Comprehensive Psychological & Wellness Center, LLC

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OUTPATIENT SERVICES

This document contains important information about the professional services and business policies of Comprehensive Psychological & Wellness Center, LLC. Please read it carefully and jot down any questions you might have so that we can discuss. When you sign this document, it will represent an agreement between you and myself, as an agent of Comprehensive Psychological & Wellness Center, LLC.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist/psychologist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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 benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But we make no guarantees that this will be your experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include. A treatment plan will also be developed at the same time. You should evaluate this information and decide whether you feel comfortable working with me. I will also evaluate whether I am the right person for you based on your needs. It may be necessary at times to refer to other therapists. Therapy involves a large commitment of time, money and energy, so you should try to be very careful when selecting a therapist. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help to set up a meeting with another mental health professional.

FAMILY THERAPY/COUPLES THERAPY: If you will be attending family or couples counseling at this time you agree and understand that it is strict policy that all members of the family or couple must be present at each session unless the therapist requests otherwise. If this is not possible at any point in time the session will have to be cancelled with 24 hours notice or a cancellation fee will apply. All members of the family/couples must sign.

MINORS: If you are under eighteen years of age, please be aware that the law gives your parents the right to examine your treatment records. On the other hand, it specifically prohibits parents from seeing records related to sexually transmitted diseases, termination of pregnancy, substance abuse, or any other information that I feel would adversely affect your health or welfare. It is my policy to request an agreement from parents that they agree to give up their rights to access your records. I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern.

PARENTS/LEGAL GUARDIAN: As a parent/legal guardian I agree to give up access to my child's records. I understand that the treatment relationship between my child and his/her therapist is confidential and in order to maintain an effective therapeutic relationship, I understand that I will be provided only with general information about their work together, unless the therapist feels there is a high risk that my child will seriously harm him or herself of someone else. In this case I will be notified of the therapist's concern.

In addition, I understand it may be necessary for me to be an integral part of my child's treatment. At times I may be expected to attend therapy sessions, work on parenting, and communication skills with my child. I agree I will do my best to work with my child and his/her therapist throughout my child's treatment.

If children will be attending the sessions, **unless biological parents are married both parents must sign the contract or provide a copy of your divorce papers to be reviewed**.

CONFIDENTIALITY

A psychologist/therapist is required by law to preserve the confidentiality of information that we obtain during the course of providing treatment. We will only release your confidential treatment information to others or to your insurance company for reimbursement of our services with your written permission. But there are few exceptions.

1. In most legal proceedings, we need your written authorization before providing any information about your treatment to attorneys or other interested parties; however, if we are presented with a court ordered signed by a judge we must by law release in the information.

2. We are also legally obligated to take action to protect others from harm, even if that requires us to reveal some information about a patient's treatment. For example, if we believe that a child is being abused or neglected or if an institutionalized elderly or disabled person is being abused, we must file a report with the appropriate state agency. In addition, if I receive a request to release information to DYFS or any state agency, I will be required to release information to them.

3. The law also requires us to take protective actions if we believe that you are threatening imminent serious bodily harm to someone else. Such protective actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, we are also obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

4. We may occasionally find it helpful to consult other professionals. During a consultation, we make every effort to avoid revealing the identity of our patients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

5. If my licensing board issues a subpoena, I may be obligated to testify before the Board and produce your relevant records and papers.

6. If you have been referred by the court or any agency of the court, I may be required to furnish information to them.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we prepare and maintain treatment records. You are entitled to receive a copy of your records, or a summary from your therapist unless your therapist believes in his or her professional judgment that the release of such information would adversely affect your health and well-being. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we will be happy to review them with you so that we can discuss the contents. You will be charged an appropriate fee for any professional time we spend reviewing records with you. In addition, we will charge for our costs in providing copies of the records.

INFORMATION TO BE DISCLOSED IF YOU ARE BEING TREATED BY A MASTERS LEVEL THERAPIST: I am aware that insurance companies require information to pay for services provided by the practice. Information to be disclosed includes: entire medical record. 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 statue, such plan will have considerably more access to all the information in your Clinical Record including progress notes and intake information. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information (indicated above) for the term of this Authorization (1 year) for the purpose of obtaining benefits from the third party payor, getting reimbursed for services and authorizing treatment.

