Ocean Township Department of Human Services

Personal Information

Last Name _____ **First Name** _____ **MI** ____

Date of Birth ___/___/_____ **Age** _____ **Gender** *M / F / Other* _____

Marital Status ____ *Single* ____ *Married* ____ *Divorced* ____ *Widowed*

Contact Information

Street Address _____

City _____ **State** _____ **Zip Code** _____

Please note! Mail addressed to the client or guardian of client will be sent to the above address.

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____ **Preferred Phone Number** *H W C*

Message Preference: ☐ **OK to leave message with name and agency phone number.**

_____

Consultation Provider _____ **Date of Consultation** _____/_____/_____

SAE Provider _____ **Date of Initial SAE** _____/_____/_____

Referral Source: ___ **Self** ___ **Parent/Guardian** ___ **School** ___ **Court** ___ **Other:** _____

Probation *Y / N* **Probation Officer** _____ **Contact** (____) _____-_____

If Client is a Minor

Name _____ *Mother Father Guardian Other* _____

Address _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____

Emergency Information

Contact Name _____ **Relationship** _____

Address _____

Home Phone (_____) _____-_____ **Other** _____ **Phone** (_____) _____-_____

Primary Care Physician _____ **Phone** (_____) _____-_____

Availability:

Monday	Hours _____
Tuesday	Hours _____
Wednesday	Hours _____
Thursday	Hours _____
Friday	Hours _____

Family and Living Information

Client is currently living with:

Name	Age	Relationship

Name of School client(s) attend (please include if Child Study Team is involved):

Name	Grade/School	Child Study Team/IEP

Additional Information

Military ☐ **Yes** ☐ **No** **If yes please explain:** _____

_____

_____

Religion : ☐ **Catholic** ☐ **Jewish** ☐ **Greek Orthodox**
☐ **Baptist** ☐ **Muslim** ☐ **Methodist** ☐ **Other**

Race: ☐ **African American** ☐ **Asian** ☐ **Caucasian**
☐ **Greek Orthodox** ☐ **Haitian** ☐ **Hispanic**
☐ **Jewish** ☐ **Native American** ☐ **Other** _____

Comments:

_____

_____

Township of Ocean
Department of Human Services

601 Deal Road, Ocean, NJ 07712 • 732-531-2600

CLIENT HEALTH SCREENING

NAME _____ DATE _____

The questions below are presented to assist your counselor and the Medical Consultant of the Department of Human Services in determining if there is any need for a referral to a physician. This screening instrument will be held in strictest confidence. Please be as accurate and complete as possible.

1) **Have you seen a physician in the past year for a regular physical examination?** YES___ NO___
If you have not seen a physician in the last year for a regular physical examination, it is recommended that you do so.

2) **Are you currently under a physician's care?** YES___ NO___
If YES, what are you being treated for _____

3) **Have you been treated in the last year by a physician?** YES___ NO___
If YES, please explain: _____

4) **Have you been hospitalized in the past five years?** YES___ NO___
If YES, please explain: _____

5) **Are you currently on any prescribed medications?** YES___ NO___
If YES, please list medication, dose, physician and duration on reverse.

6) **Do you have any allergies to medication or non medication (i.e.: food items)?** YES___ NO___
If YES, please list/explain on reverse side.

7) **Do you have a living will or advance medical directive?** YES___ NO___
Information about these documents is available upon request.

8) **Are there any health problems or symptoms which the counselor should know about or about which you are concerned?** YES___ NO___
If yes, please explain on reverse side.

9) **On the reverse side is a Medical History section to indicate with a check mark any significant medical problem.** Please complete.

10) **On the reverse side is a section to indicate Family History of certain medical problems.** Please complete.

11) **On the reverse side is a section to discuss certain health-related habits.** Please complete.

CLIENT NAME _____

MEDICAL HISTORY

On the list below, please check any medical problems of significance in your history.

