Ellen L. Gamza, MSW, LCSW, LLC
Partners in Counseling
103 Park Street, Building A, Suite 2D
Montclair, NJ 07042
(973) 202-0362

DATE: _____

IDENTIFYING INFORMATION:

Name:_____ Date of Birth:_____

Address: _____ Home phone: _____
_____ Cell phone: _____
_____ Email: _____

Social Security # _____

Marital Status: Single ____ Married ____ Other _____

Emergency Contact: Name: _____ Relationship: _____
Phone number: _____

IF MINOR:

Age:_____ Grade:_____ School:_____

☐ *Check if parent/guardian information same as above*

Mother/Guardian Name: _____ Home phone: _____
Address: _____ Cell phone: _____
_____ Work phone: _____

Father/Guardian Name: _____ Home phone: _____
Address: _____ Cell phone: _____
_____ Work phone: _____

PRIMARY CONCERNS: Please give a brief description of your reason for seeking treatment.

_____
_____
_____
_____
_____
_____
_____
_____

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PREVIOUS PSYCHIATRIC TREATMENT:

☐ Previous psychiatrists (list names, dates, reason)

_____
_____
_____

☐ Previous therapists (list names, dates, reason)

_____
_____
_____

☐ Psychiatric hospitalizations or emergency room visits (list names, dates, reason)

_____
_____
_____

☐ Previous medication trials (list names, dates, reason, and response)

_____
_____
_____

☐ History of self-injury: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of suicide attempts: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of aggression: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of alcohol or drug use: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of trauma or abuse: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

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MEDICAL HISTORY:
Primary doctor's name: _____ Phone # : _____

Medical problems:
☐ Asthma ☐ Diabetes
☐ Seizures ☐ Hearth disease
☐ Thyroid disease ☐ Stomachache/nausea/diarrhea/constipation
☐ High blood pressure ☐ Liver disease
☐ Headaches ☐ Head trauma
☐ Other (please describe) _____
_____

ALLERGIES (to food or medication): _____

CURRENT MEDICATIONS (include prescription and over-the-counter medications and vitamins):

Medication Name	Medication Dose	Reason

MEDICAL HOSPITALIZATIONS OR EMERGENCY ROOM VISITS:
_____
_____

FAMILY PSYCHIATRIC HISTORY: Please report history of psychiatric illness in all family members, including parents, siblings, grandparents, aunts, uncles, and cousins:

	Relative	Treatment (if known)
☐ Depression	_____	_____
☐ Bipolar disorder	_____	_____
☐ Anxiety disorder	_____	_____
☐ Schizophrenia	_____	_____
☐ Other psychotic disorder	_____	_____
☐ ADHD	_____	_____
☐ Behavior problems	_____	_____
☐ Learning disorder	_____	_____
☐ Autism spectrum disorder	_____	_____
☐ Substance abuse	_____	_____
☐ Legal problems	_____	_____
☐ Other	_____	_____

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FAMILY MEDICAL HISTORY: _____
_____
_____
_____

DEVELOPMENT:
Length of pregnancy: _____
Please describe any medical issues or complications during pregnancy, labor, and delivery:
_____
_____
_____

Walking: Age _____
First word: Age _____
2 word sentences: Age _____
3 word sentences: Age: _____
Toilet training: Age: _____

Please describe any delays in your child's development:
_____
_____
_____

SCHOOL:
☐ Regular Education
☐ Special Education – reason: _____

Please describe any special services received in school:
_____
_____
_____

Please describe any difficulties with friends and/or peers:
_____
_____
_____

_____

Office Use:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

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Consent For Treatment of Children and Adolescents

I/We hereby give permission to have _____,
my son/daughter, seen for psychological evaluation and treatment by Ellen Gamza, MSW, LCSW.
I furthermore release Ellen Gamza, MSW, LCSW from any legal liability resulting from the performance of these services, with the understanding that services will be rendered in strict accordance with all relevant professional and ethical guidelines. I further understand that I have the right to end this agreement at any time that I so desire.

