Discovery
PSYCHOTHERAPY CENTER

Basic Information

Date: _____

Patient's Name: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Age: _____ Birth Date: _____ Marital Status: _____

Occupation: _____

Educational History: _____

Name, Address and Phone of Child's School Counselor (If Applicable): _____

_____

Emergency Contact:

Name: _____ Phone: _____

Primary Physician: _____ Phone Number: _____

Address: _____

Are you currently on medication: _____ If So Please List: _____

_____

Name, Address and Phone of Child's Pediatrician (If Applicable): _____

_____

Family History of Psychiatric Treatment: _____

_____

Substance Abuse History: _____

_____

Has therapy ever been recommended or required? _____

Have you ever been to therapy? _____

If so please check: _____ Inpatient _____ Outpatient

Name of Therapist/ Length of Time in Therapy: _____

_____

Describe the problems you are currently experiencing and how long they've been going on:

_____

_____

_____

_____

Please check the box (es) that apply to what you are experiencing:

☐ Changes in appetite ☐ Anxiety

☐ Changes in sleeping patterns ☐ Depression

☐ Auditory or Visual Hallucinations ☐ Problems with Sexual Behavior

Person Completing Form and Providing Data:

_____ Patient/Self _____ Parent/Legal Guardian _____Other (_____)

Discovery
PSYCHOTHERAPY CENTER

Session Policies

Your therapy session will run 50 minutes and your session time will be set and agreed to on your first visit. Please discuss any potential changes with your therapist.

Your co-payment is to be paid in full at the time of each session. Credit or debit cards, cash or check are accepted.

Termination of Therapy

We recommend that when you or your therapist feels you are ready to terminate that you give the therapist two weeks notice. This allows you time to review your progress, put proper closure on your treatment and say goodbye.

Financial Agreement

For Those Covered by Insurance:

Your insurance company will be billed for therapeutic serves provided.

You have a deductible of $ _____ of which $ _____ has been met. During the deductible period, your payment/co-payment will be $ _____.

For all sessions after fulfillment of the deductible or in absence of a deductible, your copayment will be $ _____.

Note: In the event that the insurance company mistakenly sends the check to you, the patient, you agree to endorse the check over to Discovery Psychotherapy Center as well providing the Explanation of benefits paperwork.

For Those Without Insurance Coverage:

Your payment will be $ _____.

Exceptions:

Upon agreement to be seen by a therapist, that therapist may no longer be involved as an expert witness nor provide a testimony.

The only time in which doctor-patient confidentiality will be breached is if a patient is a danger to his/herself or others. Law requires that the police and next of kin be contacted in order to protect the patient and others.

Rescheduling/Cancellation Policy:

We encourage you to not cancel or reschedule sessions unless it is an emergency. In those rare occasions, we suggest that you keep a commitment to your weekly attendance by rescheduling within the same week.

Appointments missed or cancelled with less than **48 hours' notice** (except in cases of an emergency) will be **charged a fee of $75.00**. We cannot bill the insurance company for a late cancellation or missed appointment.

I understand and agree to the above:

_____ _____

Patient's Signature (Parent/Guardian, if a minor) Date

_____ _____

Therapist's Signature Date

Discovery Psychotherapy Center, LLC
26 Madison Avenue Morristown, NJ 07960 973-796-3760

Treatment Agreement

Name:_____

Address:_____

City/State/Zip:_____

Home Phone:_____Cell Phone:_____

Social Security #:_____

Insurance ID #:_____Group #:_____

Policy Holder Name:_____Date of Birth:_____

Patient Date of Birth:_____

Financially Responsible Party/Relationship to Patient:_____

I agree that Discovery Psychotherapy Center, LLC will provide services for myself or my child and I acknowledge that I am the financially responsible party, regardless of my insurance company's actions.

If I have a managed care policy, I agree to allow my provider to forward the necessary information to complete a treatment plan to obtain certification for sessions. I agree that all payments will be made directly to Discovery Psychotherapy Center, LLC.

_____ _____

Signature and Date Witness and Date

Discovery
PSYCHOTHERAPY CENTER

Insurance Changes

I, _____, agree that should my insurance seize or change, I am to notify the office administrator before said changes take place. Should I fail to notify Discovery Psychotherapy Center of these changes, I agree that I would be financially liable for all services that have been provided and not covered by my previous insurance.

_____
Patient's Signature

_____
Therapist's Signature

_____
Date

Discovery
PSYCHOTHERAPY CENTER

26 Madison Avenue
Morristown, NJ 07960

(973) 796-3760 Main Office
(973) 796-3769 Fax

Release of Information

I (Patient), _____, hereby give permission to (Therapist) _____ of Discovery Psychotherapy Center, 26 Madison Avenue, Morristown, NJ 07960 to release information and/or receive information from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

_____
Signature

_____
Witness

_____
Date

Discovery Psychotherapy Center, LLC
26 Madison Avenue
Morristown, NJ 07960
(973) 796-3760 Main Office
(973) 796-3769 Fax

I, _____, authorize Discovery Psychotherapy Center to bill a credit card left on file for the convenience of payment for any outstanding balance of one month's duration. I understand I will receive a notification to provide consent prior to use of the credit card.

