



**CogniCare Psychological Services LLC**  
**971 US 202, Suite 3**  
**Branchburg, NJ 08876**

**Phone: (908) 800-9590**

**Email: [info@cognicarepsych.com](mailto:info@cognicarepsych.com)**

**Fax: (908) 255-4687**

**Important Information and Client Consent: Please read and sign at the end stating you have fully read and understand the information below.**

**CLIENT/THERAPIST RELATIONSHIP:** You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

**AVAILABLE SERVICES:** CogniCare offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, licensed clinical social workers, and Doctors of Psychology. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

**RISKS AND BENEFITS:** Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. However, the benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

**COUNSELING:** We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that CogniCare can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.



The goal of CogniCare is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

**APPOINTMENTS:** Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at (908) 800-9590 at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

**FEE SCHEDULE:**

- \$200 Diagnostic & Evaluation Session (1<sup>st</sup> visit)
- \$150 Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)
- \$10 Written Reports

A reasonable fee will be charged for copies of any records requested by the Client.

**PAYMENT/INSURANCE FILING:** Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, CogniCare will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.



**EMERGENCIES:** You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

**CONFIDENTIALITY:** CogniCare follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. To ensure your confidentiality, recording audio or video in your session without the written consent of your therapist is prohibited. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

**DUTY TO WARN/DUTY TO PROTECT:** If my Therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give



consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name

Telephone Number

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**INCAPACITY OR DEATH:** I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

**CONSENT TO TREATMENT:** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

**NOTE:** If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, CogniCare will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Signature – Client/Parent

Date

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Signature – Spouse/Partner/Parent

Date

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Therapist

Date



**I hereby authorize the release of necessary medical information for insurance reimbursement purposes.**

Client/Parent

Date

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**I authorize the payment of medical benefits to the provider of services.**

Client/Parent

Date

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## Adult Information Form

Name  Pronouns	Date of First Appointment	Therapist
Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> M2F <input type="checkbox"/> F2M <input type="checkbox"/> Non-binary/Non-conforming <input type="checkbox"/> Other: _____



Name of Primary Care Physician	Physician's Phone
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Physician's Address

Many managed care companies require that we interact with the client's physician to coordinate care. Do you give us consent to discuss your care with the above-named doctor?  YES  NO

Please sign here for either answer

Date of last medical evaluation	Date of next appointment
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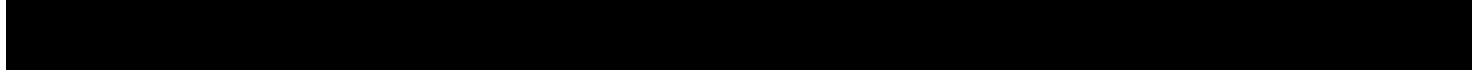
Name of medication	Dosage/Frequency	Start Date	Purpose	Prescribed By
1.				
2.				
3.				
4.				



Have you ever been hospitalized for medical or psychiatric reasons?  YES  NO



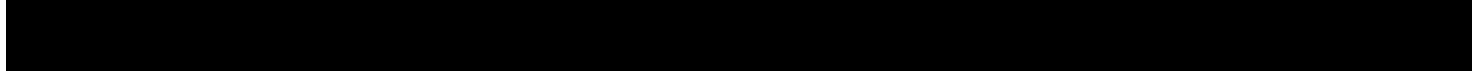
Hospital	Month/Year	Reason
1.		
2.		



Do you use recreational drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO	If no, have you used previously? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you stop?
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Type of Drug	How Much	How Often
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1.		
2.		
3.		

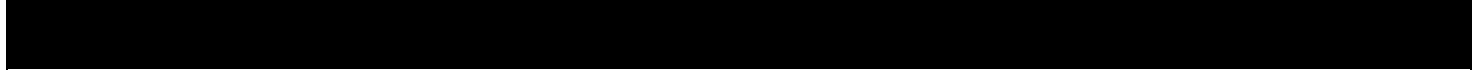


Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO	If no, did you drink previously? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you stop?
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Type of Alcohol	How Much	How Often
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1.		
2.		

Do you smoke cigarettes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you smoke electronic cigarettes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use other forms of tobacco? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO
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Describe any important medical history, chronic ailments, or other health problems you experience:



Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

Did you experience any developmental, academic, or behavior problems as a child or while in school, with peers or teachers?

YES  NO

If yes, please explain:

What was the last year of school you completed?