Date of this Consent: _____

Signed: _____

Relationship to Patient: _____

Address: _____
_____

Witness: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Ellen L. Gamza, MSW, LCSW of 103 Park Street, Montclair, NJ 07042 to release, disclose and discuss information from the clinical record of:

_____ _____
Client Name Date of Birth

With:
_____
_____
_____
_____
(Facility/Provider Name, Address, Phone)

I understand I may revoke this consent at any time.

A copy of this release shall have the same force and effect as the original.

_____ _____
Client Signature (12 yrs. or older) Date

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Witness Date Relationship

NOTICE TO RECEIVING FACIILITY: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

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Informed Consent for Treatment

Today's consultation appointment will take approximately 45-60 minutes and all others sessions will be 45 minutes (unless other arrangements are made). This document is intended to inform you of my policies, State and Federal Laws as well as your rights. If you have other questions or concerns, please ask.

Confidentiality and Emergency Situations

Your verbal communication and clinical records are strictly confidential except for: a) information shared with a treating psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company, c) information you and/or your child or children report about physical or sexual abuse; then, by New Jersey or New York State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of hurting yourself, others or personal property, f) information necessary for case supervision or consultation and h) or when required by law. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy or when different family members are seen individually, confidentiality and privilege do not apply between couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I have been authorized to do so by all adult family members, and/or parent(s) or guardian(s) who were part of the treatment. Disclosure of confidential information may be required by your insurance carrier (HMO/EPO/POS/PPO/Traditional or indemnity plan) in order to process your claims. If you instruct me to do so, I will only communicate the minimum necessary information to the carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that by submitting "a mental health invoice" for reimbursement a certain amount of risk to confidentiality, privacy and possibly to the future capacity to obtain health or life insurance. The risk stems from the fact that computers are inherently vulnerable to unauthorized access. Medical data has been reported to be sold, stolen, or accessed by enforcement agencies, which possibly puts you in a vulnerable position. Today, you may receive an authorization to release protected health information which will authorize my office to use and/or disclose your medical records to another doctor. You may refuse to sign the authorization to prevent your records from being released. Please note that by signing this contract you are aware that Ellen L. Gamza, LCSW and Partners in Counseling cannot be held legally responsible in any way for the release of your medical records.

If an emergency situation for which the client, parent(s) or their guardian(s) feels immediate attention is necessary, the client, parent(s) or their guardian(s) understands that they are to contact the emergency services in the community (911) or report to your local hospital for those services. I will follow up with those emergency services with standard counseling and support to the client or client's family in the office by appointment only. If I feel that a patient is in crisis or feel that an emergency exists in the office I have the right and legal obligation to call the police and/or any emergency personnel necessary to ensure patient safety. No legal repercussion toward that this clinician can be sought if reasonable judgment is used to establish such crisis situation. I have the right to contact immediate family members and notify them of such emergency.

The Process of Therapy/Evaluation

Participation in therapy can result in a number of benefits to you, including and not limited to improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. The goal is to attend to your individual needs. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. I will ask you for your feedback and views on therapy, its progress, and other aspects of therapy and will expect you to respond openly and honestly. Sometimes more than one approach to therapy can

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be helpful in dealing with certain situations. During the initial evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations which can cause you to feel upset, angry, depressed, challenged or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance abuse, schooling, housing or relationships. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

Client Satisfaction

If you feel dissatisfied for any reason, please let me know of your concerns. You also have the right to contact your insurance company about any concerns as well as the state licensing board. My hope is that we can work out any difficulties that may arise.

Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, we will discuss a working understanding of the problem, treatment plan, therapeutic objective and view of the problem outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the clinician's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment not provided here, we have an ethical obligation to assist you in obtaining those treatments.

