Abby Sarrett-Cooper, MA, LPC
Informed Consent for Treatment

Welcome to the office of Abby Sarrett-Cooper, MA, LPC. Today's consultation appointment will take approximately 90 to 120 minutes and all others sessions will be 45 minutes (unless other arrangements are made). This document is intended to inform you of our policies, State and Federal Laws as well as your rights. If you have other questions or concerns, please ask your clinician.

Confidentiality and Emergency Situations

Your verbal communication and clinical records are strictly confidential except for: a) information shared with a treating psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company, c) information you and/or your child or children report about physical or sexual abuse; then, by New Jersey or New York State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of hurting yourself, others or personal property, f) information necessary for case supervision or consultation and h) or when required by law. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy or when different family members are seen individually, confidentiality and privilege do not apply between couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I have been authorized to do so by all adult family members, and/or parent(s) or guardian(s) who were part of the treatment. Disclosure of confidential information may be required by your insurance carrier (HMO/EPO/POS/PPO/Traditional or indemnity plan) in order to process your claims. If you instruct me to do so, I will only communicate the minimum necessary information to the carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that by submitting "a mental health invoice" for reimbursement a certain amount of risk to confidentiality, privacy and possibly to the future capacity to obtain health or life insurance. The risk stems from the fact that computers are inherently vulnerable to unauthorized access. Medical data has been reported to be sold, stolen, or accessed by enforcement agencies, which possibly puts you in a vulnerable position. Today, you may receive an authorization to release protected health information which will authorize my office to use and/or disclose your medical records to another doctor. You may refuse to sign the authorization to prevent your records from being released. Please note that by signing this contract you are aware that Abby Sarrett-Cooper, LPC and Partners in Counseling cannot be held legally responsible in any way for the release of your medical records.

Your therapist, Abby Sarrett-Cooper, MA, LPC, engages in supervision/consultation for DBT, FBT and other treatment methods. It is considered best practice for a Licensed Professional Counselor to engage in supervision and/or consultation with a more skilled or expert licensed mental health professional to insure the highest level of quality clinical care. Supervision and/or consultation involve regular meetings designed to provide feedback to the clinician on treatment progress and concerns. Supervisors and/or consultants are bound by the same privacy and confidentiality laws and limitations as your therapist.

If an emergency situation for which the client, parent(s) or their guardian(s) feels immediate attention is necessary, the client, parent(s) or their guardian(s) understands that they are to contact the emergency services in the community (911) or report to your local hospital for those services. Your clinician will follow up with those emergency services with standard counseling and support to the

client or client's family in the office by appointment only. If your clinician feels that a patient is in crisis or feels that an emergency exists in their office they have the right and legal obligation to call the police and/or any emergency personnel necessary to ensure that patients are safe. No legal repercussion toward that clinician can be sought if they use reasonable judgment to establish such crisis situation. They have the right to contact immediate family members and notify them of such emergency.

The Process of Therapy/Evaluation

Participation in therapy can result in a number of benefits to you, including and not limited to improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Our goal is to attend to your individual needs. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. I will ask you for your feedback and views on therapy, its progress, and other aspects of therapy and will expect you to respond openly and honestly. Sometimes more than one approach to therapy can be helpful in dealing with certain situations. During the initial evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations which can cause you to feel upset, angry, depressed, challenged or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance abuse, schooling, housing or relationships. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

Client Satisfaction

We do not expect any concerns to arise between you and your clinician(s). However, if you feel dissatisfied for any reason, please discuss your concerns with them. You also have the right to contact your insurance company about any concerns as well as the state licensing board. Our hope is that we can work out any difficulties that may arise.

Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, your individual clinician will discuss with you their working understanding of the problem, treatment plan, therapeutic objective and view of the problem outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the clinician's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment not provided here, we have an ethical obligation to assist you in obtaining those treatments.

Vacations

When your clinician is on vacation, there will be another clinician covering for them. You will be provided with their name and phone number a few weeks in advance of the vacation period.