- ☐ Ringing in Ear
- ☐ Ear Infections–Frequent
- ☐ Dizziness/Fainting
- ☐ Failing Vision
- ☐ Eye Infections
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Sore Throats-Frequent
- ☐ Hay Fever/Allergies
- ☐ Pneumonia
- ☐ Bronchitis/Chronic Cough
- ☐ Asthma/Wheezing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Leg Pain-Walking
- ☐ Varicose Veins/Phlebitis
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Indigestion or Heartburn
- ☐ Persistent Nausea/Vomiting
- ☐ Peptic Ulcers
- ☐ Abdominal Pain-Chronic
- ☐ Gall Bladder Trouble
- ☐ Jaundice/Hepatitis
- ☐ Change of Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Crohn's Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Urine Infections-Frequent
- ☐ Blood in Urine

Urination:

- ☐ Overnight > Than Twice
- ☐ Painful
- ☐ Loss of Control

- ☐ Decrease in Force/Flow
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss-Recent
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Convulsions/Seizures
- ☐ Stroke
- ☐ Tremor/Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbness/Tingling Sensations
- ☐ Headaches-Frequent
- ☐ Arthritis/Rheumatism
- ☐ Osteoporosis
- ☐ Back Pain-Recurrent
- ☐ Bone Fracture/Joint Injury
- ☐ Gout
- ☐ Foot Pain
- ☐ Cold Numb Feet
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Nervousness
- ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness-Excessive
- ☐ Phobias
- ☐ Mental Illness
- ☐ Lactose Intolerance
- ☐ Prostrate Disease
- ☐ Sexual/Menstrual Dysfunction
- ☐ Frequent Infections
- ☐ Diphtheria
- ☐ Tetanus

Measles:

- ☐ Rubella
- ☐ Rheumatic Fever

- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Chicken Pox
- ☐ Polio
- ☐ Mumps

Other _____

Other _____

Females-Please Complete

Pregnant? Yes ☐ No ☐

Planning Pregnancy? Yes ☐ No ☐

Menstrual Flow:

- ☐ Regular
- ☐ Irregular
- ☐ Pain/Cramps

Days of Flow __ Length of Cycle ___

Date-First day of Last Period _____

Date-First day of Last Period _____

- ☐ Pain/Bleeding During or After Sex

Number of:

Pregnancies ___ Abortions ___

Miscarriages ___ Live Births ___

Birth Control Method _____

Birth Control Pill (Name) _____

- ☐ Flushing/Menopause

Date of Last PAP Test _____

Normal ☐ Abnormal ☐

Date of Last Mammogram _____

Normal ☐ Abnormal ☐

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	Migraine	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	Other_____	☐	☐	☐	☐	☐	☐

HABITS

Alcohol: Type _____
Amount _____

Diet: Salt Intake _____
Fat Intake _____
Other _____

Sleep: Difficulty Falling Asleep _____
Continuity Disturbances _____
Early Morning Awakening ___
Daytime Drowsiness _____
Other _____

Smoke: Packs Daily _____
How Long? _____
Interested In Stopping? _____

Exercise: Routine _____
_____

Coffee: Cups Daily _____
Other Caffeine? _____

Please list below any known medication **or non medication** (ie: food) allergies:

_____

If you are taking any prescribed medication or supplements, please complete the information below:

Medication/Supplement	Dosage	How Long Have You Been Taking	Physician

Is there any other health concerns about which we should know or about which you are concerned?

_____

_____

Township of Ocean
Department of Human Services

601 Deal Road, Ocean, NJ 07712 • 732-531-2600

Informed Consent for Counseling

Confidentiality is maintained between the client and the clinician during and after the counseling process. All information disclosed in the counseling relationship will remain confidential with the following exceptions.

Consented Disclosures: If you would like your counselor to speak or write to someone concerning your assessment, diagnostic impression, treatment or counseling process or compliance, you will need to sign a release form in order for the counselor to accommodate your request. If you are a minor, you will need to have a parent or guardian sign as well. A release form must be signed in the office in front of a witness.

Disclosures that do not need your consent: There are some circumstances in which a clinician may release information concerning your counseling process without your consent. Every effort will be made to discuss the disclosure with you prior to disclosing information to the intended party. Disclosures may be required by the ethical and legal standards in some of the following circumstances.

