There are six items contained in this document. Please read the description of each item and instructions for its use before proceeding to the forms.

1. **New Client Information**
   Please print this five page new client questionnaire, fill it out, and bring it with you to your first appointment.

2. **Health Insurance Claim Form**
   Please print this single page insurance information form, fill it out, and bring it with you to your first appointment.

3. **Notice of Policies and Practices to Protect the Privacy of Your Health Information**
   Please read this four page information bulletin concerning privacy policies.

4. **Receipt and Acknowledgement of Notice**
   Please print this single page form and fill in your name, date of birth and social security number, sign and date it, and bring it with you to your first appointment.

5. **Psychotherapist Patient Services Agreement**
   Please print and read this six page information bulletin about professional services and business policies and bring it with you to your first appointment.

6. **Signature Page**
   Please print this single page form, sign and date it in two places as indicated, and bring it with you to your first appointment.

New Client Information

Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Is it OK to Leave Messages at your Home Number? Yes_____ No_____

Work Phone_____ Is it OK to Leave Messages at your Work Number? Yes_____ No_____

Cell Phone_____ E-Mail Address_____

Date of Birth_____

Gender M_____ F_____

Marital Status_____

Name of Major Medical Insurance Plan_____

Insurance ID Number_____

Social Security Number_____

Name of Insured (if other than patient)_____

Patient's Relationship to Insured_____

Date_____

Time_____

Name of Therapist_____

COUNSELING INFORMATION

How were you referred for counseling?_____

_____

What problem or concern has brought you for counseling at this time?_____

_____

_____

_____

Duration of Problem?_____

Have you had any previous counseling or therapy?_____

When?_____

With whom?_____

Have you ever been hospitalized for any mental health condition?_____

When?_____ Where?_____

What was the condition?_____

Are you currently having any thoughts of suicide?_____

Have you ever attempted suicide?_____

Are you having difficulty sleeping?_____

Are you having difficulty with appetite?_____

_____

FAMILY INFORMATION

Others in your household_____

_____

_____

_____

_____

No. of biological children_____ Ages_____

No. of adopted children_____ Ages_____

No. of step children_____

PERSONAL INFORMATION

What is your occupation?_____

Name of Employer_____

OVERALL, HOW SERIOUS IS THE PROBLEM FOR YOU? NOT VERY SERIOUS 1 2 3 4 5 VERY SERIOUS

HOW HAS THE PROBLEM AFFECTED YOUR:	DOES NOT APPLY	NOT AT ALL				VERY MUCH
Marriage/Partner	_____	1	2	3	4	5
Family	_____	1	2	3	4	5
Job Performance	_____	1	2	3	4	5
Friendships	_____	1	2	3	4	5
Financial Situation	_____	1	2	3	4	5
Health	_____	1	2	3	4	5
Legal Situation	_____	1	2	3	4	5
Parenting	_____	1	2	3	4	5
Temper	_____	1	2	3	4	5
Spirituality	_____	1	2	3	4	5

HEALTH HISTORY

Any significant health problems? Y_____ N_____ Physical handicaps? Y_____ N_____
Describe:_____

Any conditions/symptoms that may warrant further medical attention? Y_____ N_____
Describe:_____

Current medications_____
Dosage:_____
Prescribing Doctor's name:_____ Date last seen:_____
All allergies (including allergies to medications):_____

Any adverse reactions to medications:_____

FAMILY HISTORY (Please check all that apply to your parents, grandparents and siblings)

Substance Abuse_____ Alcohol Abuse_____ Suicide Attempt_____ Anxiety_____
Depression_____ Other psychiatric disturbance_____
Please Specify:_____

PREVIOUS TREATMENT:

None_____
Outpatient Psychotherapy_____
Inpatient Psychiatric_____
Outpatient Substance Abuse Program_____
Self-Help/Peer Support_____
Inpatient Substance Abuse_____
Dates of treatment:_____
Where treated:_____

Name of Program and/or therapist:_____

Psychotropic Medication_____

(If psychotropic medication was prescribed did you have a positive response?)