Financial Disclaimer

Please note, although we may accept some insurance plans, this does not guarantee payment to us. You as the patient or patient representative are ultimately responsible for payment. All **patients** are responsible for obtaining initial authorization and/or referrals from your primary care physician regardless of your insurance company's policies concerning this matter. Obtaining authorization from your insurance company does not guarantee payment from them. Any denial of payment for any reason, payment that is pending over 30 days, deductibles or copayments is your responsibility. Deductibles and co-payments are not negotiable and must be paid at the beginning of your session. Your bill will reflect the standard rate charged by our group for any outstanding balances. You will be receiving a bill for any services which is past due 30 days. Please call your insurance carrier if you have any questions regarding your insurance policy, coverage and benefits to your plan. We at Partners in Counseling do not know the specifics of your plan or how your plan works. Please note that by signing this form you are superseding any contract signed by us and your insurance company concerning payment. You are ultimately responsible for full payment.

Outstanding balances that go beyond 90 days may be sent to small claims court for collections. A minimum charge of $1.00 processing fee will be added to your bill if it goes to collections or if our office proceeds with collections. If your bill goes to our attorney, all attorney costs, court costs and any fees will be added to your bill. A 1.5% interest charge will be added to your bill if our office needs to take legal action. Please note that our office reserves the right to collect on outstanding debt in lieu of collection agencies. All court costs will be added to your bill plus interest charges will apply. Please note that we are not a collections agency and our primary responsibility is to help you get well.

It is the responsibility of the patient or responsible party to notify this office 48 business hours (Monday thru Friday) hours in advance in the event you need to cancel or reschedule your appointment. For example, if your appointment is Monday at 6:00 PM you would need to notify the office by Thursday at 6:00 PM. Otherwise, we reserve the right to bill you for the missed session. Of course if you are hospitalized, a catastrophic event happens we are willing to discuss this with you. In the event of inclement weather, our office will call you to cancel your appointment. If we do not call you and cancel your appointment, you are expected to be here for your visit. Remember that your session has been scheduled for you and you alone. No other patient can be scheduled or seen during your time slot. Please note that your insurance company does not cover missed appointments. Please understand that any reports, out of the office meetings, or hospital visits will not be covered by your insurance company. You will be responsible for payment of these charges.

It should be noted that if we do not participate in your particular insurance plan our office would be considered as an out of network provider. Our office will attempt to contact your insurance company to verify benefits but you are ultimately responsible for contacting your insurance company to obtain authorization and/or benefit information. Unfortunately we do not know the particulars of your plan so it is your responsibility to know your plan and how it is administered. You will be responsible for your deductable even if you stop coming in for treatment. You will be billed at our regular rate toward your deductable until our session fees have been met. You are also responsible for all co pay's, coinsurance and deductibles as per your plan. Out of network patients will be held responsible for our full fees for each session. Our fees are posted in our waiting area and you can request a copy of them by asking our secretary or clinician. We are happy to accept your check for payment, however if your check is returned to us for insufficient funds or non-payment a fee of $45 will be charged per returned check. Please note that our responsibility is to treat our patients. We take this obligation seriously. Your responsibility is to make your appointment on time, call our clinician if you are going to be late to a session and to ensure that reimbursement is made to this office. We look forward to treating you. By signing this you agree to the terms listed above.

Closure/Termination

Our sessions together may end due to a decision on your part or ours or both. In psycho-therapeutic treatment, the relationship is an important part of the process. Therefore, it is most effective when we can plan for at least one session if not several to do the closure. As mentioned, after the consultation, we will assess if we can help you. We do not accept clients who, in our professional opinion, we cannot help. In such a case, you will be provided with a number of referrals that may be of help to you. You may also call your insurance company for additional lists of names of providers. You have the right at any time to consult another professional for his/her opinion. We would appreciate notification if you choose to do this so we can consult with that professional if needed. To do this you would need to sign a written consent for us to speak with another therapist.

Bill of Rights

1. Abby Sarrett-Cooper, MA, LPC, supports a Patient Bill of Rights and Responsibilities and holds that compliance with these contributes to effective and appropriate patient care and responsibility. All activities related to providing healthcare services are to be conducted with an overriding concern for the patient and the community and above all with the recognition of the patient(s) dignity as a person who has the right to determine his/her own destiny in a socially responsible manner.

2. The patient has the right to considerate, respectful, appropriate and timely services.

3. The patient has the right to participate in the development of his/her service goals and service plan.

4. The patient has the right to obtain from his/her service provider, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person on his/her behalf.

5· The patient has the right to receive from his/her service provider, information to make informed consent prior to the start of any procedure and/or treatment. This shall include such information as: the significant risks involved with any procedure and service provider. Where clinically appropriate, alternatives for care or treatment should be explained to the patient.

