

MAPLEWOOD COUNSELING SERVICES FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Maplewood Counseling Services for your behavioral healthcare services. We recognize you have many choices and we appreciate your trust in us.

We appreciate your downloading and completing the paperwork prior to your first session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- Remember, you can download and print, review, or ask for a complete set of Maplewood Counseling Services Privacy Policies.
- Your therapist will review and answer any questions about this paperwork or other matters.
- Please bring your authorization number, if given to you by your insurance company.
- Please bring your insurance card if you are using your insurance.
- We will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- We will need your primary care physician name and telephone number.
- If you have seen a counselor or psychiatrist within the last two years, we will need a telephone number to contact them.
- It is very helpful for the therapy process if you bring a list of goals for therapy.
- This will help you and your therapist make better use of the first session.

**WHAT ARE YOUR GOALS?
PLEASE LIST.**

Payments and Cancellations

Due to the high cost of billing, we ask that all copays and/or fees be paid at the time of each session. We can bill your credit card for all fees if you prefer. Also, if you forget your payment we can bill also your card to keep your account current.

Kindly give 24 hours notice if you need to cancel an appointment or \$100 will be charged for time reserved.

Please fill out the following which will only be used for the above.

CREDIT CARD INFORMATION

NAME ON CARD _____

CREDIT OR DEBIT CARD NUMBER _____

EXPIRATION _____ BILLING ZIP CODE _____

Please bill my credit card for copays (only if I do not bring to the session) and all missed sessions or sessions cancelled less than 24 hours in advance

SIGNATURE _____

NOTE:

Your credit card statement will show the email FEINDB@Gmail.com.

Maplewood Counseling Services
All Information is kept in strict confidence

AGREEMENTS AND DISCLOSURES
(for all participants over 18 years of age)

AGREEMENTS

1. I authorize Maplewood Counseling Services and the office of Debra Feinberg, LCSW to contact the referral source for treatment, payment, or health care operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits.**

____yes ____no

2. I authorize the Maplewood Counseling Services and the office of Debra Feinberg, LCSW to bill my insurance/managed care company for the psychotherapy. Maplewood Counseling Services and the office of Debra Feinberg, LCSW may need to disclose clinical information necessary to process all claims.

____yes ____no

3. I authorize _____ to make payment directly
(insurance/managed care company)
to Maplewood Counseling Services and/or Debra Feinberg, LCSW for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services.

____yes ____no

DISCLOSURES

1. I understand Maplewood Counseling Services and the office of Debra Feinberg, LCSW cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot be directly reached, any form of caller identification, **or any type of device that does not allow my therapist to make direct telephone contact with me.**

____ yes ____ no

FINANCIALS

1. My usual and customary rate for providing direct face to face psychotherapy services billed to insurance companies is \$160.00 per 45 minutes unless other arrangements are made. If you are using your insurance company for services you are responsible only for your co-pay or co-insurance.

2. **You will be charged \$100 for not giving a minimum of 24 hours notification** of cancellation for time reserved. Your credit card will be charged \$100 for missed or appointments that are cancelled late (less than 24 hrs) unless other arrangements are made in advance.

3. You will be billed for non covered and non routine services such as extended telephone consultation, crisis intervention, report writing, extended care coordination with other providers at a rate of \$2.50 per minute. You will be informed of events involving additional billing prior to the event.

SIGNATURE: _____ DATE: _____

Additional comments/special conditions:

Privacy Notice

To comply with federal health insurance portability and accountability act guidelines Maplewood Counseling Services and the office of Debra Feinberg, LCSW has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: treatment, payment and health care operations. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the patient or guardian unless we have your consent. It will be your responsibility to return the call.

Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download Maplewood Counseling Services and the office of Debra Feinberg, LCSW full privacy policy.

Signature

Date

Medical Information

Please complete for all participants in therapy

NAME	Recent Medical Issues	Current Medications	Dosage

Allergies: _____

Family Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Pediatrician Name: _____ Phone: _____

Tobacco Use: Cigarettes ____ Chewing ____ How much _____ Who _____

Alcohol and Drug Use:

Who?

Type?

Amount?

Frequency?

Family history of alcohol/drug use, mental health, physical conditions:

FAMILY MEMBER	Alcohol/drug use/ Mental Illness/Medical Issues

If you use herbal supplements or vitamins, please list:

HIPAA Signature Acknowledgment Form
(see pages to follow and please sign below)

I have received the HIPAA regulations and have read them.

Your typed name qualifies as your official signature.

Signature (typed or signature)

Print Name

Date signed

Debra Feinberg, LCSW

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 IT CAREFULLY.

What is “Medical Information”?

The term “medical information” is synonymous with the terms “personal health information” and “protected health information” for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan, or others **and 2)** relates to the past, present, or future physical or mental health or condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present, or future payment for the provision of health care to an individual (you).