Vacations

When your clinician is on vacation, there will be another clinician covering for them. You will be provided with their name and phone number a few weeks in advance of the vacation period.

Financial Disclaimer

Please note, although I may accept some insurance plans, this does not guarantee payment. You as the patient or patient representative are ultimately responsible for payment. All patients are responsible for obtaining initial authorization and/or referrals from your primary care physician regardless of your insurance company's policies concerning this matter. Obtaining authorization from your insurance company does not guarantee payment from them. Any denial of payment for any reason, payment that is pending over 30 days, deductibles or copayments is your responsibility. Deductibles and co-payments are not negotiable and must be paid at the beginning of your session. Your bill will reflect the standard rate charged for any outstanding balances. Please call your insurance carrier if you have any questions regarding your insurance policy, coverage and benefits to your plan. Please note that by signing this form you are superseding any contract signed by me and your insurance company concerning payment. You are ultimately responsible for full payment.

Outstanding balances that go beyond 90 days may be sent to small claims court for collections.

It is the responsibility of the patient or responsible party to notify this office 24 hours in advance in the event you need to cancel or reschedule your appointment. Otherwise, I reserve the right to bill you for the missed session. Of course if you are hospitalized, a catastrophic event happens we are willing to discuss this with you. In the event of inclement weather, I will call you to cancel your appointment. If you do not receive a call, you are

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expected to be here for your visit or to call if you are unable to make it. Remember that your session has been scheduled for you and you alone. No other patient can be scheduled or seen during your time slot. Please note that your insurance company does not cover missed appointments. Please understand that any reports, out of the office meetings, or hospital visits will not be covered by your insurance company. You will be responsible for payment of these charges.

It should be noted that if I do not participate in your particular insurance plan I would be considered an out of network provider. You are solely responsible for contacting your insurance company to obtain authorization and/or benefit information. It is your responsibility to know the particulars of your plan and how it is administered. You will be responsible for your deductible. You will be billed at the regular rate toward your deductible until session fees have been met. You are also responsible for all copay's and coinsurance. Out of network patients will be held responsible for full fees for each session. I am happy to accept your check for payment, however if your check is returned to you will also be expected to pay any resulting bank fees incurred. Please note that it is my responsibility to treat my patients and I take this obligation seriously. Your responsibility is to make your appointment on time, call if you are going to be late to a session and to ensure that reimbursement is made to this office.

Closure/Termination

Our sessions together may end due to a decision on your part or mine or both. In psycho-therapeutic treatment, the relationship is an important part of the process. Therefore, it is most effective when we can plan for at least one session if not several to do the closure. As mentioned, after the consultation, I will assess if I can help you. I do not accept clients who, in my professional opinion, I cannot help. In such a case, you will be provided with a number of referrals that may be of help to you. You may also call your insurance company for additional lists of names of providers. You have the right at any time to consult another professional for his/her opinion. I would appreciate notification if you choose to do this so I can consult with that professional if needed. To do this you would need to sign a written consent allowing me to speak with another therapist.

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I have read and received a copy of the notice of Privacy Practices and Informed Consent, have reviewed it and agree to abide by these guidelines. I hereby consent to my treatment. If I am bringing a minor for treatment, I have the legal authority to consent to the minor's treatment and hereby do so consent. If the minor is 14 years old or older I understand that the minor will also need to sign this form.

Client Name _____ Date of Birth _____

Signature _____ Date _____

Parent/Guardian Name (Print) _____

Signature _____ Date _____

I acknowledge and have read the Financial Disclosure and agree to its terms. I understand my obligation that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child or to the patient for whom I have legal responsibility. I understand filing a claim with my insurance company does not relieve me of my responsibility for the payment of all charges. I hereby authorize Ellen L. Gamza, LCSW, LLC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Client Name _____ Date of Birth _____

Signature _____ Date _____

Parent/Guardian Name (Print) _____

Signature _____ Date _____