Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833

jen66acker@gmail.com
917-841-0388

Licensed:
NY License # 070538-1
NJ License #44SC06635700
CT License # 014163
FL License #4283

New Client Questionnaire

Please fill out this biographical background form as completely as possible. Information is confidential as outlined in the office policy form and HIPAA Notice of Privacy Practices. If you do not wish to answer any question, just write, "Do not care to answer"

Today's Date _____

How were you referred to me?

_____

Name _____

Date of Birth _____

Gender Identity: Male ___ Female ___ Non Binary ___ Transgender ___

Gender Neutral ___

Contact Information

Street Address_____

City _____ State _____ Zip Code _____

Cell Phone (____)_____

Can I leave a message on the best reachable phone number? _____

Email address _____

Emergency Contact Information

Who do I call in case of an emergency?

Name_____

Phone Number (_____) _____

Relationship to you _____

About You Information

Education _____

_____

Occupation _____

Do you enjoy your work?

_____
_____
_____
_____

Presenting Problem

What is the presenting problem that brings you to therapy with me?

_____
_____
_____
_____

When did it start?

_____

How does this impact you?

_____
_____
_____
_____

What does this have you believing about yourself?

_____
_____
_____
_____

What are your goals for Therapy?

1) _____
_____
_____
_____

2) _____
_____
_____
_____

3) _____
_____
_____
_____

4) _____
_____
_____
_____

How would you rate how severe your above problem is?

Mild ____ Moderate ____ Severe ____

What would the best case outcome be?

_____
_____
_____
_____

What gives you the most joy or pleasure in your life?

_____
_____
_____
_____

What are your most important hopes and dreams?

_____
_____
_____
_____

What are your main worries and fears?

_____
_____
_____
_____

Estimate how many hours a day you spend online:

Facebook____ Youtube____ Video Games____ Surfing____ Work____
School____ InstaGram____ Texting____ AI use____ AI platform____

Do you feel your technology use is balanced and healthy? Or could it use some improvement?

_____
_____
_____
_____

Marital Status

Single ____ Married_____ Divorced ____ Widowed ____

Name of Spouse/Partner _____

Length of Relationship _____

Describe your relationship (What are the strengths and weaknesses)

_____
_____
_____
_____

Past Marriages/Relationships

1) Name_____

Years together _____

Nature of Relationship

_____

_____

Cause for ending _____

_____

_____

_____

2) Name_____

Years together _____

Nature of Relationship

_____

_____

Cause for ending _____

_____

_____

_____

<u>Family History Information</u>

Parents/ Stepparents

Are your parents divorced? If so, how old were you when they divorced? Do you know the reason for divorce?

_____

_____

_____

_____

How did this impact you?

_____
_____
_____
_____

1) Name _____

   Father ___ Stepfather ___ Mother____ Stepmother____

   Age or Date of Death _____

   Cause of death if applicable_____

   Occupation _____

   Personality_____
   _____

   Nature of relationship
   _____
   _____

2) Name_____

   Father ___ Stepfather ___ Mother____ Stepmother____

   Age or Date of Death _____

   Cause of death if applicable_____

   Occupation _____

   Personality_____
   _____

   Nature of relationship
   _____
   _____

3) Name_____

Father ___ Stepfather ___ Mother____ Stepmother____

Age or Date of Death _____

Occupation _____

Personality_____

_____

Nature of relationship

_____

_____

Do you have children/step-children?

1) Name _____

Biological ____ Stepchild____ Adopted ___

Age _____

Nature of relationship

_____

_____

2) Name_____

Biological ____ Stepchild____ Adopted ____

Age _____

Nature of relationship

_____

_____

3) Name _____

Biological ____ Stepchild____ Adopted ____

Age _____

Nature of relationship

_____

_____

Do you have any siblings?

1) Name _____

   Biological ____ Step/half ____ Adopted ___

   Age or Date of Death _____

   Cause of death if applicaple_____

   Occupation _____

   Personality_____

   _____

   Nature of relationship

   _____

   _____

2) Name _____

   Biological ____ Step/half ____ Adopted ____

   Age or Date of Death _____

   Cause of death if applicaple_____

   Occupation _____

   Personality_____

   _____

   Nature of relationship

   _____

   _____

Best Friend(s)

Name _____

Age _____

Local or Long Distance _____

Length of Friendship _____

Personality_____

_____

Nature of relationship

_____
_____

Childhood

Describe your childhood in general (school experiences, neighborhood, home life, etc)

_____
_____
_____
_____

Religion

Do you have a religion? _____

What is your denomination _____

Other information that is important re: religion to you?

