Transformation Counseling & Assessment Center, LLC

663 N. Main Road, Vineland, NJ 08360
Office: 215.500.4924
Dr. Tiffany Leone-Vespa, Psy.D., LPC
info@tcactherapy.com
www.tcactherapy.com
NJ License #37PC00365600

Dear Patient

Welcome to Transformation Counseling and Assessment Center, LLC. Please take the time to read and complete the following forms:

- *Information and Consent for Counseling Form: Please read and sign*
- *Personal History Intake Form: Please fill this out as completely as possible*
- *HIPAA Signature Form: Please read and sign*
  The HIPAA Policy can be found on the website under "General Forms".
- *Authorization to Release Information Form: This form allows me to communicate with whomever you choose to add to this form, including doctors. This form can be completed and/or changed at any time. One form is required per person.*
- *Initial Symptom Checklist: Please fill out as completely as possible*
- *Notice of Insurance Change Form: Please read and sign*
- *Credit/Debit Card Authorization Form: Please complete and sign*

If you have a change in your insurance carrier, or in the co-payment required, please let your therapist know.

If you will not be able to keep your appointment, you must notify your therapist 24 hours in advance. If your therapist does not receive such advance notice, you will be responsible for paying a late cancellation or no-show fee of $180 (not covered by insurance).

Payment is due prior to the therapy session.

For in-office sessions, checks are accepted and should be made payable to Transformation Counseling and Assessment Center, LLC (TCAC). For tele-therapy sessions, I only accept credit/debit card payments via IVY PAY, which is HIPAA compliant. The Credit Card/IVY PAY authorization form is required to be completed for tele-therapy sessions.

I look forward to working with you! - Dr. Tiffany

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Information and Informed Consent for Treatment

Thank you for choosing Transformation Counseling and Assessment Center, LLC. This document is designed to ensure that you understand our professional relationship.

I. Patient Agreement/Contract

Some patients need only a few counseling sessions to achieve their goals, while others may require months or years of counseling. As a patient, you have the right to end our counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

Although your sessions may be intimate psychologically, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your therapist to social gatherings, offer gifts, or ask your therapist to relate to you in any way other than in the professional context of your counseling sessions. ***Your therapist will keep confidential anything that you say during session with the following mandatory exceptions: (1) your therapist determines that you are a danger to yourself or others, (2) your therapist is ordered by a court/judge to disclose information, or (3) your therapist suspects child or elder abuse.***

Sessions are approximately 45 minutes in duration. This is includes collecting copays/ fees, as well as scheduling. *Please note that it is impossible to guarantee any specific results regarding your counseling goals. Your therapist will help identify your issues, but it is up to you to do the work. You and your therapist will work together to achieve the best possible results for you.*

Please note that if you are not seen for a period of 90 days, your file will be closed and you will need to go through an initial intake as a new patient if you choose to return.

For marital/couples therapy, *both parties are in agreement that neither party shall, for any reason, attempt to subpoena my testimony or my records to be presented in a disposition or court hearing of any kind, for any reason, such as a divorce case. Additionally, it is understood by both parties that if they request my services as a therapist, they are expected not to use information given to me during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.*

______ Patient Initial

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II. Legal Issues

If you are in the midst of any type of legal issue, such as litigation, a dispute with your employer, separation, or divorce, etc. please inform your therapist immediately.

_____ Patient Initial

III. Payment Policy

Your therapist agrees to provide therapy services to you in return for a fee. ***The fee for each session will be due at the time of service. Cash and personal checks are acceptable forms of payment. Credit card payments are not accepted at this time.*** *There is a* ***$25.00 service charge for all returned checks.*** *You will be provided with a receipt for all fees paid if you request a receipt. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. By using insurance, you are granting permission for us to communicate confidential information to your insurance company.*

*Please remember that Transformation Counseling and Assessment Center, LLC has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your co-pay changes, please let the front office know as soon as possible. Y****our initials below document that you understand you will be billed for unpaid sessions not covered by your insurance*** *and it is possible an outside billing service will be used. You give permission for the least amount of information necessary to be given to collect the balance.*

______ Patient Initial

IV. Cancellation/Office Hours

In the event that you will not be able to keep an appointment you must notify your therapist 24 hours in advance. If your therapist does not receive such advance notice, you will be responsible for paying a late cancel/no show fee of $180 (not covered by insurance). You can provide this advance notice via a phone call or text message at (215) 500-4924. This fee must be paid before you are seen. As stated above, an outside billing agency may be used to collect this fee if necessary.