- Medical Emergencies
- Threat to health of self or another
- Suspicion of child abuse/neglect
- Suspicion of elder abuse/neglect
- Court Orders

This agency utilizes the **New Jersey Substance Abuse Monitoring System** – a web-based reporting system for substance abuse treatment providers in New Jersey, which meets all federal HIPAA confidentiality standards. If your counseling is drug and/or alcohol related, statistically pertinent information will be reported through this medium.

Supervision of Counseling: Human Services is a teaching agency that often has graduate level students who have completed advanced coursework in counseling and therapy, working as clinicians. In addition, Human Services employs mental health professionals from the fields of Counseling, Clinical Social Work and Marriage and Family Therapy. All interns, Licensed Associate Counselors and Licensed Social Workers are under the direct supervision of Licensed Mental Health Providers and will discuss your treatment plan and progress with their clinical supervisor on a regular basis.

Research and Reporting: There are occasions when information and data collection may be used for research or reporting purposes. In these instances, no demographic identifying information is used. Likewise, Ocean Township Human Services receives county and state grants and records may be audited for outcome assessment and procedure compliance. Again, no identifying information is reported.

Taping: Ocean Township is a teaching agency. During the consultation process you may be asked to audio or videotape part or all of your counseling process. This is completely done on a voluntary basis and will have no affect on whether or not you are able to receive counseling at Ocean Township. If you do consent to tape, once the supervisor reviews the tape of the clinician, the information on the tape will be removed.

Client's right: As at any health care facility, the client's who receive treatment at Ocean Township Human Services have rights. The Clients rights are posted in our waiting area and your consultation provider will give you a synopsis of the rights as well as your initial meeting. If you have any questions, please ask your counselor to clarify these rights.

Consent For Treatment

"The counselor has discussed with me my rights as a client and or my rights as the parent of a client. The counselor has discussed with me the course of action for this consultation or substance abuse evaluation, as well as possible recommendations for counseling treatment. I consent to treatment for myself and/or the below named child who is a minor. I have been advised and noted that information is available to me regarding advance directives. I have been advised and understand that the individual completing this consultation or substance abuse evaluation may be a counselor intern or that my case or my child's case may be assigned to a counselor inter. In the case of the consultation or evaluation I have been advised of the name and the credentials of this supervisor. I understand that if I or my child is assigned a counselor intern for services I will be advised of the name and the credentials of the supervisor. In both instances I understand I may contact that supervisor at this agency if needed. I have been advised and it is understood that following the consultation or substance abuse evaluation, the agency treatment team will meet to discuss my case, or my child's case, and recommended course of treatment. I understand that information shared in counseling is protected as confidential and that there are certain legal limits to that confidentiality, which have been explained to me by the counselor."

Client Name (Print)	**Client Signature**	**Date**
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**
Counselor Name (Print) witness	**Counselor Signature**	**Date**

_____ The ☐ LPC, ☐ LCSW, ☐ Counselor-Intern, ☐ Masters Level Therapist, ☐ LAC, ☐ LSW named above is providing services under the supervision of the individual named below.

☐ **Sharon Moleski, LPC, LCADC, CCMHC, ACS, CCS, BCN**

Supervisor Name (Print)	**Supervisor Signature**	**Date**

Township of Ocean
Department of Human Services

601 Deal Road, Ocean, NJ 07712 • 732-531-2600

CLIENT RIGHTS

The Clients at the Ocean Township Human Services Department have the following rights:

1. To be informed of these rights by the inclusion of a copy in their clinical records, which shall also contain documentation that the client was given a copy, and also had these rights explained in language they could understand.

2. To be informed of services available in the facility, of the names and professional status of the personnel providing patient care. To be made aware of the fees and any related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by the facility's base rate.

3. Clients have the right to be informed if the OTHS has authorized other health care and educational institutions to participate in client's care. The client shall also have the right to know the identity and function of these institutions and to refuse to allow their participation in the client's treatment.

4. Clients have the right to receive from their clinical practitioner, in terms that the patient understands, an explanation of his/her complete diagnosis, recommended treatment, treatment options, including the option of no treatment, and expected results. If the client's health would be endangered by this information, or if the client is not capable of understanding this information, the information shall be provided to the client's next of kin or guardian. Such release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's written records.

