Mermini Counseling, LLC

218 Lorraine Ave
Upper Montclair, NJ 07043
(T) 973-634-2752
(F) 973-746-7731

OFFICE POLICIES

As a Licensed Clinical Social Worker, I am dedicated to providing quality care for my clients. I offer individual, marital, family, and group therapy to children, adolescents and adults. My goal is to enhance emotional well being with an emphasis on developing effective coping strategies and skills to ensure optimal functioning in all areas of daily life.

Payment and fees: Payment of fees/co-pay is expected at the time of service. I accept cash or checks. Please let me know about any extenuating circumstances. Signing this form confirms we have discussed the fees for which you are responsible.

Insurance: In-network claims will be sent to the insurance company for payment. Out-of-network claims are your responsibility. I will give you a statement at the end of each month for you to submit to your insurance company for reimbursement.

Cancellations: Please provide a minimum of 24 hours notice for cancellations. Please cancel by Friday for a scheduled Monday session. As is standard in the industry, and since your session is reserved for you, you will be charged your session fee for not showing or canceling late. The charge will be the fee you pay for a session out-of-network or the full contracted rate if I am in-network with your insurance company. I do understand that there are unforeseen situations, which may prevent you from giving ample notice.

Emergency/crises: Please contact me at 973-634-2752 in the case of a crisis. At that point, I will assist you in resolving the crises and/or set up an appointment for you as soon as possible. If you are having a life-threatening emergency or you are unable to reach me dial 911 and/or go to your nearest emergency room for help.

Complaints: If you have any concerns or issues regarding treatment at any time, please discuss them with me, so we can come to a mutual resolution as soon as possible.

Termination: Please provide ample notice (2-4 weeks) if you decide to terminate treatment. Leaving therapy abruptly can be counterproductive to a positive therapeutic outcome.

_____ _____

Client/Parent/Guardian signature and date Clinician signature and date

Mermini Counseling, LLC

PATIENT INFORMATION

(All information is regarded as confidential)

(PLEASE PRINT CLEARLY)

TODAY'S DATE _____

REVISED DATE _____

REFERRED BY _____

NAME _____ BIRTHPLACE _____
(Last) (Client/First) (Middle)

SOCIAL SECURITY _____ MARITAL STATUS _____

ADDRESS _____ ZIP CODE _____
(Street) (City)

PHONE # _____
(Home) (Cell) (Work)

EMPLOYER _____ ADDRESS _____

NAME OF
SPOUSE/PARENT _____ ADDRESS _____

SOCIAL SECURITY #
OF SPOUSE/PARENT _____ PHONE _____

PRIMARY INSURANCE
COMPANY _____ POLOCY # _____

NAME OF
INSURED _____ SOCIAL SECURITY # _____

INSURANCE THROUGH
EMPLOYER _____ IF YES, ID# _____ GROUP # _____

SECONDARY ISURANCE _____ COMPANY NAME _____

CLAIM FORM SUPPLIED _____ STANDARD FORM ACCEPTED _____

ADRESS TO SEND CLAIM _____

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*A professional's time is valuable and costly. When an appointment is scheduled, that time is set aside especially for you. That is why a 24-hour notice must be given in the event it becomes necessary to cancel. Appointments are scheduled with the understanding that if 24-hour notice is not given for cancellation you will be charged for the missed session.

*I have been given the opportunity to receive a copy of the HIPPA Policy. I understand the policy.

*I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after possible insurance benefits.

*Co-Pays are due at the time of visit.

I have read the above statements and understand them.

Signed: _____ Date _____
(Patient/Parent if Minor)

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the names provided for professional services rendered.

Signed: _____ Date _____
(Patient/Parent if Minor)

RELEASE OF INFORMATION

I authorize the release of any medical information to process this claim.

Signed: _____ Date _____
(Patient/Parent if Minor)