NFSB Counseling Center
155 Chestnut Street
Nutley, New Jersey 07110

Phone: 973-667-1884
Fax: 973-667-2285
www.nutleyfamily.org

Welcome to Nutley Family Service Bureau (NFSB) Counseling. We appreciate the opportunity to work with you.

We hope that our Client Information Brochure will provide you with clear information about who we are, some of the services we provide, and some information about how our organization works.

We are a team of experienced clinicians and staff with a variety of training and expertise. All our clinical staff are licensed in their disciplines. The below is a fact sheet with some basic information about NFSB Counseling and our clinical staff. The remainder of the Brochure is intended to provide you with additional information about NFSB and the services we provide.

The Brochure is for you to keep and use as a reference. If you have questions, please consult your therapist, our Senior Clinical Supervisor, or our Executive Director.

Nutley Family Service Bureau (NFSB) Counseling Fact Sheet

1. NFSB is an independent, nonprofit organization whose mission is to strengthen the emotional and social well-being of individuals and families through affordable mental health counseling and social service programs.

2. At NFSB we have experienced clinicians providing an array of services including individual, couples, family, and group therapy.

3. Our services are provided by licensed social workers and licensed professional counselors.

4. While our clinicians have different theoretical orientations, they are trained and open to work in a range of approaches and are focused on providing the best treatment for their clients.

5. NFSB professionals have close working relationships with colleagues and professional agencies in the greater Nutley area and are committed to helping clients find the right treatment should we not be able to provide it at NFSB. We are therefore committed to providing referrals to other professionals when we are not able to provide appropriate care or service at NFSB.

About Therapy at NFSB

We view therapy as a partnership between you and your therapist. The therapeutic relationship is best provided in an environment of trust. You can expect your therapist to be open and engaged about the progress of your therapy. Your therapist will also expect you to be open and engaged with them about your expectations and goals and other matters relevant to your treatment.

At NFSB, our clinicians have a variety of theoretical orientations. All our therapists are able to work with you on short and long-term goals, depending on your treatment needs. Your therapist would be happy to talk with you about their theoretical orientation as well as discuss alternative modalities and options that could be provided elsewhere or in addition to the work, we do at NFSB. All clinicians have the benefit of working in a collegial environment with access to different resources from which they can draw to be helpful to you.

Therapists benefit (and clients benefit by extension) from consulting with colleagues. To provide the best treatment for our clients, peer supervision and consultation are an important part of our organizational model. Only information necessary to aid in the support of a client's treatment is shared, and all information is handled confidentially among clinicians engaged in the consultation process.

Confidentiality

At NFSB we are vigilant about protecting your privacy and maintaining confidentiality. In the event of an emergency, however, we may not be able to maintain strict confidentiality. It is important for you to know that the following situations cannot be kept confidential:

1. Threats against the physical well-being or life of another person
2. Abuse or neglect of children or the elderly
3. Suicide threats or gestures
4. Other legal reasons where the law requires your therapist or NFSB to disclose confidential information.

In addition, if you are in couples or family therapy at NFSB and one member of the couple or family requests a copy of the counseling records, *it is important to understand that both members of the couple and/or all family members 14 years and older must agree to release records to the individual who requests them.*

When the New Jersey Office of Licensing conducts a review of NFSB for the purpose of licensing the agency, a consumer's clinical record may be reviewed for compliance with State standards.

Please refer to the NFSB Notice of Privacy Practices for more information on confidentiality at NFSB.

Initial Appointment/Intake

Your initial appointment at NFSB will consist of time to fill out requisite paperwork and to meet with your therapist for the first time face-to-face.

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Sessions

Session times range from 45 and 55 minutes for psychotherapy. Frequency of sessions is discussed between you and your therapist. **If you must cancel or change an appointment, we ask that you provide at least 24 hours' notice. Failure to do so will result in a $50 cancellation/ "no show" fee. Clients with Medicaid are exempt from this policy.**

Payment

The standard fee for counseling at NFSB is $150.00 per session and $200.00 for the initial intake session. NFSB is a non-profit organization supported by the people of the community it serves as well as by the support of other contributors and foundations. Our policy is that no one is refused service here because of an inability to pay full fee. For those who qualify, based on household income, limited financial assistance (our sliding scale) is available. If you are requesting financial assistance, you will be required to provide us with relevant financial information. Should your financial needs change while you are in counseling, please contact our counseling office and we will be happy to talk with you.

Payment is required before the start of your appointment. We accept cash, check, VISA or Mastercard. By signing the Informed Consent Agreement, you are agreeing to provide payment for services in a timely manner.

