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

Tax ID 27-3711833
License 070538-I
NPI 12257644848

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

917-841-0388

jen66acker@gmail.com

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____ Other____

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 _____

_____

_____

_____

Family History Information

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?

_____
_____
_____

Medical History

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

_____
_____
_____
_____
_____
_____
_____
_____

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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 or 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, 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 will it will be the next business day. Texting is for basic communication IE running late, stuck at work and not for lengthy communication

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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:_____

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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.

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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:_____

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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

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. When you make your payment, please indicate what session date(s) your payment is for and who you were seen with. This is very important.