Yes_____ No_____

Alcohol Frequency:

Never_____ Less than 1 time/month_____ 1-4 times per month_____

2-3 times per week_____ Daily_____

Usual Alcohol Consumption:

None_____ 1-2 drinks per sitting_____ 3-4 drinks per sitting_____

5 or more drinks per sitting_____

Intoxication Frequency:

Never_____ Less than 1 time/month_____ 1-4 times per month_____

2-3 times per week_____ Daily_____

Alcohol-Related Problems: (check all that apply)

Binges_____ Job problems_____

Sleep disturbances_____ Physical withdrawal_____

Hangovers_____ Medical complications_____

Blackouts_____ Passes out_____

Seizures_____ Have you noticed changes in tolerance_____

Do you have difficulty to stop after the first drink_____

Does it cause problems in your relationship with others_____

Do you have concern over drinking_____

Recency of problem onset: (If there is a problem, when did it start?)

In the last month_____ 2-3 months ago_____ 6-12 months ago_____

More than one year ago_____ More than 5 years ago_____

History of treatment attempts: (Check all that apply)

None_____ Stopped on my own_____

Attended AA/other 12 step program_____

Attended inpatient program_____

Attended outpatient program_____

Attended community-based program_____

OTHER SUBSTANCE USE ASSESSMENT (Do you use any of the following?)

Over-the-Counter drugs (please specify):	How much are you taking?	HOW OFTEN? Twice a day	Daily	Weekly	Occasionally
_____	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____
Alcohol	_____	____	____	____	____
Marijuana	_____	____	____	____	____
Cocaine/Crack	_____	____	____	____	____
Heroin	_____	____	____	____	____
Other (please specify)	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE ☐ (Medicare#) | MEDICAID ☐ (Medicaid#) | TRICARE ☐ (ID#/DoD#) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☒ (ID#) | FECA BLK LUNG ☐ (ID#) | OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 22-3838034 ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (732) 264-8878

Center for Marriage & Family Therapy
746 Highway 34, Suite 3
Matawan, NJ 07747

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CENTER FOR MARRIAGE AND FAMILY THERAPY, P.C.

746 Highway 34, Suite 3
Matawan, New Jersey 07747

Jill Stein, LCSW, LMFT, BCD
Jacalyn Held, LCSW, LMFT, BCD
Karen Spiler, LCSW, LMFT, BCD

Phone: (732) 264-8878
Fac: (732) 566-7727

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Jill Stein, LCSW at 746 Highway 34, Suite 3, Matawan, NJ, 07747.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Jill Stein, LCSW at 746 Highway 34, Suite 3, Matawan, NJ 07747 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

CENTER FOR MARRIAGE AND FAMILY THERAPY, P.C.

746 Highway 34, Suite 3
Matawan, New Jersey 07747

Jill Stein, LCSW, LMFT, BCD
Jacalyn Held, LCSW, LMFT, BCD
Karen Spiler, LCSW, LMFT, BCD

Phone: (732) 264-8878
Fac: (732) 566-7727

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Center for Marriage and Family Therapy, PC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jill Stein, 746 Highway 34, Suite 3, Matawan, NJ 07747.

_____
Signature of Patient/Client **Date**

_____
Signature or Parent, Guardian or Personal Representative * **Date**

_____
* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____
Signature of Staff Member **Date**

CENTER FOR MARRIAGE AND FAMILY THERAPY, P.C.

746 Highway 34, Suite 3
Matawan, New Jersey 07747

Jill Stein, LCSW, LMFT, BCD
Jacalyn Held, LCSW, LMFT, BCD
Karen Spiler, LCSW, LMFT, BCD

Phone: (732) 264-8878
Fax: (732) 566-7727

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Please read these documents before our next session. When you sign this document it will represent an agreement, which you may revoke in writing at any time. That revocation will be binding unless action has been taken in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Health information in your Clinical Record (see Privacy Notice) related to billing and treatment required by your insurance company.