Managed Care Organizations/Insurance Plans

Your health insurance may cover part of the costs of our services, but these benefits cannot be paid until approved by your Managed Care Organization (MCO). If you use your health insurance to help pay for your treatment, you must allow your therapist to inform the MCO of information which may include your diagnostic code, the suggested treatment, your progress, and other relevant information. Your Managed Care Organization has forms that your therapist and/or NFSB may need to complete and submit to document your progress for authorization. This information will become part of the MCO's records. MCOs are required by federal law to keep this information private. Additionally, your insurance provider may contract with a business associate to do approvals, billing, and/or risk assessment functions. Your requested health information may be provided to these business associates without additional client consent.

If you are concerned or have questions, you should discuss these issues fully with your insurance company and with your therapist before beginning treatment. You have a choice to pay NFSB directly and not use your health insurance.

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Contacting NFSB

You may reach us at 973-542-8276 during our business hours:

Monday through Thursday	9am – 9pm
Friday	9am – 6pm
Saturday and Sunday	Closed

After hours and on weekends you may leave a message for your therapist or for one of our staff on our voicemail system. Your call will be returned as soon as possible during regular business hours. **Voice mail is not monitored during non-business hours nor on weekends or holidays.**

If there is an emergency for which you require assistance, you are urged to go to your nearest emergency room. Below are some local crisis resources.

Emergency Resources:

1. Care Well Health Medical Center, Psychiatric Emergency Service 973-266-4478 (24/7/365 Hotline)
2. Call 911

Please let us know if you have any questions. In addition to your therapist, all members of NFSB staff are available to discuss any concerns or questions with you.

Grievance Policy

To whom may I talk if I have a grievance about therapy that I can't work out with my therapist? If you feel that you would like to resolve your grievance outside of Nutley Family Service Bureau (NFSB), you may contact the following:

- **Division of Mental Health and Addiction Services** – Toll Free (800) 382-6717
  DMHAS: 222 South Warren St., Capital Place One
  P.O. Box 700 Trenton, NJ 08625-0700

- **Essex County Welfare Department** -973-733-3325
  18 Rector Street, Newark, NJ 07102

- **Essex County Division of Social Services-** 973-395-8375
  465 Dr. Martin Luther King Blvd. Room #102
  Newark, NJ 07102

- **Division of Mental Health Advocacy:** 877-285-2844
  State of NJ Division of Mental Health Advocacy
  Justice Hughes Complex, 25 Market Street, Trenton 08625

- **Division of Mental Health Services Ombudsperson**
  Margaret Molnar
  PO Box 700, Trenton, NJ 08625
  609-984-4813

- **New Jersey Protection & Advocacy** (Disability Rights New Jersey)
  Toll Free (800) 922-7233, (609)292-9742
  210 S. Broad St. – 3rd Floor, Trenton, NJ 08608

- **Community Health Law Project** – (609)392-5553
  225 E. State St.- Suite 5, Trenton, NJ 08608

- **Division of Aging Services – New Jersey Department of Human Services**
  12B Quakerbridge Plaza, PO Box 715, Mercerville, NJ 08625-0715
  For Medicare counseling & general aging services questions: 1-800-792-8820
  For PAAD, Sr. Gold, or Lifeline: 1-800-792-9745
  For access to aging services in your county: 1-800-222-3737

- **Valerie Mielke – Assistant Commissioner for DMHAS**
  Contact Paula Turek, Administrative Assistant: 609-777-0702
  DMHAS- Capital Place One, PO Box 700, Trenton, NJ 08625-0700

- **Joseph Scarpelli: Essex County Mental Health Administrator** 973-571-2821

- **DCP&P (Division of Child Protection & Permanency)** 1(877) 652-2873
  Emergency Reporting

If you would like to resolve your grievance within Nutley Family Service Bureau, you should speak with the Assistant Director and NFSB ombudsperson. She will receive your complaint, act as your advocate, negotiate resolution of the issue, and submit a written report to the Executive Director. If you think that your complaint has not been sufficiently resolved with the help of the Senior Clinical Supervisor/NFSB ombudsperson, then you should feel free to speak directly with the Executive Director.

It is our goal to be helpful to you as best as we can. No adverse action will be taken against any client who files a grievance or complaint with NFSB.

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, and state law, Nutley Family Service Bureau, Inc (NFSB) has created this Notice of Privacy Practices. Your Personal Health Information (PHI) is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that we protect the privacy of your PHI which we have received or created. We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning uses and disclosures we might make of your PHI.