5. Clients have the right to participate in the planning of their care and treatment, and to refuse treatment. Such refusal shall be documented in the client's written records.

6. Clients will not be included in experimental research at this facility without their prior informed consent.

7. Clients have the right to voice grievances or recommend changes in policies and services to facility personnel, governing authority, and/or outside representatives of the patient's choice; either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.

8. Clients have the right to be free from mental and physical abuse, free from exploitation, and free from use of restraints. Clients will not be issued drugs or medication from this facility.

9. Clients have the right to confidential treatment of information about their clinical care. Information in the client's clinical records shall not be released to anyone outside the facility without the written approval of the patient or guardian if the patient is a minor, unless the release is required and permitted by law, or is needed by the NJ Dept. of Health for statutorily defined purposes. The OTHS may release data about client's for studies containing aggregated statistics when the client's identity is masked.

10. Clients have the right to be treated with courtesy, respect, consideration, and respect for their dignity, individuality and right to privacy, including but not limited to, auditory and visual privacy. The client's right to privacy shall be respected when facility personnel are discussing the client.

11. Clients will not be required to perform work for the facility unless the work is part of the client's treatment and is voluntary. Such work shall be in accordance with local, State and Federal laws and rules.

12. Clients have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance in religious services, shall be imposed on any clients.

13. Client have the right to not be discriminated against because of age, race, religion, sex, nationality, or the ability to pay; or be deprived of any constitutional, civil, and/or legal rights solely because of receiving services at the OTHS.

Any client who has a complaint or grievance pertinent to the rights defined above, or other perceived rights, may make complaint to:

Sharon Moleski, MA, LPC, LCADC, CCMHC
Community Services Director
601 Deal Road
Ocean, NJ 07712
732-531-2600

and/or

Division of Mental Health and Addiction Services (DMHAS)
P.O. Box 707
Trenton, New Jersey 08625-0707
1-877-712-1868 (Toll Free)

I have been advised of and received a copy of the above summary.

Client Name (Print)	**Client Signature**	**Date**
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**
Counselor Name (Print) **witness**	**Counselor Signature**	**Date**

Township of Ocean
Department of Human Services
601 Deal Road, Ocean, NJ 07712 • 732-531-2600

Authorization for Use and Disclosure of Protected Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and NJ confidentiality law governing mental health and substance abuse services.

Client Name: _____ Date of Birth: _____

I, _____ request and authorize The Township of Ocean
(Name of client or client's legally responsible person/personal representative)
Department of Human Services to obtain from and or disclose to:

_____
(Name of Individual or Entity)

_____
(Street Address) (Town) (State) (Zip Code)

the following protected information: (*Circle yes or no on the following specific information.)*

* Assessment (yes) (no) * Substance Abuse Evaluation (yes) (no) * Laboratory Results (yes) (no)

* Treatment Plan (yes) (no) * Progress Notes (yes) (no) * Attendance (yes) (no) * Discharge Summary (yes) (no)

* Medication Information (yes) (no) * Psychiatric Evaluation (yes) (no) * Academic History & Current Performance (yes) (no)

* Compliance (yes) (no) * Other/*Specify:* _____

Purpose: _____

This information may be given _____
(Indicate frequency)

Since I have signed authorization to release this information, I understand that the federal privacy law (45 C.F.R. Part 164) may not apply to who receives this information and, therefore, the information could be given to others. However, other laws may prohibit this. When we disclose mental health information protected by state law (NJ Administrative Code-Title 10) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we inform those we are sending this information to that releasing it again is prohibited except in the circumstances that the law allows. Our Notice of Privacy Practices describes those circumstances for disclosing information.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically one year from date signed.

Instructions for Revocation of an Authorization: Please put in writing request for revocation, specify what information you do not want disclosed and forward the request to your treating provider.

Client Name (please print)	Client Signature	Date
Name or Parent of Legal Guardian (please print)	Parent or Legal Guardian Signature	Date
Name of Staff (please print) witness	Staff Signature	Date

Update 4/2020

Township of Ocean
Department of Human Services

601 Deal Road, Ocean, NJ 07712 • 732-531-26000

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7. Clients have the right to voice grievances or recommend changes in policies and services to facility personnel, governing authority, and/or outside representatives of the patient's choice; either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.