If you did not complete high school, please explain:

Please list schools currently attending, last attended, and graduated:

Currently attending:

Year(s)





Last attended:	Year(s)
Graduated:	Year(s)
How would you describe your current support network? (friends, relatives, etc.):	
Please check all information which applies to your biological parents:	
<b>MOTHER</b>  <input type="checkbox"/> living <input type="checkbox"/> deceased <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> remarried ___ # of times	<b>FATHER</b>  <input type="checkbox"/> living <input type="checkbox"/> deceased <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> remarried ___ # of times
Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? <input type="checkbox"/> YES <input type="checkbox"/> NO    If so, whom? _____	
Where do your parents live?  Mother:  Father:	
Describe your relationship with your mother while growing up:	
Describe your relationship with your mother currently:	



Describe your relationship with your father growing up:

Describe your relationship with your father currently:

List first names and ages of brothers and sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)

Describe any family problems which occurred while growing up relating to:

Alcohol / drug abuse:

Sexual / physical / emotional abuse:



Relationship status:  Single / never married  Married  Separated  Divorced  Widowed  Partnered

If currently married, when were you married?

If living with someone, how long?

Please list your children:

Name	Age	Relationship (biological/step)	Lives With

Please check any of the following that describe how you have been feeling lately:

<input type="checkbox"/> sad	<input type="checkbox"/> anxious	<input type="checkbox"/> depressed	<input type="checkbox"/> frightened	<input type="checkbox"/> guilty	<input type="checkbox"/> angry	<input type="checkbox"/> ashamed	<input type="checkbox"/> aggressive	<input type="checkbox"/> resentful
<input type="checkbox"/> worthless	<input type="checkbox"/> tearful	<input type="checkbox"/> irritable	<input type="checkbox"/> confused	<input type="checkbox"/> extreme ups/downs	<input type="checkbox"/> jealous	<input type="checkbox"/> hopeless	<input type="checkbox"/> helpless	<input type="checkbox"/> other

Describe any other feelings you have had:

What activities or hobbies do you participate in?



Do you participate in regular exercise? YES NO

Describe:

Describe your current working environment:

Have you had any change in sleeping habits? YES NO

Describe:

Have you had any change in eating habits? YES NO

Describe:

Have you ever **considered suicide** in connection to your **current** problem? YES NO

If so, please give a brief description with dates:



Have you ever **considered suicide** in the **past**? YES NO

If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? YES NO

If so, please give a brief description with dates:

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? YES NO

If yes, please explain:

Have you ever **considered homicide** in the **past**? YES NO

If yes, please explain:



List or describe any current impediments or problems in daily psychological, social, or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, problems with supervisor, etc.):

**THOUGHTS:** Please check any of the following that apply to you:

- I sometimes hear voices even though no one nearby is talking to me.
- I sometimes feel that forces outside of me control me.
- I sometimes feel that other people control my thoughts.
- I sometimes have the same thought over and over and cannot control it.
- I sometimes feel that someone is out to hurt me or do something against me.
- I am sometimes unable to control my behavior.

Please explain:



Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.



## Consent to Use PHI for Treatment, Payment and Healthcare Operations

With my consent, CogniCare may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to CogniCare Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. CogniCare reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CogniCare.

With my consent, CogniCare may call my cell phone or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, CogniCare may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, CogniCare may e-mail to me my appointment reminder cards and patient statements. I have the right to request that CogniCare restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for CogniCare to use and disclose my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, CogniCare may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

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Print Name of Patient

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Staff Member Signature

Date

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## HIPAA Authorization Form

I, (name) \_\_\_\_\_, whose date of birth is \_\_\_\_\_, authorize CogniCare to disclose to and/or obtain information from the following \_\_\_\_\_ regarding (client name) \_\_\_\_\_:

Description of Information to be Disclosed  
(Patient/Client should initial each item to be disclosed.)

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment                | <input type="checkbox"/> Testing Information                 |
| <input type="checkbox"/> Diagnosis                 | <input type="checkbox"/> Educational Information             |
| <input type="checkbox"/> Psychosocial Evaluation   | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Psychological Evaluation  | <input type="checkbox"/> Continuing Care Plan                |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Progress in Treatment               |
| <input type="checkbox"/> Current Treatment Update  | <input type="checkbox"/> Other _____                         |

### Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_

### Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to 971 US 202, Suite 3, Branchburg, NJ 08876. I further understand that a



revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**

Unless sooner revoked, this authorization expires on \_\_\_\_\_, or as otherwise indicated:

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**Conditions**

I further understand that CogniCare will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

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**Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

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I will be given a copy of this authorization for my records.