We must comply with the provisions of this notice, although we reserve the right to change our privacy practices and the terms of this Notice, provided such changes are permitted by applicable law. In the event we make a material change in our privacy practices, we will change this Notice and make it available to you. You may request a copy of our Privacy Notice at any time.

USES AND DISCLOSURES OF PHI

The following is an accounting of the ways that we are permitted by law to use and disclose your PHI:

Treatment: We may use or disclose your health information to another healthcare provider providing treatment to you to facilitate your treatment and provide you with the highest quality of care.

Payment: We may use and disclose your health information to obtain payment for services provided to you. Generally, we may use and give medical information to others, usually your health plan(s), to bill and collect payment for services rendered. Before you receive scheduled services, we may share information about these services with your health plan(s) to obtain eligibility information and/or to get the required preapproval. We may also share information with your health plan(s) once services are rendered and the appropriate health insurance claims must be filed. NFSB may also share your health information, to the extent necessary, with an outside billing service, a business associate contracted by NFSB to provide billing services on behalf of our clients and the organization.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, applying for accreditation, certification, licensing/relicensing, or credentialing activities.

The following is an accounting of additional ways in which we are permitted or required to use or disclose PHI about you without your written authorization:

Uses and disclosures as required by law: We may use and disclose PHI about you under a number of circumstances required by law without your right to object. These circumstances include:

- **Required by Law:** When use or disclosure is required by law (i.e., when ordered by a judge for federal, state, or local law or other judicial or administrative proceedings.)
- **Public Health Activities:** When the use or disclosure is necessary for Public Health Activities, we may use or disclose PHI about you to the public health authority that is authorized by law to collect data for the purpose of preventing or controlling disease, injury, or disability.
- **Victims of abuse, neglect, or domestic violence:** We may disclose PHI about you to a government authority if it is reasonably believed that you are a victim of abuse, neglect, or domestic violence, or to report the abuse or neglect, or suspicion of abuse or neglect, of children or the elderly.
- **Serious threat to health or safety of self and/or others:** We may use or disclose PHI about you, if it is believed in good faith and is consistent with any applicable law and standards of ethical conduct to avert a serious threat to safety, health, or the life of an identified individual or group of individuals.
- **Individuals involved in your care:** It is the policy ay NFSB that we may use or disclose PHI to persons involved in a client's care when the client has been given the opportunity to agree or object to the Use and Disclosure; for example, to family members or caregivers. It is the policy of NFSB that, as permitted by the HIPAA regulations, we may rely on the client's informal permission to disclose PHI to those whom the client identifies as being involved with the client's care or payment for care.
- **Health oversight activities:** We may use or disclose PHI about you to a health oversight agency for oversight activities which may include inspections as necessary for licensure, compliance with civil law or other activities the health oversight agency is authorized by law to conduct. It is our policy to redact such information if permissible by law.
- **About the Deceased:** We may disclose PHI about a deceased individual to coroners and medical examiners as required by law. Lastly, when the use of disclosure is needed for an emergency.
- **For Judicial purposes:** When, and only if, ordered by a judge, we may disclose PHI about you during any judicial or administrative proceedings, provided that proper documentation is presented to us.
- **For law enforcement purposes:** We may disclose PHI about you to law enforcement officials for authorized purposes as required by law.
- **Specialized Government functions:** We may disclose your PHI information for military and veterans' activities, national security and intelligence activities and similar special government functions as required or permitted by law.
- **Business Associates:** We may disclose PHI about you to our business associates for services they may provide to us to assist us in providing quality health care. To ensure

the privacy of your PHI, we require all business associates to apply HIPAA appropriate safeguards to any PHI they receive or create.

Other Uses and Disclosures:

- **Fundraising:** If we participate in fundraising activity, including submitting grants and proposals, we may submit aggregated demographic PHI to the institutionally related foundation, individual or entity to clarify our fundraising purpose. We do not use your PHI in our fundraising activities.

All Other Uses and Disclosures:

- We will obtain a written authorization from you for all other uses and disclosures of your PHI, and we will only use or disclose information pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. In any event, this document expires 1 year after it is signed by you.
- **Your Authorization:** In addition to our use of your PHI for the above reasons, you may request and/or give us written authorization to use your personal health information or to disclose it to specific individuals or entities for any purpose.
- If you give us such authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in the notice.
- **Appointment Reminders and Treatment Alternatives:** We may use your health information to provide you with appointment reminders such as voice mail messages or letters, or information about treatment alternatives or other services that may be of interest to you.

