KIC
BEHAVIORAL & COUNSELING SERVICES

5051 Route 42, Unit 4
Turnersville, NJ 08012
Tel: 505-565-5068

Referral / Demographics Assessment

Name_____ DOB _____SS#_____

Address_____ Zip Code_____

Home Telephone_____ Cell Phone Number _____

Which do you prefer us to call? House ☐ Cell ☐

Is it ok to leave a message? Yes ☐ No ☐

Health Insurance Company _____

Primary Subscriber _____ DOB_____

Are you the Primary Subscriber? Yes ☐ No ☐

Pharmacy Name _____ Pharmacy Number _____

Emergency Contact

Name _____ Relationship _____

Telephone _____ Home ☐ Cell ☐

Any Legal or Disability Issues Pending? _____

Smoker: Current ☐ Former ☐ Never_____

Referral Source (Who referred you to our services?):

_____

_____

Reason for Referral (Reason you are seeking services):

_____

_____

Previous Mental Health Treatment:

_____

_____

Previous Substance Abuse Treatment:

_____

_____

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Current Medications:

Medical Issues:

Current Suicidal Ideations:

Current Homicidal Ideations:

Past Suicidal Attempts:

Current Mental Health Programs / Services:

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KIC Behavioral & Counseling Services Financial Agreement

Patient Name:

Please select one of the following financial arrangements:

☐ **Insurance**

I hereby request that payment for services rendered to me or my child by KIC Behavioral & Counseling Services be paid directly to KIC Behavioral & Counseling Services.

Please check and complete all that apply below:

KIC Behavioral & Counseling Services may bill my insurance for services received.

Insurance ID#_____**COPAYMENT FEE $**_____

☐ **Medicare**

I hereby authorize KIC Behavioral & Counseling services to release the Medicare offices or its authorized agent's nay information about me needed to process claims.

Medicare ID#_____**INITIAL COPAYMENT $**_____ **FOLLOW UP $**_____

☐ **Flat Rate (Self Pay)**

I agree to pay the following rate each day that I engage in billable services.

INITIAL FLAT RATE FEE $_____ **FOLLOW UP FLAT RATE FEE $**_____

Patient/Responsible Party Signature_____Date _____

Staff Signature_____Date_____

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CONSENT FOR SERVICES

I have been informed of the services that I may receive from KIC Behavioral & Counseling Services.

SERVICES MAY INCLUDE

- ☐ Psychiatric Evaluation
- ☐ Activities of Daily Living
- ☐ Medication Management
- ☐ Assessment & Evaluation
- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Treatment Planning
- ☐ Psycho-Education Services
- ☐ Linkage to Other Services

I consent to these services and understand that I am expected to be involved in all aspects of my care services. I will be informed and involved as new or different services are implemented.

I understand that my decision to consent to services is voluntary and that I can withdraw my consent and /or terminate treatment at any time. If I consider withdrawing my consent and/or terminating treatment, staff at KIC Behavioral & Counseling Services will explain what other options that may help me make informed decisions.

I hereby give my informed consent to receive services from KIC Behavioral & Counseling Services.

Patient / Responsible Party Signature_____Date_____

Staff Witness Signature_____Date_____

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Dear Patients,

If you have applied for disability or are planning to, please be aware of our policies, which extends to other paperwork documents (i.e., work forms, governmental support forms, etc.):

- We cannot complete your paperwork until at least 6 visits, and this may take up to 6 months.
- We cannot send or release your documents if you have any outstanding balances.
- We charge fees for completing paperwork. The fee must be paid before paperwork is completed.
- We do expect that you will continue to attend your follow up appointment with us.

Please feel free to ask us for clarification regarding the above statements if needed.

We thank you in advance for your cooperation.

Sincerely,

KIC Behavioral & Counseling Services

Patient Acknowledgment / Signature_____Date_____