Name as it appears on the card: _____

Credit Card Number: _____

Expiration Date: _____/_____ Security Code: _____

Please Circle: MasterCard / Visa / Discover

_____
Signature

_____
Date

NEW JERSEY NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
Psychologists may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations" – Treatment* is when a psychologist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when a psychologist consults with another health care provider, such as your family physician or another psychologist. - *Payment* is when a psychologist obtains reimbursement for your healthcare. Examples of payment are when a psychologist discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. - *Health Care Operations* are activities that relate to the performance and operation of a psychotherapy practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within the Psychotherapy Center such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of the Psychotherapy Center, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
Psychologists may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when a psychologist is asked for information for purposes outside of treatment, payment and health care operations, a psychologist will obtain an authorization from you before releasing this information. A psychologist will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes a psychologist has made about your conversation during a private, group, joint, or family counseling session, which a psychologist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.
III. Uses and Disclosures with Neither Consent nor Authorization

Psychologists may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If a psychologist has reasonable cause to believe that a child has been subject to abuse, a psychologist must report this immediately to the New Jersey Division of Youth and Family Services.
- **Adult and Domestic Abuse:** If a psychologist reasonably believes that a vulnerable adult is the subject of abuse, neglect, or exploitation, a psychologist may report the information to the county adult protective services provider.
- **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, a psychologist may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that a mental health professional has provided you and/or the records thereof, such information is privileged under state law, and the mental health provider must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. The mental health professional must inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to your mental health professional a threat of imminent serious physical violence against a readily identifiable victim or yourself and the mental health professional believes you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps he/she takes to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 19 and warning your parents if you are under 18.
- **Worker's Compensation**: If you file a worker's compensation claim, your mental health professional may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

IV. Patient's Rights and Psychologist's Duties Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, a psychologist is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, any written correspondence will be sent to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the Psychotherapy Center mental health records used to make decisions about you for as long as the PHI is maintained in the record. Your request to access your PHI may be denied under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your therapist will discuss with you the detail of the

amendment process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. A psychologist may deny your request. On your request, your therapist will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, a psychologist will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologists Duties

- Psychologists are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- Psychologists reserve the right to change the privacy policies and practices described in this notice. Unless a psychologist notifies you of such changes, however, a psychologist is required to abide by the terms currently in effect.
- If current policies and procedures are revised, you will be notified in writing.

V. Complaints

If you are concerned your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact the Directors of Discovery Psychotherapy Center.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on 4/15/03.

The Psychotherapy Center reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that a psychologist maintains. The Psychotherapy Center will post a notice of any revisions in our policies regarding PHI in the waiting room.

Discovery
PSYCHOTHERAPY CENTER

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices.

I have read, or will read, the Notice and can ask any questions regarding the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

_____
Patient's Name (Please Print)

_____
Parent or Authorized Representative (If Applicable)

_____
Signature

_____
Date

EMAIL POLICY

As email communication becomes more prevalent, Discovery Psychotherapy Center must inform you that despite all efforts to keep privacy and confidentiality in the forefront, there are risks involved in communicating in any electronic medium. We ask that you give informed consent to use email within these parameters.

I understand that Discovery Psychotherapy Center offers NO guarantee of privacy for email communication I send.

- If I accidently mistype an email address, private clinical information could be sent to a stranger.
- Employees at the company that provides our email service can potentially access our messages
- Email communication can be intercepted by unscrupulous people through spyware or other hacking methods.

Therapists may not respond right away to email. If I need to speak with my therapist before our next scheduled appointment, I should use his/her office phone number (973-796-3760). I can also communicate to him/her via regular mail sent to his/her office address.

Discovery Psychotherapy Center's email address is publicly available. However, due to the risks listed above, this form is designed to specifically warn me NOT to use email for sensitive clinical information. Sensitive clinical information includes, but is not limited to names, symptoms, diagnoses, and the fact that I am or my child is their client.

Discovery Psychotherapy Center informs me that confidentiality is one of the most important ethical principals in psychotherapy and that email communication could compromise confidentiality. My therapist will strongly urge me NOT to send him/her any email messages pertaining to sensitive clinical information. If I choose to send him/her email communication despite these warnings, I assume full responsibility for the risks, and I will not hold him/her liable for any possible breach in confidentiality or failure to respond in a timely manner.

My signature below indicates that I have read the information in this document and agree to abide by it.

Signature of Client or Parent/Guardian:_____

Date:_____

Discovery PSYCHOTHERAPY CENTER

CLIENTS' RIGHTS AND RESPONSBILITIES STATEMENT

Clients have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Have their treatment and other client information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
- Share in developing their plan of care
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about their insurance company services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Clients' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Clients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Follow the treatment plan. The plan of care is to be agreed upon by the client and the provider.
- Follow the agreed upon medication plan**.**
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Clients should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Client Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

Statement Authorization

In our efforts to go paperless, we are offering our clients electronic statements. We respect your privacy and take protecting it seriously. We do not share your information with anyone else.

My signature below will authorize Discovery Psychotherapy Center to send statements by email. I understand that all future statements will be sent electronically to the address provided.

E-Mail Address:

_____

Please check if you would also like to receive:

- € Reminders for sessions
- € Receipts
- € Monthly Newsletter
- € Notices of Special Events
  - € Groups
  - € Workshops
  - € Community Speakers

_____

Patient's Name (Please Print)

_____

Parent or Authorized Representative (If Applicable)

_____

Signature

_____

Date

Discovery
PSYCHOTHERAPY CENTER

LEGAL CAUSE DISCLAIMER

Discovery Psychotherapy Center LLC, and Discovery Wellness Center, LLC do not perform evaluations to be used in court cases, for parole/probation, or custody determinations. Forensic Psychologists normally perform such evaluations, and it is illegal and unethical for a therapist to have a dual role as an evaluator and a therapist (i.e. entering into one relationship precludes the other).

By signing below, I am acknowledging that I will not now, or any point in therapy, request such an evaluation.

_____
Printed Name

_____
Signature

_____
Witness

_____
Date