_____
_____
_____

<u>Medical History</u>

Primary Care Physician Name _____

Phone number (____) _____

Any major medical problems? (surgeries, falls, illness, etc)

_____
_____
_____
_____

Are you currently on any medications?

1) Name of medication _____

   Dose_____

   Prescribed by _____

2) Name of medication _____

   Dose_____

   Prescribed by _____

3) Name of medication _____

   Dose_____

   Prescribed by _____

Past/ Present Drug/ Alcohol Use/Abuse?

_____
_____
_____
_____

Suicidal Ideations? Attempts?

Age(s) _____

Circumstances

_____
_____
_____
_____

Violent Behavior?

Age(s) _____

Circumstances

_____
_____
_____
_____

Family History of Addiction

_____
_____
_____
_____

Family History of Mental Illness (Suicide, depression, etc)

_____
_____
_____
_____

Family Medical History (Describe any illness that runs in the family)

_____
_____
_____
_____

Past/ Present Psychotherapy

Who provided the treatment?

_____

Length of treatment

Date Started _____

Date Ended _____

Why did the therapy
terminate?_____
_____
_____
_____

Was it successful? Describe why or why not

_____
_____
_____
_____

Are you involved in any current or pending civil or criminal litigations/ lawsuits? If yes, please explain.

_____
_____
_____
_____

Are you involved in a divorce or custody dispute? If yes, please explain.

_____
_____
_____
_____

TO BE FILLED OUT BY JENNIFER ACKER

Diagnosis ICD 10

_____

Criteria

_____
_____
_____
_____
_____
_____
_____
_____

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

Practice Policy

It is important for patients and therapists to have a clear understanding of the general policies and procedures that govern their work together. I am therefore describing these policies to allow our joint efforts to proceed smoothly and efficiently.

Consultation

There will be an initial consultation/evaluation session to determine the nature and best approach toward resolving the problems to be addressed. At the end of the consultation, we will agree on a mutually convenient day and time to conduct our sessions.

ANY SCHEDULING CHANGES MUST BE MADE 48 HOURS PRIOR TO OUR SCHEDULED TIME.

- If this is not done, and the appointment is not kept, you, the patient, will be charged for the session. There are no exceptions i.e. sickness, last-minute business meetings etc.

Sessions

Clinical Sessions are 50 minutes, and every effort will be made to start and end on time.

- Regular sessions are 50 clinical minutes long.
- Intensive Sessions are 3-5 clinical hours long

Payments

All sessions must be paid in full at the time of the session unless otherwise agreed upon. Payment is preferred prior to each session.

Intensive Sessions must be paid 48 hours prior to the appointment. If payment is not received 48 hours prior to the intensive, the intensive will be canceled.

In the event your account is overdue and turned over to collections, the patient will be responsible for any collection fee.

Billing

Statements and paid receipts are prepared monthly at the end of the month.

Insurance

I do not accept or work with any insurance.

Email and Text

Emails and phone calls are returned 24/48 hours, with the exception of weekends, which will be the next business day.

Texting is for basic communication IE running late, stuck at work, and not for lengthy communication

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

In the event you need me to contact you, please call

_____

If I'm unable to reach you,

If unable to reach me:
___Leave a Message
___Please leave a message only asking for a returned call

Client Agreement

I agree to pay the psychotherapy fee of $_____ per session. I have read the above practice policy statements and agree to abide by its terms, including releasing fiscal information to insurance companies and collection companies as needed.

Name(Printed)_____

Name (Signature)_____

Date:_____

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

Medical Information Release Form - HIPAA Release Form

Name: _____

Date of Birth _____

Release of Information

I authorize the release of information, including diagnosis, records, examination rendered to me, and claims information. This information may be released to:

___ Spouse
Name:_____

___Child(ren):
Name:_____
Name:_____

___ Other
Name:_____
Name:_____

This release of information will remain in effect until terminated by me in writing

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

Patient Contact Information Release Form

In the event you need to contact me, please call
___Home
___Work
___Cell

If unable to reach me:
___Leave a Message
___Please leave a message only asking for a returned call

Name (Printed)_____
Name (Signature)_____
Date:_____

Witness (Printed)_____
Witness (Signature)_____
Date:_____

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

Paying your Invoice with Jennifer Acker, LCSW, PC

We take 2 forms of payment: Zelle or Venmo.