______ Patient Initial

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V. Emergencies

Transformation Counseling and Assessment Center, LLC is an outpatient facility. Your therapist cannot assume responsibility for day to day functioning, as some more intensive treatments are designed to do. ***In the case of an emergency, when a client fears harm to him/her self or another, please dial 911 or go to your nearest emergency room,*** *as Transformation Counseling and Assessment Center, LLC is not an emergency facility.*

______ Patient Initial

VI. Social Networking

It is the policy of Transformation Counseling and Assessment Center, LLC that employees/ therapists do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, etc. This applies to active as well as non-active clients.

______ Patient Initial

My signature below indicates that I understand these policies and I grant consent for Transformation Counseling and Assessment Center, LLC to provide psychological services and counseling to myself. I also understand that in order for information to be released I must sign a Release of Information Form, with stated exceptions above.

Patient Signature: ____ *Date:* ______________

Patient Name: ____

Doctor Signature: ____ *Date:* ______________

Doctor Name: ____

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Personal History Intake Form – Adult 18+

Patient's Name: ____ Date: _________________

Gender: □ F □ M Date of birth: _______________ Age: _____________

Form completed by (if someone other than patient): ____

Address: ___________________________City: ___________State: _____ Zip: ______

Phone number: _________________□Cell □ Landline Text: □ Y □ N Leave msg: □ Y □ N

Primary reason(s) for seeking services: ____

____

Current Employer: ____

Number of years: _________ Position: ____

Medication

Current Prescribed Medications	Dose	Date Started	Purpose	Side Effect

Family history of medical problems: ____

____

Please check if there have been any recent changes in the following:

□ Sleep patterns □Eating patterns □Behavior □Weight
□ Energy level □General disposition. □Nervousness/tension. □Physical activity

Describe changes in areas in which you checked above: ____

____

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HIPAA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- *Obtaining payment from third party payers (e.g. my insurance company);*
- *The day-to-day healthcare operations of your practice.*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices (found on the website under General Forms), which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may obtain the most current copy of this notice on the website

Patient Signature: _______________________________________ *Date:* ______________

Patient Name: ____

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Authorization to Release Information

This form authorizes Transformation Counseling and Assessment Center, LLC to disclose to and/or obtain from:

____

Insert Name of Person or Organization *Phone* *Email*

For the following information:
Patient should initial each item to be disclosed

_________	*Assessment*	_________	*Progress in Treatment*
_________	*Diagnosis*	_________	*Demographic Information*
_________	*Psychological Evaluation*	_________	*Treatment Plan or Summary*
_________	*Psychotherapy Notes**	_________	*Other*______________________
_________	*Discharge/Transfer Summary*		___________________________

**Cannot be combined with any other disclosure.*

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Transformation Counseling and Assessment Center, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
This authorization is valid one year from the date signed unless otherwise specified here __________________.

Patient Signature: ____ *Date:* _____________

Patient Name: ____

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Initial Symptom List

Name:_______________________________________ Date:_________

Over the past few weeks, how have you been doing in the following areas of your life? Score each statement 1-4 with "1" indicating low levels such as "not doing well at all" and "4" indicating high levels, such as "doing very well".

___ Physical well-being
___ Emotionally
___ Close relationships
___ Work
___ School
___ Overall well-being

If therapy is successful, how will your life be better (in terms of thinking and acting)

____

____

What responses are true for you when you think about what brought you here today?

___ I am hoping Dr. Tiffany Leone-Vespa will help me to better understand myself.

___ As far as I am concerned, I do not have any problems that need changing.

___ I am already doing something about the issue that is bothering me.

___ I am not the one with the problem, so it does. Not make sense for me to be here.

___ I have a problem and I really think I should work on it.

___ I worry that I might slip back on a problem I have already worked on, so I am here to prevent that from happening.

___ I thought that once I had worked on the problem, I would be free of it, but sometimes I still find myself struggling with it.

