Welcome to Beach Counseling!

120 East River Road, Suite 2
Rumson, NJ 07760
732-305-4532

Please bring this completed **INTAKE FORM** to your first session.

PLEASE PRINT CLEARLY Today's Date ____________________

PERSONAL INFORMATION

PATIENT (S) ____________________
Date of Birth ____________________ Gender __________
Address ____________________
____
City, State ____________________Zip __________
Home Phone ____________________
Email Address ____________________
Cell Phone ____________________

RESPONSIBLE PARTY ____________________
Responsible Party's SSN ____________________
Address (if different) ____________________
____
City, State ____________________ Zip __________
Home Phone (if different) ____________________
Email Address (if different) ____________________
Cell Phone (if different) ____________________

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self______ Spouse______ Child______ Other ______

Relative or friend in case of emergency ____________________
Name Phone # Relationship

Source of referral ____________________ Reason for referral ____________________

How did you hear about this practice? ____________________

FINANCIAL

I understand that Beach Counseling LLC/Lisa Kreutzberg, LPC does not accept insurance other than Aetna. I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

____________________ ____________________ ____________________
Signature of Responsible Party Printed Name Date

MEDICAL INFORMATION

1. **Patient Name** ________________________

Have you ever been treated for emotional difficulties before (When and Where?) ________________________

____

Physician: Name/Practice ________________ Address ______________ Phone ________________

Date of last physical exam ________________ Height ______________ Weight ________________

How is your general health now? ______________ Medications? ________________

Are you presently being treated by a physician for any physical condition? ________________

Have you had any serious illness? (List) ________________________

Have you ever had any surgery? (List) ________________________

PLEASE MARK ALL THAT APPLY:

___Anger ___Anxiety ___Behavior Problems ___Changes in Appetite/Eating Habits ___Criminal Activity ___Decreased Energy ___Delusions ___Depressed Mood ___Disruption of Thought Process/Content ___Emotional/Physical/Sexual Trauma ___Excessive Crying ___Family Conflicts	___Grief ___Guilt ___Hallucinations ___Hopelessness ___Hyperactivity ___Impulsiveness ___Interpersonal Conflicts ___Irritability ___Manic ___Mood Swings ___Oppositional ___Panic Attacks	___Paranoia ___Physical Aggression ___School/Work Problems ___Self Abusive Behavior ___Sleep Disturbance ___Somatic Complaints ___Suicidal Thoughts/Attempt ___Weight Gain ___Weight Loss ___Worthlessness ___Other (Specify)

How could your life be better?

Privacy Practices Form

PRACTICE POLICIES

You are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview will be approximately 60 minutes in duration. At the time of this appointment, the following decisions will be made with you:
   - Type of therapy needed (individual, group, medication referral, etc.)
   - Frequency of therapy sessions (weekly, biweekly, etc.)
   - Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each subsequent appointment will be approximately 45-50 minutes in duration. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance.

4. PAYMENTS: Please plan for payment in full for each office visit when you come for your appointment. We accept cash, check and credit cards Please make checks out to Beach Counseling LLC. The cost of the initial 60-minute session is $175. Subsequent 45-50 minute sessions are $150.00.

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans other than Aenta.. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. Payments for services received through Beach Counseling LLC are ultimately your responsibility. (This does not apply to Aetna subscribers)

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Beach Counseling LLC and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

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If more than one adult patient, each person should check and initial boxes.

☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

☐ Yes ☐ No I consent to the exchange of treatment information between Lisa Kreutzberg, LPC and my primary care physician.

Patient(s):

Physician's Name/Office and Phone Number ______________________________

Signed: ______________________________ Date: ____________________

Signed: ______________________________ Date: ____________________

Privacy Practices Form
CLIENT COPY

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Physician's Name/Office and Phone Number ____

Signed: ________________________________ Date: ____________________

Signed: ________________________________ Date: ____________________

Beach Counseling

Lisa Kreutzberg, MS, LPC
120 East River Road, Suite 2
Rumson, NJ 07760
732-305-4532

Clients Insured by Aetna

Client____ Date___________________________

Address_________________________________City_____________________State/Zip________________

Home Telephone______________________________ Cell Phone ____

Primary Insurance ___________________________________ Phone: _____________________________________

Subscriber ____ DOB___________________________________

Subscriber Number________________________________ Group Number _______________________________

Assignment of Insurance Benefits: I hearby authorize Beach Counseling and Coaching LLC, to provide or collect from my insurance company information needed to process claims and or determine benefits. I hearby authorized payments directly to physician/provider. I am responsible for all non-covered services rendered by the physician/provider.

X____ Date:_________________________