My Venmo is: @jennifer-acker-5
My Zelle is: jen66acker@gmail.com

Intensive Sessions- Half of your session total payment is due at the time of booking to secure a spot. Payment in full is due a week before your intensive session.

Libby, my assistant, handles all of my invoicing. Please reach out directly to her at officeof.jenniferackerlcswpc@gmail.com with any questions you have regarding anything related to invoices.

Before making your *first* payment, please email Libby and let her know what platform you intend to use so she can update our system. We need to know where your payment will be coming from.

Each time you make your payments, please indicate what session date(s) your payment is for and who you were seen with, and email Libby once you have made your payment. This is very important.

Jennifer Acker, LCSW, CSAT-S, CPTT-S, SP Certified, EMDR

NPI# 1225764848
Tax ID# 27-3711833
NJ License #44SC06635700
NY License # 070538-1
CT License # 014163
FL License #4283

jen66acker@gmail.com
917-841-0388

Venmo : @jennifer-acker-5
Zelle:jen66acker@gmail.com

Professional Disclosure & Informed Consent with Jennifer Acker, LCSW, PC

This document is intended to be added to the end of the current New Client Packet without replacing any existing forms or policies.

Professional Relationship

The therapeutic relationship is a professional relationship designed to support your treatment and well-being. To maintain appropriate ethical boundaries, therapists do not engage in personal relationships, friendships, social media connections, or other dual relationships with current or former clients.

If we happen to see one another in public, your therapist will not initiate contact in order to protect your privacy. If you choose to greet your therapist, they will respond respectfully while maintaining appropriate professional boundaries.

Your Rights as a Client

You have the right to:
• Participate in decisions regarding your treatment.
• Ask questions about your care and treatment recommendations.
• Be informed of the therapeutic methods being used.
• Request access to your records as permitted by law.
• End therapy at any time.

Confidentiality

Your privacy is extremely important. Information discussed during therapy is confidential except when disclosure is required or permitted by law. These situations include, but are not limited to:
• Risk of serious harm to yourself.
• Risk of serious harm to another person.
• Suspected abuse or neglect of a child, elderly adult, or vulnerable adult.
• Court orders or other legal requirements.

When clinically appropriate, your therapist may consult with Jennifer Acker or another qualified clinical supervisor regarding your treatment. Any consultation remains confidential and is conducted in accordance with professional ethical standards.

Mental Health Emergencies

Jennifer Acker & Associates does not provide emergency or crisis services.

If you are experiencing a mental health emergency, believe you may harm yourself or someone else, call 911, go to your nearest emergency room, or contact the 988 Suicide & Crisis Lifeline.

Email and text messages are not monitored continuously and should never be used for emergency situations.

Court Involvement

Jennifer Acker & Associates provides psychotherapy services and is not a forensic practice.

Our therapists do not prepare custody recommendations, legal evaluations, court reports, or provide testimony in legal proceedings unless required by law or subpoena.

If you anticipate needing a mental health professional for legal matters, including custody or court proceedings, we recommend seeking a provider who specializes in forensic evaluations.

Telehealth Services

Telehealth sessions are subject to the same confidentiality standards as in-person therapy. Recording therapy sessions by either the client or therapist is prohibited unless prior written consent has been obtained.

Use of Artificial Intelligence (AI)

Jennifer Acker & Associates may utilize secure AI-assisted technology to assist with clinical documentation, treatment planning, and administrative tasks.

These tools are used solely to support your therapist's work and never replace professional clinical judgment. All documentation is reviewed, edited, and approved by your therapist before becoming part of your clinical record.

Only the minimum information necessary is used, and all applicable privacy and confidentiality standards are maintained.

If you have questions regarding the use of AI-assisted documentation, please discuss them with your therapist.

Ending Therapy

You have the right to end therapy at any time.

Whenever possible, we encourage discussing your decision with your therapist and scheduling a final session to review your progress, answer remaining questions, and provide referrals or additional resources if appropriate.

Acknowledgement & Consent

I acknowledge that I have read and understand the Professional Disclosure and Informed Consent contained in this packet. I have had the opportunity to ask questions, and any questions I had have been answered to my satisfaction.

I understand the nature of the therapeutic relationship, confidentiality and its limitations, practice policies, and my rights as a client. By signing below, I voluntarily consent to participate in psychotherapy services provided by Jennifer Acker & Associates.

Client Name (Printed): _____

Client Signature: _____

Date: _____

Therapist Name (Printed): _____

Therapist Signature: _____

Date: _____