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Signature of Client

Date

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Signature of Parent, Guardian, or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

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\_\_\_\_\_ Check here if client refuses to sign authorization.

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Signature of Staff Witness

Date



## Policy Regarding Cancellations and Payments

Your appointment time is especially reserved for you. I do not double book appointments, but give each patient my full attention and time for the entire appointment. If you do not cancel your appointment or do not show up for it, I'm unable to see another client because the time slot was allotted specifically for you. That is the reason for the following policies:

1. If an appointment needs to be cancelled or rescheduled, I would ask you to provide as much notice as possible but **AT LEAST TWENTY-FOUR (24) HOURS IN ADVANCE**. A **\$85 no show** fee will be charged for appointments cancelled with less than 24 hours advanced notice.
2. If you do not show up for your appointment, you will be charged a No-Show fee of \$85.
3. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.
4. Repeated late cancellation of appointments and/or failure to keep scheduled appointments by a patient may make it impossible for me to continue serving that client.
5. If you are late to the appointment, I will still have to end the session at the allotted time.
6. I understand that I am responsible for knowing my co-payment amount and deductible amount.

Signing this form acknowledges that you understand and agree to the cancellation policy.

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Signature of Client

Date



## Social Media Policy

This document outlines my office policies related to use of social media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to interactions that may occur between us on the Internet. Please discuss any questions or concerns you may have with your therapist.

### **Separate Accounts**

All therapists hold separate and isolated accounts to be used for the sole purpose of professional matters regarding CogniCare. These accounts are separate from any personal accounts held by therapist as an individual.

### **Email**

Please use email to contact me for administrative reasons only (modifying appointments, billing information, etc.). Please remember that if you email content related to our counseling sessions, it is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your mental health record.

### **Text Messages**

Please do not send text messages, unless otherwise agreed upon. Any text message I receive from you becomes a part of your mental health record.

### **Friending**

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.

### **Following**

I will not follow any client on Facebook, Twitter, Instagram, Tumblr, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

### **Search Engines**

It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites.



### **Location-Based Services**

To protect your privacy, do not check-in at my office on Facebook, Foursquare, Google+, or any other location-based service. If you have enabled location services on your mobile phone, check-ins on such services could make it possible for others to surmise you are a counseling client at my office location.

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(Printed name of client)

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(If child is a minor, signature of parent or legal guardian)

(Date)

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(Signature of client if 18 years or older)

(Date)

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(Staff Witness)



## This Notice Describes How Medical Information About You May Be Used and Disclosed and How Can You Get Access to This Information

### **PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.



For Health Care Operations. **We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.**

**Required by Law.** Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

**Abuse and Neglect**

**Judicial and Administrative Proceedings**

**Emergencies**

**Law Enforcement**

**National Security**

**Public Safety (Duty to Warn)**

Without Authorization. **Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:**





- **Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)**
- **Required by Court Order**
- **Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.**
- 

Verbal Permission. **We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.**

With Authorization. **Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.**

#### YOUR RIGHTS REGARDING YOUR PHI

- **Right of Access to Inspect and Copy**  
You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend**  
If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**  
You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**  
You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication**  
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.



- **Breach Notification**

If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself

- **Right to a Copy of this Notice**

You have the right to a copy of this notice.

**The effective date of this Notice is \_\_\_\_\_.**



## Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of CogniCares Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the CogniCare at (908) 800-9590.

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Signature of Patient/Client

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Signature of Parent, Guardian, or Personal Representative\*

Date

*\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

*Patient/Client Refuses to Acknowledge Receipt:*

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Signature of Staff Member

Date



## Request For Access to Protected Health Information (PHI) Form

I, \_\_\_\_\_, whose date of birth is \_\_\_\_\_, Street  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Social Security Number \_\_\_\_\_ Phone Number  
\_\_\_\_\_

Request that the following information be disclosed to me:

Description of information to be disclosed  
(Patient/Client should initial each item to be disclosed.)

- Review my client/medical records
- Copy my records
- Review and copy my records

Possible denial of request

While Federal HIPAA (Health Information Portability and Accountability Act) regulations give you the right to access your protected health information, denial of access may apply to the following:

- a. Psychotherapy notes;
- b. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or other legal matter;
- c. When Therapist is acting under the direction of a court order;
- d. PHI was obtained from someone other than a health care provider under a promise of confidentiality.