I am a mental health care provider. licensed by the State of New Jersey through the Department of Professional Licensing and New York through the Department of Education. I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as “medical records” or “mental health records,” and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein. The following is a partial list of the information that may be contained in your mental health record:

- a. Name, address, telephone numbers, emergency contacts, insurance information, employment information
- b. Medical information
- c. Medication information
- d. Family history of mental health issues and medical conditions
- e. Agreements about treatment issues
- f. Informed consent and financial agreements
- g. Therapist disclosure information
- h. Clinical tests and assessments
- i. Diagnosis, functional status, symptoms
- j. Treatment planning information
- k. Session documentation, progress notes
- l. Prognosis
- m. All correspondence and reports
- n. Documentation related to telephone calls
- o. History of Disclosures
- p. Closing summary
- q. Claims data

- r. Treatment authorizations
- s. Requests for additional sessions
- t. Releases of information

Uses and Disclosures Without Your Authorization - For Treatment, Payment, or Health Care Operations

Federal privacy rules (regulations) allow health care providers (me) who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

An example of a use or disclosure for treatment purposes:

If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

An example of a use or disclosure for payment purposes: If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, I am permitted to use and disclose your personal health information.

An example of a use or disclosure for health care operations purposes:

If your health plan decides to audit my practice in order to review my competence and my performance, or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes.

PLEASE NOTE: I, or someone in my practice acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Other Uses and Disclosures Without Your Authorization:

I may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

- 1)** If disclosure is compelled by a court pursuant to an order of that court
- 2)** If disclosure is compelled by a board, commission, or administrative agency
For purposes of adjudication pursuant to its lawful authority
- 3)** If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.
- 4)** If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
- 5)** If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
- 6)** If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.
- 7)** If disclosure is compelled by the patient or the patient's representative pursuant to New Jersey Disclosure of Confidential Information.
- 8)** If disclosure is compelled or by the New Jersey Child Abuse and Neglect Reporting Act (for example, if I have a reasonable suspicion of child abuse or neglect).
- 9)** If disclosure is compelled by the New Jersey Elder/Dependent Adult Abuse Reporting Law (for example, if I have a reasonable suspicion of elder abuse or dependent adult abuse).
- 10)** If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
- 11)** If disclosure is compelled or permitted by the fact that you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
- 12)** If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine the cause of your death.
- 13)** As indicated above, I am permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health related benefits and services that may be of interest to you. Be sure to let me know where and by what means (e.g., telephone, letter, email, fax) you may be contacted.
- 14)** If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but limited to, audits, criminal or civil investigations, or licensure or disciplinary actions. The New Jersey Department of Professional Licensing, who license mental health therapists, is an

example of a health oversight agency.

15) If disclosure is compelled by the U. S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the “Privacy Rule”).

16) If disclosure is otherwise specifically required by law.

PLEASE NOTE:

The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information “in a specific and meaningful fashion.” You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you.

If New Jersey law protects your confidentiality or privacy more than the federal “Privacy Rule” does, or if New Jersey law gives you greater rights than the federal rule does with respect to access to your records, I will abide by New Jersey law.

In general, uses or disclosures by me of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when I request your personal health information from another health care provider, health plan or health care clearinghouse, I will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, in the section dealing with uses or disclosures for treatment purposes, the “minimum necessary” standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

Your Rights Regarding Protected Health Information

1) You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. I am not required to agree to your requested restriction. If you request a restriction that I feel will adversely impact treatment, payment or health care operations, I will refer you to a non Maplewood Counseling Services therapist.

2) You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations.

3) You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my “psychotherapy notes.” The term “psychotherapy notes” means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

4) You have the right to amend protected health information in my records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, I am permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.

5) You have the right to receive an accounting from me of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, I am permitted to deny the request for specified reasons. For instance, I do not have to account for disclosures made in order to carry out my own treatment, payment or health care operations. I also do not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you might sign.

6) You have the right to obtain a paper copy of this notice from me upon request.

PLEASE NOTE:

In order to avoid confusion or misunderstanding, I ask that if you wish to exercise any of the rights enumerated above, that you put your request in writing and deliver or send the writing to me. If you wish to learn more detailed information about any of the above rights, or their limitations, please let me know. I am willing to discuss any of these matters with you. As mentioned elsewhere in this document, I am the Privacy Officer of this practice.

My Duties

I am required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of my legal duties, your rights, and my privacy practices with respect to such information. I am required to abide by the terms of the notice currently in effect. I reserve the right to change

the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that I maintain, even if it was created or received prior to the effective date of the notice revision. If I make a revision to this notice, I will make the notice available at my office upon request on or after the effective date of the revision and I will post the revised notice in a clear and prominent location. As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I am the individual who is responsible for assuring that these privacy policies and procedures are followed not only by me, but by any employees that work for me or that may work for me in the future. I have trained or will train any employees that may work for me so that they understand my privacy policies and procedures. In general, patient records, and information about patients, are treated as confidential in my practice and are released to no one without the written authorization of the patient, except as indicated in this notice or except as may be otherwise permitted by law. Patient records are kept secured so that they are not readily available to those who do not need them. Maplewood Counseling Services and the office of Debra Feinberg, LCSW has policies and procedures for protecting privacy, the security and any technology related to your mental health records. You may request a copy of only those policies and procedures from me. Because I am the Contact Person of this practice, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights may have been violated either by me or by those who are employed by me.

You may file a complaint with me by simply providing me with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. I will not retaliate against you in any way for filing a complaint with me. You can also file a complaint through Debra Feinberg, LCSW at 973.902.8700, owner of Maplewood Counseling Services. Complaints can also be sent to U.S Health and Human Services Dept., Office for Civil Rights, 200 Independence Ave., S.W., Room 509F, Washington, D.C. 20201.

If you need or desire further information related to this Notice or its contents, or if you have any questions about this Notice or its contents, please feel free to contact me. As the Contact Person for this practice, I will do my best to answer your questions and to provide you with additional information.