCS? ☐ Yes ☐ No

How did you hear about Trinity Counseling Service? _____
What is your reason for seeking counseling? _____
_____

TCS Therapist _____

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Employment Information

Applicant Occupation _____ Employer _____
Spouse Occupation _____ Employer _____

The state of New Jersey, in regulation #***NJAC 10:37-6.74(a)5,*** requires that we ask the following questions:

1. Do you have an Advanced Psychiatric Directive? _____
2. If so, where is the Advanced Psychiatric Directive kept? _____
3. Would you like to be provided with information on advanced directives? _____
4. Do you desire to have an Advanced Psychiatric Directive? _____

Fees

Trinity Counseling Service is a non-profit agency supported by the people it serves. Our policy is that no person will be turned away due to an inability to pay our standard fees. Limited financial assistance is available for those who need financial aid. Our standard fee per session (including the intake session) is $155.00.

If you require financial assistance, please check here ☐and agree to the statement below.

By initialing below, I agree to provide my most recent tax return to TCS for the purpose of determining my Sliding Scale/Financial Aid payment. I understand that the fee is determined based upon my household income and family size. I understand that it is my responsibility to continue to provide updated tax return and/or relevant financial information as it changes or becomes available.

Initial here: _____

If you come to us through a Managed Care Organization, please:

1. Verify your co-pay with your Insurance Provider. This will be the amount due for each session and is payable at the time of each session.
2. If you have a coinsurance obligation (see below) you will need to pay this at the time you receive your Explanation of Benefits (EOB) from your insurance.
3. Complete the TCS release of Information form.

If you are utilizing insurance, please check here ☐ and agree to the statement below.

By initialing below, I agree to provide my insurance card to TCS and to continue to provide the most up-to-date insurance information to TCS for the purpose of payment for service. I understand that by initialing here I am giving TCS and/or an outside billing agent, working as a business associate of TCS, permission to bill my insurance carrier for the services I receive.

Initial here: _____

Name of Insurance Company _____ Relationship to Client: ☐Self ☐Spouse ☐Parent
Name of Insured _____ Date of Birth of Insured _____

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Appointments

The staff and clinicians of Trinity Counseling Service will make every effort to arrange appointment times that are convenient for you. Specific hours vary by clinician, but are generally during normal business hours. Appointments at other times may be available.

In the event that you must cancel an appointment, please contact your clinician directly, at least 24 hours in advance. Failure to give adequate notice of cancellation or failure to show up for appointments may result in a $50 "No Show/Late Cancel" fee.

Trinity Counseling Service is strictly an out-patient facility. Our business and administrative offices are open Monday-Friday 8:30am- 8pm. Messages left at the front desk are not retrieved at other times. Your therapist should be contacted directly whenever possible. In the event of an emergency, **please dial 911 or go to your nearest emergency room.**

Client Informed Consent Agreement

- I have received a copy of the Client Information Brochure, including my legal and ethical rights and responsibilities.
- I understand that if I have questions about my therapy or about any of my rights or concerns, I can talk with my therapist, the Director of Clinical Operations and/or the Executive Director at any time.
- I understand that I may revoke my informed consent at any time, for any reason.
- I understand that laws regulating the client-therapist relationship provide that the following topics of information cannot be considered confidential:
    1. Threats against the physical well-being or life of another person.
    2. Abuse or neglect of children or the elderly.
    3. Suicide threats or actions.
    4. Other legal reasons where the law requires my therapist to disclose confidential information.
- I understand that I may terminate this therapy relationship at any time. I also realize that my therapist can determine that the relationship is no longer a good *therapeutic* fit and would at that time provide me with referrals to other treatment professionals if I so request.
- I understand that if I choose to use insurance, specific information required by my managed care or insurance company or their business associates will be provided to them so that I may use my insurance benefit.
- **I understand that my signature below indicates that I will not seek to subpoena material disclosed in counseling sessions for the purpose of litigation.**
- *I understand that* ***I am responsible for knowing the terms of my fee*** *and what I am responsible for paying for the service I am provided, and* ***agree that I will pay these obligations to TCS****.*
- *I understand that TCS clinicians and staff are* ***only available during normal business hours****. If I am experiencing an emergency, after hours, on a weekend, or on a holiday, I will go to my nearest emergency room.*
- *I understand that TCS uses an authorized, certified billing service and agree to allow TCS to release any protected health information required for insurance and billing purposes.*

I have read, understand, and agree to the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

Counseling Service
Transforming lives, one at a time
50TH ANNIVERSARY

Telemental Health Informed Consent

I _____, (name of client) hereby consent to participate in telemental health with _____ (name of provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.
In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____ Date _____

Signature of therapist _____ Date _____

3/2020