INFORMATION TO BE DISCLOSED IF YOU ARE BEING TREATED BY A PSYCHOLOGIST: I am aware that insurance companies require information in order to pay for services provided by the practice: Information to be disclosed: Administrative and demographic information, including your name, insurance ID number, date of birth, age, address, gender, educational level, date of onset of psychological difficulties, date this therapy began, fees, dates of sessions and nature of sessions (restricted to frequency and length of sessions); A Diagnostic and Statistic Manual (DSM-V) diagnosis; Whether your treatment is voluntary or involuntary and outpatient or inpatient; The reason for continued psychological services, based on and limited to the current level of functioning (mildly, moderately, severely, or extremely affected by the symptoms) and the level of distress (mild, moderate, severe, or extreme); your prognosis, along with an estimate of the minimal length of treatment deemed required. 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 statue, such plan will have considerably more access to all the information in your Clinical Record including progress notes and intake information. Confidential communication between a patient and a licensed psychologist is protected under New Jersey law. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information (indicated above) for the term of this Authorization (1 year) for the purpose of obtaining benefits from the third party payor, getting reimbursed for services and authorizing treatment.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to your office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the Authorization.

I understand that treatment is not conditioned on whether I sign this Authorization except (1) if my treatment is related to research; or (2) if health care services are provided solely for the purpose of creating protected health information for disclosure to a third party.

I understand that in addition to providing information for continued authorizations, insurance companies will also require a clinical review to authorize further sessions. I understand that the practice will have to release clinical information to insurance companies in order to get reimbursed for services and I agree to authorize such

release. If I fail to authorize the release of this information, I understand that I will be financially responsible for the full cost of the services.

ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY NOTICES

Our practice is dedicated to maintaining the privacy of your confidential, protected health information (PHI). In conducting business we create records regarding your health status and the healthcare and services you receive at this practice. We are required by law to give you this Notice of Privacy Practices. It will tell you about the ways in which this practice may use or disclose health information about you. It also describes your rights and obligations regarding the use and disclosure of that information. By signing below you acknowledge that you have received our Notice of Privacy Practices.

TELEMENTAL HEALTH SERVICES

I understand that Telemental health services (also referred to as e-therapy, teletherapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemental health services. My rights to confidentiality with Telemental health services are exactly the same as my rights for in-person therapy services. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I further understand that there are risks unique and specific to Telemental health services, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs contact the office at 609-693-4343.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telemental health services interaction to any other entities shall not occur without my explicit written consent. Your therapist and Comprehensive Psychological & Wellness Center, LLC also agree to under no circumstances take any personally identifiable images from the session or store any of these images on personal or business devices from Telemental health services.

Also, due to licensing requirements I agree to be physically in New Jersey each session and to give my current physical address accurately at the beginning of each session.

In accordance with the American Telemedicine Association (ATA) I agree to have Telemental health services sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed using the google speed test. Google ‘speed test’ and use the google version. These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.

I understand that Telemental health services appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a “room scan” to ensure that I am the only one present in the room.

In the case that the client is a minor child, the child’s parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via

phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telemental health services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Comprehensive Psychological & Wellness Center, LLC at 609-693-4343.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Telemental health services Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemental health services via an online HIPAA compliant telemedicine platform with the clinician listed below:

CONSENT TO TREATMENT

I agree and consent to participate in behavioral healthcare services offered and provided by, a behavioral healthcare provider at Comprehensive Psychological &Wellness Center, LLC. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within (1) the scope of the provider's license, certification, and training; (2) or the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If patient is under 18 or unable to consent to treatment, I attest that I am authorized to initiate consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____	_____	_____
Patient Name (print)	Patient Signature	Date
_____	_____	_____
Patient Name (print)	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

(* Both biological parents must sign)

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FINANCIAL AGREEMENT

Psychologist fees: Psychiatric Diagnostic Interview $230; Individual Psychotherapy 45 Minutes $180: Family Psychotherapy With or Without Patient Present $195: Group Psychotherapy Per Person $125: Comprehensive Psychological Evaluation per hour $200; Neuropsychological Testing Per Hour $250; Written Report for Legal or Consultative Purposes $350 Per Hour. If you would like a full list of fees for other procedures not indicated here you may ask for this at any time.

Masters level therapist fees: Psychiatric Diagnostic Interview $210; Individual Psychotherapy 45 Minutes $160; Family Psychotherapy With or Without Patient Present $175; and Group Psychotherapy Per Person $105. If you would like a full list of fees for other procedures not indicated here you may ask for this at any time.

In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you request. If you become involved in legal proceedings that require our participation, you will be expected to pay for all our professional time, including preparation and transportation costs, even if we are called to testify by another party. Fees for legal involvement are $300 per hour.

INSURANCE: We currently participate with a number of different insurance companies. **We do not participate with Medicaid or NJ Family Care.** Please check with us to see if we participate with your insurance. For those companies with which we participate, we have agreed to accept their allowance as payment in full. Their allowance consists of their payment to us plus your copayment or deductible for which you are responsible paying at the time of service. If you have secondary insurance, your medical claim will be forwarded to your secondary insurance after payment has been received from your primary insurance. Please note that under certain circumstances, your insurance plan will not pay for our services, and you will be responsible for payment in full. All fees are ultimately your responsibility.