YOUR HEALTH INFORMATION RIGHTS:

The following are a list of your rights with respect to your PHI.

- **Right to Request restrictions on certain uses and disclosures of your PHI:** You have the right to request additional restrictions of our uses and disclosures of your PHI. We are not required to accommodate such a request, except that we are required to agree to a request to restrict disclosures to health insurance plans for services you pay for out of pocket.
- **Right to have your PHI communicated to you by alternative means or locations:** You have the right to request that we communicate confidentially with you using an address or phone number other than your residence. However, state, and federal laws require us to have an accurate address and home phone number in case of emergencies. We will consider all reasonable requests.
- **Right to inspect and/or obtain a copy of your PHI:** You have the right to inspect or request a copy of your PHI that is contained in your NFSB record for the duration that we maintain PHI about you, except for psychotherapy notes which are not a part of the record. This request must be in writing. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges. If

you prefer, we will prepare a summary or an explanation of your health information for a fee.

- **The right to amend your PHI:** You have the right to ask for correction or inclusion of a statement of disagreement for anything in our record you feel is in error. Your request must be in writing and include supporting documentation.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations, or where you have provided an authorization, for the last six years. ***If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.***
- **The right to receive additional copies of the Facility's Notice of Privacy Practices:** You have the right to receive additional paper copies of this notice, upon request.
- **Notification of Breaches:** You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES: NFSB reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also make the revised version of this document available in our facility.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with NFSB and/or DMHAS Assistant Commissioner. If you wish to file a complaint with NFSB, please contact the privacy officer listed below. If you wish to file a complaint with DMHAS, please write to: DMHAS: 222 South Warren St, Capital Place One, PO Box 700 Trenton, NJ 08625-0700.

NFSB will not take any adverse action against you because of your filing of a complaint. If you want more information or clarification about our privacy practices, please contact:

Contact Person: Katherine Carmichael, MSW, LSW, MSEd, Executive Director

Telephone:	973-542-8276 Ext 200.
Fax:	973-667-2285
Address:	Nutley Family Service Bureau, 169 Chestnut Street, Nutley, NJ 07110

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I acknowledge that I have received a copy of Nutley Family Service Bureau's *Client Information Brochure* so that I may read it and be fully informed about therapy at Nutley Family Service Bureau, as well as my rights as a client, the *Grievance Policy*, and legal expectations to my confidentiality. As well, I acknowledge that I have received a copy of Nutley Family Service Bureau's *Notice of Privacy Practices*.

If I do not understand my rights, or the *Grievance Policy*, or if I have any questions, I understand that I may discuss my concerns with my therapist, the Program Director, or any member of the Nutley Family Service Bureau staff. If I have any questions about Nutley Family Service's *Notice of Privacy Practices*, I may contact NFSB's Privacy Officer, Katherine Carmichael, MSW, LSW, MSEd, Executive Director, as directed in the *Notice of Privacy Practices*.

Signed: _____ Date:_____

Print Name: _____

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Telemental Health Informed Consent

I _____, **(**name of client**)** hereby consent to participate in telemental health with _____ (name of provider) as part of my psychotherapy. I understand that telemental health is a practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I'm having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ (client's phone number) to discuss since we may have to reschedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of emergency.

I have read the information above and understand the information contained in this form and all my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian: _____ Date: _____

Signature of therapist: _____ Date: _____

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Application for Counseling

Personal Information

Name_____ **Date**_____

Date of Birth _____

Billing Address _____

Physical Address _____

(PO Box is not acceptable, or if you reside on campus, please provide a dorm or campus location)

Contact Telephone Numbers:

Home: _____

Cell: _____

Work: _____

Please indicate preferred contact number between 9am and 5pm Mon.-Fri.

Please initial if you agree to receive text messages _____

Please initial if you agree to allow your minor child to receive text messages_____

Email: _____

Marital Status_____ **Name of Spouse**_____

Dependents:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Person to contact in case of Emergency:

Name_____ Relationship _____ Phone _____

Primary Care Physician:

Name _____ Phone _____

Address: _____

May we contact your physician if necessary to coordinate care? Yes _____ No _____

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Have you or a member of your family ever been seen at NFSB? Yes☐No ☐Unknown_☐__

How did you hear about Nutley Family Service Bureau Counseling? _____

_____

Do you have a service animal? If yes, provide documentation with this paperwork.

_____

_____

Do you have a custody agreement? If yes, provide a copy with this paperwork.

