THE WOMEN'S WELLNESS CENTER OF BERGEN COUNTY

Welcome to The Women's Wellness Center. Thank you for choosing us for your behavioral health needs. We know you have many choices and we appreciate the trust you put in us.

We thank you in advance for downloading and completing the paperwork prior to your first session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues. Please bring completed paperwork to your first session.

Some things to keep in mind:

• Remember, you can download and print, review, or ask for a complete set of The Women's Wellness Center Privacy Policies.
• Your therapist will review and answer any questions about this paperwork or other matters.
• We will need your primary care physician name and telephone number.
• If you have seen a therapist or psychiatrist within the last two years, we will will ask for a telephone number to contact them with your permission.

Please list your goals:

_____
_____
_____
_____

CLIENT INFORMATION

NAME: _____

ADDRESS: _____
street city state zip

BIRTH DATE:_____ AGE:_____ GENDER: MALE FEMALE

SOCIAL SECURITY #: _____

RELATIONSHIP STATUS: MARRIED ____ SEPARATED _____SINGLE____
DIVORCED____ COHAB_____.

I AGREE TO PAY THE AGREED UPON FEE AT EACH SESSION

_____ _____

SIGNATURE DATE

CONTACT INFORMATION:

EMAIL ADRESS: _____

HOME PHONE:_____ CELL PHONE: _____WORK:_____

PRIMARY CARE PHYSICIAN:

DOCTOR'S NAME:_____

DOCTOR'S PHONE:_____

DOCTOR'S ADDRESS:_____

WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?

NAME:_____

PHONE:_____

RELATIONSHIP TO YOU: _____

PAYMENT & CANCELLATION POLICY

Due to the high cost of billing, we ask that all fees be paid at the time of each session.

K**indly give 24 hours notice if you need to cancel an appointment or $100 will be charged for time reserved.** We understand that emergencies such as illness, come up from time to time, therefore we will allow for one cancellation in less than 24 hours without a charge. After that one grace session you will be charged the $100 fee for any missed session without 24 hours cancellation.

FEES

Individual Therapy Session (50 minutes) $125
Couples/or Family Therapy Session (75 minutes) $160

CREDIT CARD INFORMATION

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

NAME ON CARD:

CREDIT OR DEBIT CARD NUMBER:

EXPIRATION:

BILLING ZIP CODE:

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

_____ _____
Signature Date

Privacy and Procedures

In order to make our time together the most valuable it can be here is some information you should know about our center. Please make a copy of this information for your records but bring all its contents to your first session

Contacting Us: You may contact TWWC during regular business hours and someone will return your call promptly (usually within 24 hours). If you need to cancel an appointment you may leave that information on our voicemail. If you have an emergency crisis and you do not get your clinician on the phone right away, please hang up and call 911 or your local emergency room.

Professional Records: The laws and standards of healthcare require that we keep Protected Health Information about you in your Clinical Record. Except in an unusual circumstance that involve danger to yourself/and or others or when an individual is referenced and we believed disclosing that information puts the other person at risk of substantial harm, you may examine or receive a copy of your Clinical Record. You may receive this copy if you put the request in writing. However, because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your clinician's presence, or have them forwarded to another mental health professional so you can discuss its contents. We charge a copying fee of $1 per page.

Patient Rights: HIPAA provides you with several expanded rights with regard to your Clinical Records and disclosures of protected health information (PHI). These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to or authorized; the location to which PHI disclosures were sent, recourse to any complaints you have about the policies and procedures we have pertaining to the care of your PHI, the to a paper copy of this Agreement (the attached Notice Form) and our privacy policies and procedures. Our clinician will be happy to discuss any of these rights with you.

Confidentiality: In general, our work together is private and the law protects this privacy. In most situations, we can only release information about your treatment to other is you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are situations that require only that you provide only written advanced consent.

There are some situations which may involve revealing some information about your treatment and which we are LEGALLY obligated to take action. These situations are unusual in our practice but include:

- If we have reasonable cause to believe that a child has been subject to abuse, the law requires that we must report it to the Division of Youth and Family Services. Once such a report is filed we may be required to provide additional information.

- If we have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and we believe that the disclosure is necessary to prevent serious harm to that adult or other potential victims, we will report the information to the county adult protective service provider. Once such report is filed, we may be required to provide additional information.

- If a patient communicates a threat, or if we believe the patient presents a threat of imminent serious or physical violence against a readily identifiable individual, we may be required to make protective actions. These actions may include notifying the potential victim, contacting the police or seek their hospitalization.

- If we believe a patient presents a threat of imminent serious physical harm to him/herself, we may be required to take protective actions. These actions may include contacting the police or others who could assist in protecting the patient or obtain hospitalization for them.

Signature Page (Privacy and Procedures)

If you have any further questions or concerns about the above stated confidentiality exceptions please ask your clinician. If she cannot provide adequate information we will refer you for legal advice.

Again thank you for choosing The Women's Wellness Center of Bergen County we hope that the above information provided makes you an informed consumer of behavioral health services. Please bring this page to your first appointment.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS INFORMATION AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature Date

_____

Print Name

Authorization to Release

Psychotherapy Information

This form is signed and completed by you, authorizing The Women's Wellness Center of Bergen County to release protected health information from behavioral health records to the person(s) you designate.

I authorize The Women's Wellness Center to release/discuss assessments, progress notes, and treatment plans.

This information should only be released to (PLS PRINT NAME, PHONE AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN, REFERRING DOCTOR AND OR PSYCHOTHERAPIST IF APPLICABLE TO WHOM THE INFORMATION BE RELEASED).

_____
_____
_____
_____

I am requesting The Women's Wellness Center of Bergen County to release this information for the purpose of treatment collaboration and continuity.

This authorization shall remain in effect until termination of treatment.

You have the right to revoke this authorization, in writing, at anytime by sending written notification to our office's address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPA Privacy Rule.

I wish to make no designation at this time _____

_____ _____

Signature Date

_____ _____

Signature of Witness Date