J&T Behavioral Health and
Counseling Services

700 Liberty Place
Sicklerville, NJ 08081
Tel: 856-776-7540
Fax: 856-776-7512

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 *(Reasons why you are seeking services)*

Previous Mental Health Treatment

Previous Substance Abuse Treatment

Current Medications

Medical Issues:

Current Suicidal Ideations: _____
Current Homicidal Ideations: _____
Past Suicidal Attempts: _____
Current Mental Health Programs / Services:

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CONSENT FOR SERVICES

I have been informed of the services that I may receive from **J&T Behavioral Health and Counseling Services**.
SERVICES MAY INCLUDE:

- Psychiatric Evaluation
- Activities of Daily Living
- Medication Management
- Assessment and 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 actively involved in all aspects of my care. I will be informed and included as new or different services are implemented. I understand that my decision to consent to services is voluntary and that I may withdraw my consent and/or terminate treatment at any time. If I consider withdrawing my consent and/or

terminating treatment, staff at J&T Behavioral Health and Counseling Services will discuss other available options to help me make an informed decision.
I hereby give my informed consent to receive services from **J&T Behavioral Health and Counseling Services**.
Patient / Responsible Party Signature: _____ Date: _____
Staff Witness Signature: _____ Date: _____

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J&T Behavioral Health and 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 **J&T Behavioral Health and Counseling Services** be paid directly to the provider.
Please check and complete all that apply:
J&T Behavioral Health and Counseling Services may bill my insurance for services received.
Insurance ID #: _____
Copayment Fee: $ _____
☐ **Medicare**
I authorize **J&T Behavioral Health and Counseling Services** to release any necessary information to Medicare or its authorized agents for the purpose of processing claims.
Medicare ID #: _____
Initial Copayment: $ _____
Follow-Up: $ _____
☐ **Flat Rate (Self-Pay)**
I agree to pay the following rate for each day I receive billable services.
Initial Flat Rate Fee: $ _____
Follow-Up Flat Rate Fee: $ _____

Patient / Responsible Party Signature: _____ Date: _____
Staff Signature: _____ Date: _____

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

I, _____, a client at **J&T Behavioral Health and Counseling Services**, understand that certain controlled substances— including, but not limited to, benzodiazepines (Ativan, Klonopin, Xanax, etc.), stimulants (Adderall, Vyvanse, Focalin, Concerta, etc.), narcotic pain medications, barbiturates, and others—can be misused or abused, leading to dependency or relapse of a prior addiction. I have been informed by **J&T Behavioral Health and Counseling Services** to follow strict guidelines regarding their use.

I Understand and Agree to the Following:

1. This agreement applies to all medications prescribed for my condition by my providers.
2. Medications for the management of my mental health will be prescribed by **J&T Behavioral Health and Counseling Services** only if I comply with all rules and conditions in this agreement. Failure to comply may result in discontinuation of medications and/or discharge from services.
3. All prescriptions from other providers must be filled at the same pharmacy. Any pharmacy changes must be reported to **J&T Behavioral Health and Counseling Services**.
4. I will inform **J&T Behavioral Health and Counseling Services** of any other medications I take from any other provider.
5. I will not obtain medications from other providers for conditions related to my treatment, as combining medications may cause harm.
6. I will not share, sell, or allow anyone—including family or friends—to have access to my medication(s).
7. I will store medication(s) securely to prevent theft or loss. I will not assist in, allow, or participate in the misuse or diversion of medication(s). Lost or stolen medications/prescriptions will not be replaced.

8. I understand that refills will not be provided before the scheduled refill date, even if I run out early. When traveling, I must arrange refills in advance.
9. If my provider determines that my medication(s) are not providing sufficient benefit, they may change or discontinue my prescription(s).
10. I acknowledge my condition may require additional therapies (e.g., psychotherapy, alternative medical care) and that my active participation in the recommended treatment plan is essential.
11. I agree that consultation with or referral to a specialist may be necessary for medical or substance abuse concerns.
12. I give permission for my providers to discuss my medication(s) with other treating physicians or pharmacists.
13. I must attend all recommended follow-up appointments to avoid discontinuation of treatment or medication(s).

Patient Signature: _____ Date: _____
Staff Signature: _____ Date: _____