_____

What is your reason for seeking counseling? _____

_____

Have you recently been hospitalized? If so, when was the last hospitalization? _____

_____

Do you have any present or past suicidal/homicidal ideation? Attempt? In the event you are experiencing suicidal/homicidal ideations, please dial 911 or go to your nearest emergency room.._____

_____

Do you have a history of substance use? When? What substance(s)? Have you recently been in treatment? If so, when were you last in treatment? _____

_____

_____

Do you have a history of eating disorder? Have you recently been in treatment? If so, when were you last in treatment?_____

_____

Employment Information:

Applicant Occupation _____ Employer _____

The state of New Jersey, in regulation #NJAC 10:37-6,74(a)5, requires that we ask the following questions:

1. Do you have an Advanced Psychiatric Directive? _____
2. If so, where is the Advanced Psychiatric Directive kept? _____
3. Would you like to be provided with information on advanced directives? _____
4. Do you desire to have an Advanced Psychiatric Directive? _____

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Emergency Protocols

Nutley Family Service Bureau needs to know your location in case of emergency. You agree to inform your therapist of the address where you are at the beginning of each session. Your therapist also needs a contact person who they may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In the case of an emergency, my location is: _____ I understand that for my safety my therapist will require me to confirm my location at the beginning of each session.

In the event of an emergency, my emergency contact person's information is the following:

Emergency contact name: _____

Address: _____

Phone: _____

Fees

Nutley Family Service Bureau is a non-profit organization. Our policy is that no person will be turned away due to an inability to pay our standard fees. Limited financial assistance is available for those who need financial aid. Our fee for the initial intake session is $200.00 and our standard fee per session thereafter is $150.00.

If you require financial assistance, please check here ___ and agree to the statement below:

By initialing below, I agree to provide my most recent tax return to NFSB for the purpose of determining my Sliding Scale/Financial Aid payment. I understand that the fee is determined based upon my household income and family size. I understand that it is my responsibility to continue to provide updated tax return and/or relevant financial information as it changes or becomes available:

If you come to us through a Managed Care Organization, please: **Initial here: _____**

1. Verify your co-pay with your Insurance Provider. This will be the amount due for each session and is payable at the time of each session.
2. If you have a coinsurance obligation (see below) you will need to pay this at the time you receive your Explanation of Benefits (EOB) from your insurance.
3. Complete the NFSB Release of Information form.

If you are utilizing insurance, please check here _____ and agree to the statement below:

By initialing below, I agree to provide my insurance card to NFSB and to continue to provide the most up-to-date insurance information to NFSB for the purpose of payment for services. I understand that by initialing here I am giving NFSB and/or an outside billing agent, working as a business associate of NFSB, permission to bill my insurance carrier for the services I receive.

Initial here: _____

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Name of Insurance Company _____

Relationship to Client: ____ Self ___ Spouse ____ Parent

Name of Insured _____ Date of Birth of Insured _____

Appointments

The staff and clinicians of Nutley Family Service Bureau will make every effort to arrange appointment times that are convenient for you. Specific hours vary by clinicians.

If you must cancel an appointment, please contact the NFSB Counseling Center office, at least 24 hours in advance. Failure to give adequate notice of cancellation or failure to show up for appointments may result in a $50 "No Show/Late Cancel" fee.

Contacting NFSB

You may reach us at 973-542-8276 during our business hours:

Monday through Thursday	9am – 9pm
Friday	9am – 6pm
Saturday and Sunday	Closed

After hours and on weekends you may leave a message for your therapist or for one of our staff on our voicemail system. Your call will be returned as soon as possible during regular business hours. Voice mail is not monitored during non-business hours nor on weekends or holidays. In the event of an emergency, **please dial 911 or go to your nearest emergency room**.

Client Informed Consent Agreement

- I have received a copy of the Client Information Brochure, including my legal and ethical rights and responsibilities.
- I understand that if I have questions about my therapy or about any of my rights or concerns, I can talk with my therapist, the Senior Clinical Supervisor and/or the Executive Director at any time.
- I understand that I may revoke my informed consent at any time, for any reason.
- I understand that laws regulating the client-therapist relationship provide that the following topics of information cannot be considered confidential:
    1. Threats against the physical well-being or life of another person.
    2. Abuse or neglect of children or the elderly.
    3. Suicide threats or actions.
    4. Other legal reasons where the law requires my therapist to disclose confidential information.
- I understand that I may terminate this therapy relationship at any time. I also realize that my therapist can determine that the relationship is no longer a good therapeutic fit and would at that time provide me with referrals to other treatment professionals if I so request.