6. The patient has the right to refuse any and all treatment to the extent permitted by law and to be informed of any of the psychological and/or medical consequences of his/her actions.

7. The patient has the right to every consideration of confidentiality and privacy concerning his/her own care limited only by state statues, rules, regulations or imminent danger to the individual or others

8. The patient has the right to be advised if the clinician, hospital, and/or clinic proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research.

9. The patient has the right to examine and receive an explanation of his/her bill

The patient's responsibilities are as follows:

1. The patient has the responsibility to give their providers of care complete and accurate information related to their condition and their past and current care.

2. The patient has the responsibility to comply with the treatment plan, which they and their provider of care have mutually developed. Patients are responsible for the medical consequences, which may result, from refusing recommended treatment or for not following the instructions of the provider of care.

3. The patient has the responsibility to be considerate and respectful to the provider and provider's staff who are committed to assisting all parties in providing effective care.

4. The patient has the responsibility to give complete and accurate insurance coverage information in a timely fashion and to pay for services promptly, so that the provider of care can continue to service the community effectively.

5. The patient has the responsibility to read and sign all forms provided to them to continue continuity of care, payment for such care and to cover all insurance issues.

HIPPA Introductory Letter & Informed Consent

Welcome to the Office of Abby Sarrett-Cooper, MA, LPC. In order for you to make an informed decision about counseling, we would like to explain our work and policies. Please feel free to ask questions.

Individual counseling sessions are scheduled in advance and are usually 45 minutes in length. The duration and frequency of appointments vary depending on your circumstances and needs. If you need to cancel an appointment, 48 hours notice is expected when possible; otherwise you will be charged for the missed session. Payment is requested at the time of service unless other arrangements are made. We will work with you and your healthcare insurance, including developing a plan for deductibles and payments.

We will keep the information you share completely confidential. What you discuss will not be shared without your written permission. There are certain limits to confidentiality which are important for you to know.

If you have been referred by the court or an agency of the court, we may be required to provide information to them.

If you are involved in litigation and inform the court of our services, you may be waving your rights to keep your records private.

If you threaten to harm yourself, others or personal property, we are obligated to inform potential victims or police. If *someone's* life is in danger, information will be divulged.

If there is reason to suspect child abuse or neglect, we are obligated by law to report this to an appropriate state agency.

If you are a minor, specific details of your discussions will not be revealed without your permission unless it is decided that your safety is at risk. Parents and guardians will be informed generally of your progress if they inquire.

Your therapist, Abby Sarrett-Cooper, MA, LPC, engages in supervision/consultation for DBT, FBT and other treatment methods. Supervision and/or consultation involve regular meetings designed to provide feedback to the clinician on treatment progress and concerns. Supervisors and/or consultants are bound by the same privacy and confidentiality laws and limitations as your therapist.

Healthcare insurance companies sometimes require information to process claims and you will be informed if such a request is received.

You have the right to ask your clinician not to share certain information for counseling and payment reasons. Please inform us of that in writing.

You have the right to revoke consent after signing it. Please let us know in writing and we shall honor your request. After you have read the above information if you have any questions please feel free to ask your clinician. This form complies with federal regulations (HIPAA) and serves as a Notice of Privacy Practice.

Thank you,

Abby Sarrett-Cooper, MA, LPC

Abby Sarrett-Cooper, MA, LPC
Informed Consent for Treatment
103 Park Street, Suite 2D
Montclair, NJ 07042

I have read and received a copy of the above notice of Privacy Practices and informed consent, have reviewed it and agree to abide by these guidelines. I hereby consent to my treatment. If I am bringing a minor for treatment, I have the legal authority to consent to the minor's treatment and hereby do so consent. If the minor is 14 years old or older I understand that the minor will also need to sign this form.

Client Name____ **Date of Birth**_________________

Signature____ **Date**_______________________

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Client's parent(s) /Guardian(s) Name (print)   Date   Signature

I acknowledge and have read the Financial Disclosure and agree to its terms. I understand my obligation that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians or personal representative are responsible for all fees and services rendered for a treatment of a minor/child or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me of my responsibility for the payment of all charges. I hereby authorize Abby Sarrett-Cooper, MA, LPC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client Name____ **Date of Birth**_________________

Signature____ **Date**_______________________

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Client(s), Parents(s)/Guardians(s) Name (print)   Date   Signature