INFORMATION TO BE DISCLOSED IF YOU ARE BEING TREATED BY A MASTERS LEVEL THERAPIST: I am aware that insurance companies require information in order to pay for services provided by the practice. Information to be disclosed includes entire medical record. 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 statue, such plan will have considerably more access to all the information in your Clinical Record including progress notes and intake information. By my signature below, I hereby authorize the

Practice to use or disclose to the recipient my health information (indicated above) for the term of this Authorization (1 year) for the purpose of obtaining benefits from the third-party payor, getting reimbursed for services and authorizing treatment.

INFORMATION TO BE DISCLOSED IF YOU ARE BEING TREATED BY A PSYCHOLOGIST: I am aware that insurance companies require information in order to pay for services provided by the practice: Information to be disclosed: Administrative and demographic information, including your name, insurance ID number, date of birth, age, address, gender, educational level, date of onset of psychological difficulties, date this therapy began, fees, dates of sessions and nature of sessions (restricted to frequency and length of sessions); A Diagnostic and Statistic Manual (DSM-V) diagnosis; Whether your treatment is voluntary or involuntary and outpatient or inpatient; The reason for continued psychological services, based on and limited to the current level of functioning (mildly, moderately, severely, or extremely affected by the symptoms) and the level of distress (mild, moderate, severe, or extreme); your prognosis, along with an estimate of the minimal length of treatment deemed required. 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 statue, such plan will have considerably more access to all the information in your Clinical Record including progress notes and intake information. Confidential communication between a patient and a licensed psychologist is protected under New Jersey law. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information (indicated above) for the term of this Authorization (1 year) for the purpose of obtaining benefits from the third party payor, getting reimbursed for services and authorizing treatment.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to your office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the Authorization.

I understand that in addition to providing information for continued authorizations, insurance companies will also require a clinical review to authorize further sessions. I understand that the practice will have to release clinical information to insurance companies in order to get reimbursed for services and I agree to authorize such release. If I fail to authorize a release of this information, I understand that I will be financially responsible for the full cost of the services.

I understand that it is my responsibility to inform the practice of any change in my insurance plan or of correspondence that I receive from my insurance company notifying me of a change or cessation of payment for medical bills. I am also responsible for updating the practice as to any change in my address or contact information. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to your office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the Authorization.

SELF PAY: If you do not have insurance or if our practice does not participate with your plan, payment in full is due at the time of service.

COPAY: Copay must be paid at time of service. When a copay is not paid you are in violation of your contract with your insurance company. If copay is not paid at time of service a $5.00 charge will be applied for billing.

REFFERALS/AUTHORIZATION: You are responsible for obtaining a referral or authorization, if required by your insurance, from your primary care physician prior to us providing services to you. If such authorization or referral is not obtained, you will be responsible for payment in full at the time of service.

BILLING STATEMENTS: A statement of your financial responsibility will be sent to you after your claim has been processed by all of your insurance carriers. Your failure to pay your responsibility may result in your

account being assigned to collections or us filing a claim against you in small claims court. If this occurs there will be additional costs for which you will be responsible. Please contact our office if you have any questions of difficulty with your bill. A fee of $35 will be added to your account for returned checks.

24 HOUR CANCELLATION POLICY:

We require that you provide us notice of cancellation 24 hours in advance. Failure to cancel your appointment with more than 24 hours notice, will result in you being charged a cancellation fee of $100. If you simply do not show up for an appointment you will be charged $125. Please note that your insurance company will not pay for late cancellations or "no show" appointments. This cancellation policy is standard in the mental health fields and will be strictly enforced. There will never be any exceptions to this. The credit card on file will be charged at the time of no show or late cancel. In the event that the credit card is declined, all late cancel fees and no show fees must be paid before any future appointments can be scheduled.

If you will be late for an appointment, please notify the office ahead of time and if you are no later than 10 minutes your appointment time will be held for you. After 10 minutes you will be charged for a missed appointment. This will be considered a no show and you will be charged a no show charge of $125.

I have read the above policy regarding my financial responsibility to the practice of Comprehensive Psychological & Wellness Center, LLC for providing medical services to the below named patient. I agree to pay the full and entire amount of all bills incurred by me or the below named patient or any amount due after payment has been made by my insurance plan and any contractual adjustments have been made.

_____	_____	_____
Patient Name (print)	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
_____	_____	_____
Credit Card Holder (Print)	Credit Card Holder Signature	Date

In order to avoid costly collection procedures, we request that all clients provide a Visa or Master Card number and authorization for use for services provided or no show/cancellation fees due. By signing this waiver, I give authorization for charges to be made to my credit card by Comprehensive Psychological & Wellness Center, LLC.

Card Type: ☐ VISA ☐ MasterCard

Card Number: _____Expiration date: _____V-Code: _____

Person whose name appears on the credit card: _____

Address where the bill for this credit card is received: _____

_____	_____
Signature	Date

Submit Form Reset Form