THERAPY AND ASSESSMENT

INFORMED CONSENT FORM

(ADULT)

PATIENT NAME: _____

DATE OF BIRTH: _____

I, _____, hereby give my consent for
(name of patient)
Dr. Natalie Schuberth (Psy.D., BCBA-D, Licensed Psychologist #5563), to provide me with assessment and/or treatment. I understand that sessions are confidential and will only be shared with other staff at the practice involved in the client's care and administrative task as necessary (i.e., billing, mail). There are certain circumstances where we are required to disclose otherwise confidential information such as cases of suspected child or elder abuse and neglect or where a patient is threatening imminent harm to himself/herself or others.

I have been informed of the issues and responsibilities related to payment for service. I understand that cash, check, and credit card are accepted forms of payment. All payments will be processed with administrative staff and not directly with the psychotherapist. Services will be paid for before services are rendered. Failure to pay may result in a disruption or discontinuation in treatment. Insurance is not accepted. The client will be presented with a bill at the end of each service that the client may submit to his/her insurance company for reimbursement.

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

You have the right:

1. To receive service appropriate to your needs and to expect staff to provide safe, professional care at the level of intensity needed. If staff cannot provide the necessary treatment, they will make their best effort to provide appropriate referrals.
2. To be informed of the benefits and risks of receiving treatment vs. not receiving treatment.
3. To be actively involved in all decisions regarding treatment planning.
4. To be notified in a timely manner if your appointment has to be canceled.

CLIENT RESPONSIBILITIES

You have the responsibility:

1. To attend sessions on a timely and regular basis.
    a. If you arrive over 20 minutes late for your appointment (without first communicating with Dr. Schuberth), you may be asked to reschedule your appointment.
    b. If you fail to show for 2 sessions without canceling, service may be discontinued. Individual clinicians have flexibility in extenuating circumstances.
2. To call in advance if you need to cancel an appointment. If you need to cancel your appointment, please inform your clinician by phone at least 24 business hours before your appointment. Failure to do so will result in responsibility to pay for the missed service. Individual clinician have flexibility in extenuating circumstances.
3. To not come to sessions under the influence of (non-prescribed) mind altering substances and to keep the therapeutic environment safe (e.g., do not bring weapons in to the office).

I understand that if a clinical emergency arise during business hours (Monday through Friday 9am-5pm, excluding holidays), and I am unable to reach Dr. Schuberth, I can call (609) 419-0400 and ask to have her (or my psychiatrist if s/he works in the same office) paged. I also understand that if an emergency arises after business hours or on weekends, I should call 9-1-1 or go to an emergency room.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Representative (if applicable) Date

Alexander Road Associates
707 Alexander Road Building 2 Suite 202 Princeton, NJ 08540
Tel: (609)419-0400 FAX: (609)419-9200
info@araprinceton.com

Dr. William Hayes ___
Dr. Jennifer Kearney___
Dr. Asma Mian ___
Dr. Sara Popkin___

Dr. Matthew Brightman ___
Pasquale Sargiotto ___
Dr. Natalie Schuberth___

Patient Name: _____ **DOB:** _____/_____/_____
Street: _____
_____ Home: (____) _____-_____
City: _____ State:___ Zip: _____ Work: (____) _____-_____
E-Mail Address: _____ Cell: (____) _____-_____
(for adult or responsible party only)

Responsible Party: (if child or dependent)_____
Relationship to Patient: __ Parent __ Spouse __ Other: _____
Street: _____ Home: (____) _____-_____
_____ Work: (____) _____-_____
City: _____State: ___ Zip: _____ Cell: (____) _____-_____

Preferred Payment Method: ___ Cash ___Check ___Credit Card

We are able to e-mail you reminders of your upcoming appointments currently and plan to text message reminders later in 2016. Check if you would like reminder by email or text:
Yes _____ No _____

Known Allergies: _____
_____

Current Medications:

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Medical Conditions: _____
_____

Referred By:_____
Referral Type __Physician __ School __Other:_____

I understand I am responsible for payment-in-full for services rendered at the time of service. I also understand that Alexander Road Associates does not accept Private Insurance, Medicare or Medicaid. I am also responsible for payment of any appointment cancelled without 24 business hours advance notice.

Responsible Party: _____**Date:** _____/_____/_____

Client Information Form (Adult)

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Nickname (if you prefer therapist call you by this): _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Is it okay to leave a voicemail? _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

C. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

D. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

E. Psychological Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:

When?	From whom?	Which medications?	For what?	With what results?

F. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

1. Problems with hearing? Corrective measures? _____

2. Problems with vision? Corrective measures? _____

3. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis/Injury	Treatment received	Treated by	Result

4. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

5. List *all* medications, drugs, or other substances you take or have taken in the last year–prescribed, over-the--counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

G. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .
2. How much tobacco do you smoke or chew each week? _____
3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes
6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes
7. How much beer, wine, or hard liquor do you consume each week, on the average? _____
8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes
9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

_____

_____

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

I. Abuse history:

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

J. Religious and racial/ethnic/culturalv identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

K. Your education and training

Dates		Schools	Special education?	Adjustment to school	Did you graduate?
From	To				

L. Employment and military experiences

Dates		Name of employer	Job title or duties	Reason for leaving or "current"
From	To			

M. Family-of-origin history

Relative	Name	Current age (or age at death)	Learning, emotional, or medical problems?	Education	Occupation	Describe your relationship (e.g., tense, don't speak, close, up & down)
Father						
Mother						
Brothers						
Sisters						
Stepparents						
Grandparents						
Uncles/aunts						
Other significant family relations						

N. Marital/relationship history

How do you get along with your present spouse or partner? _____

_____

_____

_____

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed or "current" if together	Reasons for ending
First					
Second					
Third					

O. Significant nonmarital relationships

	Name of other person	Person's age when started	Your age when started	Your age when ended Or "current"	Reasons for ending
First					
Second					
Third					
Current					

P. Children (In the relationship column, indicate biological daughter/son, step-child, foster, adopted, etc.)

Name	Current age	Sex	School	Grade	Learning, emotional, or medical problems?	Relationship

How do you get along with your children? _____

_____

_____

_____

Q. Describe your current living situation: what type of dwelling (house, apartment, shelter, etc), who you live with, and satisfaction and/or problems with living situation.

R. What do you enjoy doing in your free-time/for fun/hobbies?

S. Is there any other information you think we should know?