Life Navigation, LLC

14 Ann Street
West Haven, CT 06516
(203) 910-1111 phone fax (203) 717-0210

Name: ____ DOB:_________________

Address: ____

Phone: __________________________ Email: _____________________________________

Status: Single Married Other employed full time student part time student

Insurance:__________________________ Relationship to Insured:
____

If not self, Insured name: __________________________________ Insured DOB: ______________
Insured address: ____

This information is to be used for billing purposes. I agree to allow my insurance or employee assistant company to be contacted for billing purposes which includes a medical diagnosis. I am aware that my signature will be kept on file to be used on HCFA 1500 (CMS forms)

X____ Date: __________________

Client Information

Fees & Cancellation Policy: The copay must be paid at each session. It is necessary to cancel appointments within 24 hours of scheduled appointment time. **You will be charged $50** for the session, if you do not cancel within 24 hours or you do not show.
Treatment Planning & Recommendations: We have a shared responsibility for achieving the goals and objectives in our work. We meet for 50 minutes and the frequency of the meetings, usually weekly or bi-monthly, will be decided together and based on the work to be accomplished.
Medication: It is important at times for me to coordinate with your primary care physician or psychiatrist if medication is necessary. If medication is recommended and you decide to end counseling or therapy, you must continue to work with the medical provider who monitors medication.
Confidentiality: Information shared in sessions is confidential. For any information to be shared, a release of information must be signed by you. As psychotherapists are mandated reporters according to the Connecticut State Law this does not apply to situations where there is potential harm to yourself or others as well as suspected child abuse. I am required to supply medical diagnosis to your medical insurance company if you wish to utilise your benefits. Finally, if a court subpoenas a record or a chart, I am responsible to provide the requested information.
Record Keeping: I maintain minimal records of our meetings which include: identifying information, data about referrals and medications, dates of visits, family histories that are relevant, goals and objectives of our work and closing notes to our meetings. This information is kept confidential.
With your permission I will contact you via text message or email to confirm your appointment 24-48 hours in advance.
Which method do you prefer to use: Text Email
I have read and understand the policies outlined above.

X ____ Date: __________________

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Jennifer Brothers MS, LADC

X__________________________ Relationship: __________________ Date: ______________