In addition, the provider may deny request if:

- a. The disclosure may endanger the life and physical safety of the client or another person referenced in the PHI.

When a request to access PHI is denied in part, the therapist or health provider will give the individual access only to other protected health information that is not excluded or denied.

When an individual is denied access to all protected health information, the Therapist or health provider will issue a denial letter to the individual requesting access.

**Expiration**

Unless sooner revoked, this request expires on \_\_\_\_\_, or as otherwise indicated:

**Conditions**

I further understand that Cognicare will not condition my treatment during or after pendency of this request.

I will be given a copy of this request for my records.

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Signature of Client Date

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Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

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Signature of Staff Witness

Date



## What To Expect on Your First Visit

Your first visit will consist of an interview between you and your Therapist in which the two of you will determine if the Therapist is a good fit for your counseling needs. If you and the Therapist agree that the Therapist is not right for you, the Therapist will refer you to another Therapist.

Fees and times may seem incidental to the actual therapy, but consistency in the temporal aspect of the frame contributes greatly to your sense of security. If your schedule is constantly changing, you will find that it is difficult to get any work done in therapy, and you will likely find yourself with subtle feelings of discomfort. If, however, these details remain solid and secure, your unconscious mind will see your Therapist as healthy, consistent, safe, strong, and devoted to your care.

**SCHEDULE and TIME:** The usual appointment schedule is once a week, though you and your Therapist may decide to meet every other week. At your first session, you and the Therapist should agree on a regular day and time for your appointment. Therapy sessions are typically 45 or 50 minutes. To maintain the secure frame, your Therapist will hold you to that time. If you arrive late, you still must stop at the agreed time. If, on the other hand, the Therapist is late, he/she should give you the full appointment time.

Your absences and lateness, as well as persistent silence, wanting to leave therapy, forgetting to pay, or delaying payment, are often symptoms of "resistance," or fighting therapy. These may (or may not) reflect outside issues and should be discussed with your Therapist. In most cases, you will be responsible for paying for any regularly scheduled sessions that you miss or cancel; you are not responsible for paying for sessions cancelled by the Therapist.

**FEES:** At your first session, the Therapist will inform you of the counseling fee. Fees vary *enormously* with the geographical area, the Therapist's qualifications, and the setting. Your health insurance may pay a portion of the fee. For your own mental health, you should keep your account current and paid up to date.

**UNATTENDED CHILDREN:** Due to the nature of the therapeutic process, a quiet, peaceful, and private atmosphere is necessary. We have found that children left in the waiting area while parents are in session may be disruptive to other waiting clients as well as other clients in session and may also be a distraction to our office staff. Therefore, it is our policy that no children be left unattended in our offices at any time. If you must bring your child(ren) with you to an appointment, please bring another adult (over age 18) to stay with them during your session. If you are unable to do so, please reschedule your appointment at a time when arrangements can be made for the care of your child(ren). Also, if your child is the client, the Therapist may wish to have a private consultation with you during the appointment time. In this instance, your Therapist



will advise you in advance so that you may bring another adult with you to that appointment to wait with your child during the consultation.

**CELL PHONE USE:** To protect the privacy and therapeutic process of our clients and maintain the appropriate clinical atmosphere, we ask that you turn off your cell phone while in our offices. Should you need to make a call, you may either step outside the building to make the call or use one of our office telephones. However, it is best if you can postpone any telephone calls until your appointment is concluded.

**PRIVACY AND CONFIDENTIALITY:** It should go without saying that you can expect absolute privacy and confidentiality. Under no circumstances may your Therapist ever reveal, without your permission, even the fact that you are a client, let alone any information at all about you or your case, to anyone. There may be instances when you choose to allow information to be released; in that case, your Therapist should obtain a signed consent form from you. If your therapy is provided as an employment benefit, there should be no requirement for the Therapist to report back to an employer about your progress. Managed health care programs increasingly intrude on this.

**TERMINATION:** In most cases, you will be the one to decide when it is time to stop therapy. This decision should be discussed in great depth with your Therapist to make sure you are not terminating prematurely as an unconscious reflection of some important issue in your life. If, however, you both agree that problems have been resolved and termination is appropriate, set a specific date for termination and stick to it. The frame should remain absolutely intact right to the end. After terminating, you have no further contact with your Therapist unless you experience some new emotional disturbance, in which case you