Jewish Family SERVICES

Adult Therapy (Current Client)

Please complete all paperwork prior to your appointment. Insurance card must be presented at each appointment.

Client Legal Name or as listed on insurance: _____

Name you prefer to be called, if different than above: _____

Client DOB: _____/_____/_____

Client Address: _____

City: _____ **County** _____ **Zip**_____

Preferred Phone _____ ❒ *Check if JFS is authorized to leave message*

Other Phone _____ ❒ *Check if JFS is authorized to leave message*

Email _____ ❒ *Check if JFS is authorized to send information*

Gender: _____ **What pronouns do you use:** _____ **(ex., He/Him; She/ Her; They/ Them)**

Race: _____ **Religion:**_____

Marital Status: _____ **Sexual Orientation :** _____

Employment Status: *Full-Time* *Part-Time* *Temporary* *Unemployed* *Retired* *Student* *Other*

Yearly Household income : $_____, Number of people living in home : Adults: _____, children_____

Reason for Contacting JFS: _____

_____

How did you hear about JFS: ☐Friend/Family ☐JFS Marketing ☐Jewish Agency ☐Non-Jewish Agency ☐Physician ☐Self ☐Clergy

☐ Synagogue: which one _____☐Volunteer ☐Website ☐Psychology Today ☐Other _____

Primary Care Physician: _____**Phone:** _____

Preferred Hospital/Clinic: _____**City:**_____

Primary Insurance Carrier _____**Name of Policy Holder:**_____

Policy #: _____ **Group #:** _____ **DOB of Policy Holder:** ____/_____/_____

Adult Therapy (Current Client)

Secondary Insurance Carrier _____ ____Name of Policy Holder:_____

Client Legal Name: _____Client DOB: _____/_____/_____

In Case of Emergency, Please Contact the Following Individual:

Name: _____ Relationship: _____

Preferred Phone Number: _____

I hereby give permission for JFS to provide, seek, and consent to emergency treatment for the client named above, as may be necessary.

_____ Date_____/_____/_____
Signature of JFS Client or Guardian

_____ Date_____/_____/_____
Printed Name of JFS Client or Guardian

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Adult Therapy (Current Client)

Client Legal Name: _____ Client DOB: _____/_____/_____

PLEASE INITIAL THE FOLLOWING:

_____ I have read and agree to the Office Policies, Clients Rights & Privacy Practices (you may view a copy of these on the JFS website or request a copy from the JFS office).

_____ I understand that I must complete the following forms prior to consultation, and update them annually:

1. Emergency Information
2. Policies and Guidelines
3. Clinical Surveys

_____ I grant permission for JFS, and their representatives, to communicate with me via email as indicated below. I confirm that the email address that I have given is a private email and I release JFS from any responsibility for access to my private email by any person not authorized by me. See JFS Email Informed Consent Policy.

I authorize my therapist/case worker to communicate with me via e-mail. Yes❒ No❒
I authorize JFS staff to send appointment reminders via e-mail. Yes❒ No❒
I would like to receive email communication regarding JFS services and programs. Yes❒ No❒

_____ All fees or costs have been explained to us/me.

CLIENT CONSENT FOR SERVICES

PLEASE INITIAL EACH LINE:

_____ We/I agree to allow Jewish Family Services of Greater Charlotte (JFS) to provide services to me/my child/my ward.

_____ We/I will participate in developing a service plan, which will identify goals to work toward, time frames and methods to achieve these goals.

_____ JFS services have been described to me/us.

_____ We/I have been informed about the alleged benefits, potential risks, and possible alternative methods of treatment and the ways that JFS can support the achievements of the desired outcomes.

By signing below, I certify that I have answered the questions above honestly and accurately.

_____ Date_____/_____/_____
Signature of JFS Client or Guardian

_____
Printed Name of JFS Client or Guardian

_____ Date_____/_____/_____
Signature of JFS Staff Member