- I understand that if I choose to use insurance, specific information required by my managed care or insurance company, or their business associates will be provided to them so that I may use my insurance benefit.
- **I understand that my signature below indicates that I will not seek to subpoena material disclosed in counseling sessions for the purpose of litigation.**
- I understand that **I am responsible for knowing the terms of my fee** and what I am responsible for paying for the service I am provided and **agree that I will pay these obligations to NFSB.**
- I understand that NFSB clinicians and staff are **only available during NFSB business hours**. If I am experiencing an emergency, after hours, on a weekend, or on a holiday. I will go to my nearest emergency room and/or call 911.
- I understand that NFSB uses an authorized, certified billing service and agree to allow NFSB to release any protected health information required for insurance and billing purposes.

I have read, understand, and agree to the above.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian if applicable: _____Date:_____

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Health History

Client Name: _____ Date of Birth: _____

Are you currently experiencing any physical health problems? Yes _____ No _____

If yes, please specify: _____

_____

Please list any past physical health problems (if any): _____

_____

Please list all prescription and non-prescription medication taken, including dosage and frequency:

Medication	Dosage	Frequency

Have you experienced any allergic reactions to any medications? If yes, please explain:

_____

_____

Have you experienced any side effects from medications? If yes, please explain:

_____

_____

Client Signature: _____ Date: _____

Nutley Family Service Bureau
Counseling Center
155 Chestnut Street, Nutley, NJ 07110
(t) 973-667-1884 (f) 973-667-2285
www.nutleyfamily.org

Authorization to Release or Receive Medical, Psychiatric, Substance Use Records, and HIV-Related Information

PATIENT INFORMATION:

Patient/Client Name: _____

(If you are the parent/guardian please only write the name of the Nutley Family Service Bureau (NFSB) client.)

Date of Birth: _____ SSN: _____ Telephone: _____

Maiden name/Other name used in the: _____

Dates of treatment covered by this authorization: From: _____ To: _____

EXPLANATION:

This authorization confirms to requirements of State and Federal laws governing release and receipt of Protected Patient Health Information (PHI).

AUTHORIZATION:

I hereby authorize the following healthcare provider/agency to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged.

FROM: Name: **Nutley Family Service Bureau – Counseling Center**

Address: **155 Chestnut Street**

City, State, Zip: **Nutley, New Jersey 07110**

Please clearly print the name and address of the party you wish to receive your medical records. Please check all the following that apply:

_____ I authorize the below named person to participate in my psychotherapy session (s).
_____ I authorize phone consultation only with the below named person.
_____ Please forward the requested medical records:

TO: Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Re: Self _____ Minor Child _____ Other _____

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INFORMATION TO BE RELEASED OR RECEIVED:

Please be aware that any items which are not checked CANNOT be included in the record released to the above named.

I give authorization to release or receive information regarding:

Substance use _____ HIV Information _____ Psychiatric/Mental Health _____

Disclosure shall include the following types of information. Check all that apply:

____ Evaluations/Assessments/Treatment Plans

____ Outpatient Records, including: Progress Notes and Termination Summary

____ Lab Reports

____ Inpatient Records

____ Other (Please be specific) _____

Exception(s): Information that you do not want released or received. Specifically list below any information or parts of your record that should not be sent to the above named:

Please initial here if there are no exceptions: _____

I understand that such information cannot be released or received without my special consent, except when required by law, and that all restrictions contained in this authorization as to use, transfer, or disclose of such information apply to such records.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Nutley Family Service Bureau. I understand that the revocation will not apply to information that has already been released or received in response to this authorization.

If you want to specify a date on which the release will become invalid. If you do not wish to specify, this authorization expires one year from date signed.

***Date of Expiration: _____**

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PROHIBITION OF USAGE, TRANSFER, OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released or received for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:

I understand that I have the right to receive a copy of this signed authorization.

I have received a copy of this authorization: _____ yes _____ no

I understand that authorizing the use of disclosure of this information identified above is voluntary.

Signature of patient/client: _____ **Date**: _____

Signature of guardian/legal representative (required for clients under 18 years of age):

_____ **Date:** _____

If signed by legal representative, please explain authority/relationship to patient: _____

_____

MINORS: By federal regulations in drug/alcohol abuse or HIV/AIDS related material both the patient/client and parent/guardian, or other person authorized to act by state law in his/her behalf is required.

EXCEPTIONS: Where minor may consent to treatment by state law, only minor must sign.