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CLIENT COPY

Update 01/14

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Community Services Director
601 Deal Road
Ocean, NJ 07712
732-531-2600

and/or

Division of Mental Health and Addiction Services (DMHAS)
P.O. Box 362
Trenton, New Jersey 08625-0362
1-877-712-1868 (Toll Free)

☐ *"I have been advised of and received a copy of the above summary."*

Client Name (Print)	**Client Signature**	**Date**
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**
Counselor Name (Print) witness	**Counselor Signature**	**Date**

CLIENT COPY

Township of Ocean
Department of Human Services

601 Deal Road • Ocean, NJ 07712 • 732-531-2600

Client Information and Informed Consent for Telehealth Counseling and Therapy

Telehealth services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for therapy, follow-up contacts, and consultations. It is important that both the client and the therapist be located in a private place during their sessions, and that the security of their technology be up-to-date with appropriate security protection.

In agreeing to participate in telehealth counseling, I, the client, understand the following:

• I understand that telehealth services are completely voluntary. I can withdraw my consent at any time and either commence traditional in-person therapy (when available at this office) or terminate the counseling relationship.
• I understand that none of the telehealth sessions will be recorded or photographed without my written permission and the written permission of the therapist.
• I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
• I understand that because this is a technologically-based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
• I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
• My therapist has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.
• I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing, text, email, or telephone connections are not adequate for the situation.
• I understand that I will be required to be in a safe and private place with no distractions, at the appointment time and for the duration of the counseling session.
• I understand that if there is an emergency during a telehealth session, then my therapist will call emergency services and my emergency contacts.
• I understand that if the video conferencing or telephone connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.
• I understand that I am required to provide and keep current a safety plan that is shared with my therapist in case of an emergency (see below).
• I understand that telehealth-based services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area.
• I understand that this form is signed in addition to the Personal Information, Client Health Screening, Informed Consent for Counseling and Client Rights and that all policies and procedures within the Personal Information, Client Health Screening, Informed Consent for Counseling and Client Rights document apply to telehealth services.

• I understand I may be requested to install applications specific to treatment onto my phone, tablet or computer device. Some applications specifically interact via phone / tablet, device,etc. and have the capability to report activity, GPS location, etc.

Consent:
I consent to engaging in telehealth as part of my treatment with Ocean Township Department of Human Services and my therapist. I understand the information provided above regarding telehealth. I hereby give my informed consent for the use of telehealth in my care. I understand this document, **Client Information and Informed Consent for Telehealth Counseling and Therapy,** as well as the **Personal Information, Client Health Screening, Informed Consent for Counseling** and **Client Rights** documents must be completed in full, signed and returned to Ocean Township Department of Human Services, 601 Deal Road, Ocean, NJ 07712 prior to the date of my initial appointment.

Client Name (please print)	Client Signature	Date
Name or Parent of Legal Guardian (please print)	Parent or Legal Guardian Signature	Date
Name of Staff (please print)	Staff Signature	Date

Telehealth Safety Plan Addendum (must be completed for telehealth services)

Client Name (first and last): _____
Physical Address of Client during telehealth sessions:
Street: _____
City: _____ County: _____ State: _____ Zip: _____
(It is required that the client announce their location at each session when using telehealth services.)
Client's Phone Number: _____ Alternative Phone Number: _____
Emergency Contact (1): _____ Relationship: _____
Phone Number: _____ City/State: _____
Emergency Contact (2): _____ Relationship: _____
Phone Number: _____ City/State: _____

• I have provided two emergency contact numbers and the number to the local hospital or other facility as deemed appropriate.
• If there is an emergency during a session, my therapist has permission to contact my emergency contacts and the local hospital.
• I have provided a working telephone number to reach me if the video conferencing connection fails during a session.
• My therapist has provided me with a contact number (732-531-2600). If connections fail and my counselor does not call me back within 5 minutes, then I will call my therapist.

Client Name (please print)	Client Signature	Date
Name or Parent of Legal Guardian (please print)	Parent or Legal Guardian Signature	Date