Jill Essery, LCSW LLC
New Client Intake Form

Information you provide here is protected as confidential information.

TODAY'S DATE: _____

Name: _____

Birth Date: _____ /_____ /_____ **Age**:

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home: __ __ __ - __ __ __ - __ __ __ __
Cell: __ __ __ - __ __ __ - __ __ __ __

Best number to reach you? Home or Cell

May I leave a message? Y N

E-Mail: _____

How Did You Find My Service: _____

Medicare ID: _____

Effective Date: _____

Group #: _____

Status & Employment:

I am:

Single Divorced Other

Married Widowed

I am:

Employed Full Time Self Employed Retired

Employed Part Time Unemployed Student

Emergency Contact Info:

Notify:

Phone:

Relationship to Client:

Psychiatric History:

Are you currently receiving psychotherapy from anyone else?

Have you had previous psychotherapy: Yes No

If Yes, approximately when?

Please list any psychiatric medications you are currently taking (anti-depressants, anti-anxiety, sleep aide):

Psychiatrist Name and Phone #:

Are you interested in group therapy? Yes No

Who are your supports:

Personal and Family History:

Have you or a close relative ever been hospitalized for a psychiatric illness? Yes No

Does anyone in your family have depression, anxiety, or other mental illness? Yes No

Have you or anyone in your family ever attempted or committed suicide? Yes No

Do you or anyone in your family have a substance abuse problem? Yes No

Have you ever been arrested? Yes No

If yes, to any of the above questions, please briefly explain:

Current Concerns:

Please describe what concerns brought you in today:

How long have you been feeling this way?

Please indicate if you've previously been in treatment and know your diagnosis:

Have you experienced any significant stressors in the past year or so (loss, birthday, moves, hospitalizations, illness, financial problems, etc.)

Please describe any significant history of trauma you have experienced:

Please indicate any goals you have for psychotherapy at this time:

Symptom History:

How is your physical health at present? Please circle:

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (chronic pain, headaches, etc.)

Are you having problems with sleep? (Sleeping too little, too much, broken sleep, poor quality)

Please Circle any of the following issues causing you concern:

Depressed	Anxious	Rapid Breathing/Panic	Sleep Disturbance
Hopelessness	Fear	Restlessness	Poor Concentration
No Motivation	No Energy	Lack of Interest/joy	Tearfulness
Feelings of Failure	Irritable/Agitated	Poor/over active appetite	Racing Thoughts
Suicidal Thoughts			

Jill Essery, LCSW LLC
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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of patient: _____

Date of Birth: _____/_____/_____

Name of parent/guardian if patient is a minor child: _____

The above named individual hereby authorizes Jill Essery, LCSW to communicate with the individual and/or institution listed below:

Name of provider/person: _____

Contact address: _____

Contact telephone: _____

Contact fax: _____

Purpose of disclosure:

☐ School-related ☐ Employment-related ☐ Legal

☐ Coordination of Care with Professional Provider

☐ Other (describe): _____

I understand this grants permission to the individual named to both obtain and/or release verbal information and/or written records, which may be relevant to the current evaluation of the patient(s) or their families. The released information may include information regarding the diagnosis and treatment of any mental health of substance abuse problem including psychotherapy notes or any educational records and information. I understand that this consent may be revoked in writing by me at any time by giving such notice to both the above-named and the recipient of the information named in this authorization. However, such revocation will not be effective to the extent that Jill Essery, LCSW LLC and the professionals or institutions named above have already taken action in reliance of this authorization. A photocopy or facsimile of this release shall be valid as the original.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Provider Signature: _____ Date: _____

Jill Essery, LCSW, LLC
LIC. # 44SC0548300

Consent for Treatment

Welcome to the psychotherapy practice of Jill Essery, LCSW, LLC. I am a New Jersey Licensed Clinical Social Worker and I have been in practice for over twenty years. This "Consent for Treatment" form documents my office policies and identifies what you can expect during your professional relationship with me.

As we work together to understand the issues that brought you into treatment, we will determine your goals for therapy and how you can achieve them. Psychotherapy has been shown to be highly effective in helping people overcome many challenges, but there are no guarantees. I can say however, that you get out of therapy treatment what you put into it.

Please keep me notified whether or not you are working with any other providers, including a psychiatrist, and if you are on psychiatric medication. If you are working with other providers, I may ask you to give signed consent for me to communicate with those providers in order to coordinate treatment. We can discuss this as we move forward in treatment.

I only participate in network with Medicare. However, if you have private insurance with out of network benefits and wish to submit for reimbursement, I can provide you with an invoice. Please be advised that your insurance plan may require that you first meet a deductible each year prior to reimbursement. It is your responsibility to fully understand your benefit plan.

It is my policy to collect my fee/copay at the time service is rendered via cash, check, Venmo©, Paypal© and Zelle©.

The primary method that you may communicate with me is via email or my cell phone. Aside from confirming an appointment, I request that you do not use text messaging for other communications. You may leave me voicemail messages, as these are private and confidential.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___

- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. ___
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Therapist Date

Confidentiality

Confidentiality is a cornerstone of mental health treatment and is protected by law. What you disclose to me can only be released to others with your written permission. However, while your information is considered confidential, there are limits to that confidentiality. For instance:

* When you, or another person are in physical danger (such as a plan to harm yourself or another person, suicide, child or elder abuse or neglect) the law requires me to report such information. This may include informing a potential victim, family member, notifying the police or notifying the Division of Child Protection and Permanency.

Should you need to contact me between sessions, please leave me a confidential message at (917) 575-2272, and your call will be returned as soon as possible. If you call on a Friday, your call will likely be returned the following Monday. If your call is of an urgent matter, please indicate this clearly in your message. If you need to talk to someone immediately, you can call (201) 262-HELP (4357), for the Psychiatric Emergency Screening Program for crisis services, call 911 or visit your local emergency room.

Cancellation Policy:

Outside of emergencies, I maintain a 24-hour cancellation policy. This appointment time is reserved especially for you, and therefore unable to be filled last minute due to your absence. In the event of a true emergency, I will do my best to reschedule you at another time the same week. However, I cannot guarantee this will always be possible.

If cancellation occurs with less than 24-hour notice, and we are unable to reschedule that same week, you are still responsible for the full payment for the session. My goal is to promote continuity and a mutual respect to be maintained throughout the treatment process.

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