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I may also have contracts with other professionals. As required by HIPAA, I have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these people and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the social worker-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim related to the services I am providing, I may, upon appropriate request, disclose protected information to others authorized to receive it by the workers' compensation law.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to believe that a child has been subject to abuse, the law requires that I must report it to the Division of Youth and Family Services. Once such a report is filed, I may be required to provide additional information.

- If a reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and I believe that the disclosure is necessary to prevent serious harm to the patient or other potential victims, I may report the information to the county adult protective services provider. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a threat, or if I believe the patient presents a threat of *imminent* serious physical violence against a readily identifiable individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. I may also be required to break confidentiality if a patient presents a clear and present danger to the health or safety of an individual.

- If I believe the patient presents a threat of imminent serious physical harm to him/herself, I may be required to take protective actions. These actions may include contacting the police or others who could assist in protecting the patient or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Please be aware that in cases where the treatment has involved more than one adult (couples counseling, for example), no release of information can be made without the written authorization of both parties.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

CLIENT BILL OF RIGHTS

1. The client has the right to participate in the development of his/her treatment goals and treatment plan.
2. The client has the right to have a safe environment, free from sexual, physical, and emotional abuse.
3. The client has the right to request and receive information about the therapist's professional capabilities, including licensure, education, specialized areas of practice, and limitations on practice.
4. The client has the right to ask any questions about the procedures used during therapy and to receive clear, specific answers.
5. The client has the right to discuss their therapy with anyone they chose, including another therapist.
6. The client has the right to be freely informed about the terms of therapy such as its cost, appointment times, confidentiality, and any other aspects of treatment.
7. The client has the right to read a copy of the therapist's code of ethics.
8. Should the therapist determine that he or she is not able or qualified to provide needed services, the client has the right to be given that information in a clear and timely manner and referred to an appropriate therapist or facility for further treatment.

MINORS & PARENTS

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objection he/she may have.

COUPLES COUNSELING

In cases where the treatment is couples counseling and involves both partners, information shared in any individual sessions may be brought up in joint sessions, or in individual sessions with either person, if the therapist deems it necessary for the continuation of couples counseling.

CANCELLATON POLICY

Your time is being reserved for you. For this reason, payment is required for cancelled or missed sessions with less than 48 hours notice. Frequent cancellations, even with adequate notice, may make it difficult to hold your hour for you. Please note that the therapist cannot bill an insurance company for a missed session, so you will be responsible for payment in full for any cancelled or missed appointments.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. An insurance company or other third-party payor regulated under NJ regulations may request that the patient authorize the psychotherapist to disclose certain confidential information to the third-party payor in order to obtain benefits, *only if* the information is limited to:

1. Administrative information (i.e., patient's name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees);
2. Diagnostic information (i.e., therapeutic characterization as found in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM III), or other professionally recognized diagnostic manual);
3. The patient's status (voluntary or involuntary; inpatient or outpatient);
4. The reason for continuing psychological services, limited to an assessment of the patient's current levels of functioning and distress (both described by terms of mild, moderate, severe or extreme); and

5. A prognosis, limited to the estimated minimal time during which treatment might continue.

You should be aware that if your health benefits are provided by a self-insured employee benefit plan or other arrangement regulated by the federal ERISA statute, as most benefits currently are, such plan will have considerably more access to information in your Clinical Record. If you have any questions about the nature of your health benefits, you should contact the group that provides the benefits for you.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in the hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED A COPY OF BOTH THIS PSYCHOTHERAPY AGREEMENT AND THE HIPAA PRIVACY NOTICE.

Client Name _____ Date _____

Psychotherapist _____ Date _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PSYCHOTHERAPY AGREEMENT, AND AGREE TO ITS TERMS.

Client Name _____ Date _____

Psychotherapist _____ Date _____