Meredith O'Brien & Affiliates, LLC
License#: 44SC05384300, NPI#1841558756
65 Mechanic Street, L2, Red Bank, New Jersey, 07701
732-977-9729 Tax ID #45-4926269

Client Profile:

Referred by _____

Last Name_____ First Name_____

Street Address_____ City/State/Zip_____

Email Address_____ Receive our Newsletter? Yes No

DOB_____ Age_____ Grade/School/Employer_____

Home Phone _____Cell Phone _____Can leave message?_____

Emergency Contact_____Relationship_____Phone_____

Responsible Party for Payment: Check_____ if the information above is the same.

Last Name_____ First Name_____

Street Address_____ City/State/Zip_____

Home Phone _____Cell Phone _____Can leave message?_____

Family History

	Name	Sex	Age	Yes/No (live with you?)
Client				
Mother				
Father				
Spouse				
Children/Siblings				
Others in household				
Other significant members				

Background information

Please state why you are here today

_____
_____
_____
_____

What would you like to see changed after treatment is completed?

_____
_____
_____

What prior treatment/counseling history have you had?

Type	Dates	Who/Where?	Was it helpful?
_____	_____	_____	Yes/No
_____	_____	_____	Yes/No
_____	_____	_____	Yes/No

Health Background

Current Provider of Medical Care/Psychiatrist

Physician	Address	Telephone #
_____	_____	_____
_____	_____	_____

List all current medications and doses

_____	_____	_____
_____	_____	_____

List all past Diagnoses

_____	_____	_____
_____	_____	_____

Have the following changed in the last 6 months?		Yes (explain)
Sleeping habits	No	_____
Energy level	No	_____
Amount of water you drink daily	No	_____
Urination/ Bowel movement frequency	No	_____
Do you?		Yes, how often?
Smoke	No	_____
Drink alcoholic beverages	No	_____
Drink coffee/tea	No	_____

Please list all past and current medical symptoms/illnesses/pain/treatment

_____
_____
_____

Stressors	**Yes**	**No**
Unemployment	_____	_____
Recent decrease in income	_____	_____
Illness in family member	_____	_____
Death in family	_____	_____
Any other significant losses	_____	_____
Drug/alcohol abuse in family	_____	_____
Exposure to violence	_____	_____

Payment is requested at time of service. If you need to cancel an appointment 24 hour notice is required to avoid being charged for the session, which is not billable for insurance reimbursement.

Client Signature_____ Date _____

Therapist Signature_____Date_____

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Jessica Lupon, LPC	**Barbara Tatum, LPC**	**Carianne D'Oriano, LPC**	**Tatiana Grant, LPC**
License #37PC00496300	License #37PC00586700	License #37PC00629400	License #37PC00614900
NPI #1881109577	NPI #1164952115	NPI #1003209552	NPI #1861885931
732-239-3388	732-794-7833	732-768-4520	732-902-0156

Consent for Release of Confidential Information

Client's Name _____

Address _____

I, the undersigned, authorize Meredith O'Brien, LCSW and her Affiliates listed above, 65 Mechanic Street, L2, Red Bank, NJ 07701 to:

[ ] Release information to

[ ] Receive information from

Organization/Individual _____

Address/Phone _____

_____

Nature of information requested: _____

_____

_____

Purpose of the need for disclosure: _____

_____

_____

Date of treatment: _____

I hereby authorize the release of the information requested above from my record. I understand that the information to be released is confidential and protected from disclosure without additional written authorization from me. I also understand that my consent will expire one year from this date if not acted upon prior to that time. This release was fully explained and consent was given of my free will.

_____

Client/Parent/Legal Guardian Signature Date

_____

Witness Signature Date

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Consent to Treatment

Name of client: _____

Meredith O'Brien, LCSW and/or her Affiliates and I have discussed my situation. I have been informed of the risks and benefits of different treatment choices. I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment, as shown by my signature below.

_____ _____

Signature of client Date

I, the therapist, have discussed the issues above with the client. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the treatment.

_____ _____

Signature of therapist Date

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Consent to Treatment of a Child/Minor

Name of child client: _____

Meredith O'Brien, LCSW and/or her Affiliates and I have discussed my child's situation. I have been informed of the risks and benefits of different treatment choices. I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment, as shown by my signature below.

_____ _____

Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____

Signature of therapist Date

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Notice of Privacy Practices (Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND

HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices.

How I use and disclose your protected health information with your consent

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice I will ask you to sign a **consent form** to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of the notice of privacy practices.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but there may be a charge for it.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing. You must also tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this notice, you can always get a copy of it from me at that time.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or health information privacy policies, please let me know.

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The effective date of this notice is January 1, 2010.

Meredith O'Brien, LCSW, LLC
65 Mechanic Street, L2
Red Bank, New Jersey, 07701
732-977-9729

Privacy Policies Consent

Your signature below indicates that you have received the abridged HIPAA Notice of Privacy Practices for Meredith O'Brien, LCSW, LLC, and that a copy of the unabridged notice is available to you upon request. You also authorize Meredith O'Brien, LCSW, LLC to leave messages for you at:

Home: _____ Cell Phone: _____

(Please check all that apply)

Signature _____ Date _____

Signature _____ Date _____

Appointments/Cancellation Policy

I understand I ***will be charged for sessions not cancelled at least 24 hours before my scheduled appointment*** and that ***cancellations are accepted by voicemail or text.*** I also understand that payment is due at the time of service.

Signature _____ Date _____

Signature _____ Date _____

Credit Card Payments

#_____

Exp. Date_____

CSC#_____

Billing zip code_____

Signature _____ Date _____