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Please rate the symptoms you have been experiencing over the last two weeks on a scale of 0-3 with "0" = Never; "1" = Seldom; "2" = Sometimes; "3" = Always

Symptom	***0-3***	***Symptom***	***0-3***
Feeling depressed		*Thoughts of hurting self*	
Feeling anxious		*I have hurt myself in the last two weeks by:* *__Cutting __Not eating __Purging* *__Overeating __Substance abuse* *__Other ( )*	
Feeling overwhelmed		*Suicidal thoughts*	
Feeling hopeless		*Homicidal thoughts*	
*Sleep **Less Than** 6 hours most nights*		*Feeling Agitated, Hyper*	
*Sleep **More Than** 6 hours most nights*		*Having irrational thoughts/fears*	
Loss of appetite (in the past month I have lost ___lbs.)		*Engaging in compulsive behavior*	
Increase in appetite (ion the past month I have gained ___ lbs.)		*Feeling confused*	
Panic attacks		*Feeling restless or on edge*	
Having mood swings		*Isolating and avoiding interaction with others*	

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Please rate the symptoms you have been experiencing over the last two weeks on a scale of 0-3 with "0" = Never; "1" = Seldom; "2" = Sometimes; "3" = Always

Symptom	***0-3***	***Symptom***	***0-3***
Feeling lonely		*Having negative thoughts about my future*	
Having problems in relationships		*Having negative thoughts about myself*	
Feelings of unreality		*Having negative thoughts about my situation*	
Feelings of being detached from oneself		*Having racing thoughts*	
Tearful		*Having trouble concentrating*	
Excessive worrying or obsessions		*Having trouble remembering things*	
Nightmares		*Feeling unable to go to work, school, etc.*	
Feelings of apathy or indifference		*Feeling unable to keep up with family life and social life*	

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Notice of Insurance Change Form

Transformation Counseling and Assessment Center, LLC bills services under your insurance company. Typically, the coming new year results in changes of insurance coverage. In some cases, your insurance carrier may change altogether. In other cases, there may be changes in your insurance plan that will result in co-pay changes. Please remember:

- *Contact me immediately if your insurance changes for any reason.*
- *You are ultimately responsible for the bill. If your insurance changes and I do not accept that insurance, then you are responsible for the bills.*

My signature below indicates that I understand that I am responsible for notifying the billing department of any changes in my insurance at 215.500.4924. I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Current Insurance Information:

Name of Insurance: ____

Name of Insurer: ____________________________________ *Birthdate:* ___________

ID Number: ____

Group Number: _____________________________________

Patient Signature: ________________________________ *Date:* ______________

Patient Name: ___________________________________

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CREDIT CARD AUTHORIZATION FORM
IVY PAY AUTHORIZATION FORM

I authorize Transformation Counseling and Assessment Center, LLC to charge my credit card on file with "IVY PAY" (HIPAA compliant) for the following:

- *copay or coinsurance rate for all attended appointments*
- *$180 for any appointment missed or canceled with less than 24 hour notice*
- *any portion of billable services not covered by my insurance policy*

Name as shown on Credit Card: ____

Type of Credit Card: □ *Visa* □ *Mastercard* □ *Discover* □ *Amex*

Credit Card Number: ____

Expiration Date: ________ *CV 3- or 4-Digit code:* _____ *Billing address zip code:* __________

By signing below, I certify that my above information is true and accurate and that I am an authorized user on the credit/debit card account above.

I authorize Transformation Counseling and Assessment Center, LLC to keep my credit card information on file and charge the above fees.

I understand that I am responsible for notifying Transformation Counseling and Assessment Center, LLC if my credit/debit card information needs to be updated.

Transformation Counseling and Assessment Center, LLC agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance.

I understand that if I wish to cancel an appointment I will need to contact my therapist at (215) 500-4924 via text or phone call.

*Patient Signature:*____ *Date:* _____________

Patient Name: ____